



Waitemata
District Health Board

Best Care for Everyone

Community and Public Health Advisory Committees Meeting

Wednesday, 16th October 2013

2.00pm

Venue

**Waitemata District Health Board
Boardroom
Level 1, 15 Shea Tce
Takapuna**

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind

As we seek to be of service to those in need.

Give us the courage to do what is right and help us to always be aware

Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

**AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
16th OCTOBER 2013**

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna

Time: 2.00pm

COMMITTEE MEMBERS

Lee Mathias - Committee Chair (ADHB Deputy Chair)
Warren Flaunty - Committee Deputy Chair (WDHB Board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Deputy Chair
Jo Agnew - ADHB Board member
Peter Aitken - ADHB Board member
Judith Bassett – ADHB Board member
Pat Booth - WDHB Board member
Susan Buckland - ADHB Board member
Chris Chambers - ADHB Board member
Sandra Coney - WDHB Board member
Rob Cooper - ADHB and WDHB Board member
Robyn Northey - ADHB Board member
Christine Rankin - WDHB Board member
Allison Roe - WDHB Board member
Gwen Tepania-Palmer – WDHB Board member
Tim Jelleyman - Co-opted member
Eru Lyndon - Co-opted member

MANAGEMENT

Dale Bramley - WDHB, Chief Executive
Ailsa Claire – ADHB, Chief Executive
Debbie Holdsworth – ADHB and WDHB, Director Funding
Simon Bowen – ADHB and WDHB, Director Health Outcomes
Naida Glavish – ADHB and WDHB Chief Advisor, Tikanga
Paul Garbett - WDHB, Board Secretary

Apologies: Rob Cooper (leave of absence)

AGENDA

KARAKIA

DISCLOSURE OF INTERESTS

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that might give rise to a conflict of interest with a matter on the agenda?

Items to be considered in public meeting

All recommendations/resolutions are subject to approval of the ADHB and WDHB Boards.

2.00pm (please note agenda item times are estimates only)

	1 AGENDA ORDER AND TIMING	
	2 CONFIRMATION OF MINUTES	
2.05pm	2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 04/09/13	1
	3 DECISION ITEMS	
2.10pm	3.1 Cervical Screening Update	10
	4 INFORMATION ITEMS	
	5 STANDARD MONTHLY REPORTS	
2.30pm	5.1 Planning and Funding Update	24
2.45pm	6 GENERAL BUSINESS	

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Professor (Adjunct) of Leadership – University of Auckland Business School Co-Director – New Zealand Leadership Institute Deputy Chair – Health Benefits Limited Independent Chairman – Tonkin & Taylor Chair – Auckland District Health Board Chair – Waitemata District Health Board Chairman – Auckland Transport	01/11/12
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Board Member – Health Workforce New Zealand Board Member, AUT Millennium Ownership Trust Chair – Social Services Online Trust Board Member – The Rotary National Science and Technology Trust	28/09/11
Jo Agnew	Professional Teaching Fellow – University of Auckland Casual Staff Nurse – Auckland District Health Board	12/10/11
Peter Aitken	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd Shareholder/Director – Pharmacy New Lynn Medical Centre	15/05/13
Judith Bassett	Nil	09/12/10
Pat Booth	Consulting Editor – Fairfax Suburban Papers in Auckland	24/06/09
Susan Buckland	Self employed – Writing, editing and public relations services Professional Conduct Committee member – Medical Council of New Zealand Professional Conduct Committee member – Occupational Therapy Board Member – Northern Regional Ethics Committee	12/10/11
Chris Chambers	Employee – Auckland District Health Board (wife employed by Starship Trauma Service) Clinical Senior Lecturer – Anaesthesia Auckland Clinical School Associate – Epsom Anaesthetic Group Member – ASMS Shareholder – Ormiston Surgical	20/04/11
Sandra Coney	Elected Member – Chair, Parks Committee, Auckland Council	02/05/11
Rob Cooper	Board Member – Auckland District Health Board Board Member – Waitemata District Health Board Chief Executive – Ngati Hine Health Trust Advisory Board Member – James Henare Research Centre, University of Auckland	19/09/12
Warren Flaunty	Member of Henderson – Massey, Rodney and Upper Harbour Local Boards, Auckland Council Trustee - West Auckland Hospice Trustee - Waitakere Licensing Trust Shareholder - Metlifecare Shareholder - EBOS Group Shareholder – Pharmacy Brands Ltd Shareholder – Westgate Pharmacy Ltd Chair – Three Harbours Health Foundation Director – Trusts Community Foundation Ltd	20/03/13
Lee Mathias	Managing Director – Lee Mathias Ltd Director – Midwifery and Maternity Providers Organisation Ltd Shareholder/Director – Pictor Ltd Director – John Seabrook Holdings Ltd Governance Advisor – AuPairlink Ltd Council member – NZ Council of Midwives Chair – Tamaki Transformation Transitional Board Chair – Health Promotion Agency Board Chair – iAC IP Ltd Chair – Health Vision Ltd	18/07/13

Robyn Northey	Project management, service review, planning etc. – Self employed Contractor Board member – Hope Foundation Northern Region Trustee, A+ Charitable Trust	18/07/12
Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Director – The Transformational Leadership Company CEO – Conservative Party	17/05/13
Allison Roe	Shareholder – Optimisewellbeing.com Founding member – Breast Health Foundation Director – Spiritus NZ Trustee – Allison Roe Trust Founder – Takapuna 2020 Community Group Board member – North Shore Hospital Foundation	28/03/11
Gwen Tepania-Palmer	Chairperson – Ngatihine Health Trust, Bay of Islands Committee Member – ACC's ERMG Committee Life Member-National Council Maori Nurses Alumni – Massey University MBA Director – Manaia Health PHO, Whangarei Board Member – Auckland District Health Board Committee Member – Lottery Northland Community Committee	11/03/13
Co-opted Members		
Dr Tim Jelleyman	Head of Division (Medical) - Child Women and Family Services, WDHB Member - Active Clinic Network for Greater Auckland Integrated Health Network Member - ASMS Chair - Child Health Network, Northern Regional Health Plan Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland	13/03/13
Eru Lyndon	Honorary Research Fellow – Auckland University Member – AUT Business School Industry Advisory Committee Regional Commissioner, Social Development, Northland - Ministry of Social Development Director – Tamaki Development Company	01/05/13

**Auckland and Waitemata District Health Boards
Community and Public Health Committees
Member Attendance Schedule 2013**

NAME	FEB	MAR	MAY	JUNE	JULY	SEPT	OCT	NOV
Lee Mathias (ADHB / WDHB combined Committees Chair and ADHB Deputy Chair)	✓	✓	✓	✓	✓	✓		
Warren Flaunty (ADHB / WDHB combined Committees Deputy Chair)	✓	✓	✓	✓	✓	✓		
Dr Lester Levy (ADHB and WDHB Chair)	✓	✓	✓	✓	x	✓		
Max Abbott (WDHB Deputy Chair)	✓	✓	✓	✓	✓	✓		
Jo Agnew	✓	✓	✓	✓	✓	✓		
Peter Aitken	x	✓	✓	✓	✓	✓		
Judith Bassett	✓	✓	✓	✓	✓	x		
Pat Booth	✓	✓	✓	✓	x	✓		
Susan Buckland	✓	x	✓	✓	✓	✓		
Chris Chambers	✓	✓	✓	✓	✓	✓		
Sandra Coney	✓	✓	✓	✓	x	✓		
Rob Cooper	^	^	✓	✓	x	^		
Robyn Northey	✓	✓	✓	✓	✓	✓		
Christine Rankin	✓	✓	✓	✓	✓	✓		
Allison Roe	x	✓	✓	✓	✓	✓		
Gwen Tepania-Palmer	✓	x	x	✓	x	x		
Co-opted members								
Dr Tim Jelleyman	✓	✓	x	✓	✓	✓		
Eru Lyndon	x	x	✓	x	x	✓		

x absent

^ leave of absence

** attended part of the meeting only*

absent on Board business

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 04th September 2013

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 04th September 2013 be approved.

Note: The public excluded minutes of the above meeting are included under separate cover with Committee members' copies of this agenda. It is suggested that, unless there are any issues which require discussion, approval of the public excluded minutes could be incorporated in the above resolution, without moving into public excluded session.

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 4 September 2013

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna,
commencing at 2.05p.m.

COMMITTEE MEMBERS PRESENT:

Lee Mathias (Committee Chair) (ADHB Deputy Chair)
Warren Flaunty (Deputy Committee Chair) (WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair)
Max Abbott (WDHB Deputy Chair)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Pat Booth (WDHB Board member) (present until 3.15p.m)
Susan Buckland (ADHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member) (present until 3.23p.m)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Allison Roe (WDHB Board member)
Tim Jelleyman (Co-opted member)
Eru Lyndon (Co-opted member) (present from 2.15p.m)

ALSO PRESENT:

Ailsa Clare (ADHB, Chief Executive)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Stuart Jenkins (ADHB and WDHB, Clinical Director, Primary Care)
Andrew Old (ADHB, Medical Advisor, Public Health Medicine)
Tim Wood (WDHB, Group Manager, Funder, ADHB and WDHB, Acting Group
Manager, Primary Care)
Jean McQueen (WDHB, Primary Care Nursing Director)
Stephanie Muncaster (WDHB, Programme Manager, Chronic & Palliative Care)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the
minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Brian O'Shea, ProCare
Jude Spratt, ProCare
Charlotte Harris, Auckland PHO
Lorelle George, Comprehensive Care/Waitemata PHO
John Ross, Comprehensive Care/Waitemata PHO
Gaylene Sharman, Healthwest
Rocky Tahuki, Healthwest
Tracy McIntyre, Waitakere Health Link
Adrian Collier, Pfizer

APOLOGIES: Apologies were received and accepted from Judith Bassett and Gwen Tepania-Palmer, together with apologies for early departure from Pat Booth and Sandra Coney.

KARAKIA Allison Roe lead the Committee in the English version of the karakia.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no declarations of interest with regard to the open agenda for this meeting.

WELCOME

Lee Mathias welcomed those present.

PRESENTATION – AUCKLAND REGIONAL PUBLIC HEALTH SERVICE

Dr William Rainger (Service Manager, Auckland Regional Public Health Service) and Dr Julia Peters (Clinical Director, Auckland Regional Public Health Service) provided this presentation which included an overview of the service and its roles, followed by a summary of the community water fluoridation issue and the service's priorities in addressing that issue. Copies of the presentation are available on request from the Waitemata DHB Board Secretary.

2.15p.m – Eru Lyndon present.

Matters covered in discussion and response to questions included:

- The lobbying that the Auckland Council is receiving from those opposed to fluoridation. It was suggested that in addressing that, as well as using research and evidence, there is a need to counter emotive concerns and claims about mass medication and lack of consent and about claimed adverse health consequences. The importance of the Regional Public Health Service talking to the newly elected Council as soon as possible in the new term was noted, because of the pressure they will come under from the anti-fluoridation lobby.
- Julia Peters advised that they are meeting regularly with Council officers and are prepared to provide a workshop to the new Council as soon as the Council is ready for that. They are not totally sure to what extent the issue is gaining traction in the Auckland region.
- It was noted that it will also be important to have the support of stakeholders such as the National Council of Women and the Maori Women's Welfare League.
- The Committee Chair advised that <http://www.fluoridefacts.govt.nz/> would be available on the Health Promotion Agency website from Friday 6th September.
- In answer to a question, Julia Peters said that she saw the ethical issue with fluoridation to be that to deliver the benefit of water fluoridation, the whole community needs to be part of it.
- Julia Peters advised that that there was no scientific evidence of any systematic adverse impacts from fluoridation and no evidence in New Zealand that at the population level we are receiving too much fluoride. The scientific evidence supporting fluoridation included at least four recognised international reviews of evidence, the review by the Ministry of Health

and a number of other New Zealand reviews. She advised that many governments still see fluoridation as a local issue; New Zealand is not unique in this.

- Robyn Northey spoke of her experience as a school dental nurse in the 1960's showing her exactly what a difference fluoride makes. She mentioned that the New Zealand Dental Association had made a very good presentation on this to the Local Government NZ Conference.

Dr William Rainger and Dr Julia Peters were thanked for their presentation.

PRESENTATION – PHO CARDIOVASCULAR RISK ASSESSMENT UPDATE

The Committee Chair welcomed the presenters and commented on how delighted Board members are with the improvement in CVD results in the 2012/13 year.

The presentation was provided by Kate Moodabe, Dr Charlotte Harris and Paul Roseman on behalf of the Auckland and Waitemata DHB PHOs. Copies of the presentation are available on request from the Waitemata DHB Board Secretary.

Paul Roseman spoke of the last six months being an empowering period and how the PHOs had greatly appreciated the support from the DHBs to achieve these results. On behalf of both DHBs, Lester Levy expressed to the PHO representatives the Boards' gratitude and congratulations on achieving the results, which provided an excellent example of how all can work together for the population's health.

Matters covered in discussion and response to questions included:

- It does make sense to provide advice to quit smoking in conjunction with CVD checks, although the age groups differ slightly. In practice brief advice to quit smoking is often given at that time, but recording the fact that has occurred does not always take place. The PHOs are trying to make sure that practices improve their systems to record this and management support in the practices is also very important. Guidelines have been issued and peer groups are used to understand the issues. The peer groups are working well, with those people who have performed less well being enthusiastic in finding out what others are doing and trying to improve.
- Paul Roseman advised that the PHOs do work together in common forum at all levels in their organisations, meeting and sharing what each is doing, including conversations about how to structure and share information.
- In answer to a question, Paul Roseman advised that the PHOs had spoken with the two DHBs about the level of support needed to achieve the 90% target and this was not greater than the 2012/13 level.
- The Board Chair noted that increasingly in health the theme is interdependence and it is becoming harder and harder to separate out the different elements. More can be achieved by working together than by operating separately.
- Ailsa Clare suggested that the questions now to be asked are:
 - what does good management of CVD risk look like?
 - how are we collectively reducing the risk?
 - how do we use our collective resource to get into that space?

She noted that targets are a way of achieving earned autonomy and also a way of demonstrating accountability to the public.

- In answer to a question, Paul Roseman advised that nothing has changed in the national contract for Care Plus re eligibility. The contract does not require free visits to be offered; that is an option that PHOs can take.

- There was a short discussion about moving from process measures to outcome measures. Simon Bowen, the new Director Health Outcomes, was introduced to the meeting. The Committee Chair noted the need for a stronger focus on getting appropriate definitions in measures and also commented that Simon will be leading some of the work over the next year to get a better understanding of outcome measures.
- The Committee Chair thanked the presenters. She said that the Board members are delighted with the progress made with CVD Risk Assessments and are looking forward to that being sustained over the next period.

1. AGENDA ORDER AND TIMING

Items were taken in the order listed on the agenda.

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 24 July 2013 (agenda pages 1-9)

Resolution (Moved Warren Flaunty/Seconded Peter Aitken)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 24 July 2013 be approved.

Carried

Matters Arising:

At the site visit to the Wilson Centre on 24 July, Wilson Centre management had indicated their keenness to be engaged in the review of Child Health services, which would impact on how they proceed with the redevelopment of their campus. Dale Bramley had provided them with the name of a contact person for this process. The Committee Chair requested that this be kept as a "matter arising" so that it is not lost sight of. It was agreed that a report on the review of Child Health Services come back to the Committee in February 2014, when a proposal is expected to be ready.

3 DECISION ITEMS

There were no decision items.

4. INFORMATION ITEMS

4.1 Health and Social Development Forum, West Auckland, 2nd October 2013 (agenda page 10)

Sarah McLeod (WDHB Workforce Development Manager) and Jan McCarthy (Awhina Education Manager) were present for this item.

It was noted that if members wished to attend the Forum, there is a registration process for this. The registration form will be e-mailed to members.

The report was received.

5. STANDARD MONTHLY REPORTS

5.1 Primary Care Update Quarter 4, 2013 (agenda pages 11-35)

Tim Wood (Acting Group Manager Primary Care, ADHB and WDHB) and Dr Stuart Jenkins (Clinical Director Primary Care, ADHB and WDHB) presented the report.

Tim Wood introduced the report, noting that:

- There will be an update report to the next meeting on cervical screening.
- With immunisation, the transfer to the single provider across both DHBs had gone smoothly, with uplift in Auckland DHB's immunisation rates experienced already. It is looking very promising for both DHBs to be on target this year.

Matters covered in discussion and response to questions included:

- With regard to the help for smokers to quit sub-target for pregnant women (page 16 of the agenda), Lee Mathias advised that it will be important to record intervention information from those operating outside the PHO system, in particular the 1,100 midwives who use a different system.
- The percentages of immunisation declines and opt outs (chart on page 15 of the agenda) do fluctuate up and down over time.
- The reference to new methodology for calculating re-admission rates for 75+ (page 23 of the agenda) simply involves resolving such issues as patients transferred from Waitakere Hospital to North Shore Hospital being counted as an admission and discharge for each hospital (and other such data issues). Wendy Bennett of Waitemata DHB is working on fixing these.
- With regard to Primary Options for Acute Care (POAC) (page 20 of the agenda) they are endeavouring to get data provided on a DHB basis. The Committee Chair commented that this had been an issue of contention since the early days of POAC and needed to be resolved.
- Lee Mathias noted that diabetes is the next big area that the DHBs will need to focus on.

The report was received.

5.2 Planning and Funding Update (agenda pages 36-39)

Debbie Holdsworth introduced the report by welcoming Simon Bowen. She noted that Planning and Funding is going through a major collaboration process, involving significant change management and impact on staff members. Both DHBs had now had their Annual Plans signed off by the Minister of Health and work is taking place to finalise the Annual Reports, which are expected to come to the Boards' Audit and Finance Committee meetings in October.

In response to a question relating to the transition process, Debbie Holdsworth advised that the interview process for the nine Tier Three positions was at the half way stage and it is hoped to make the Tier Three appointments by the end of September. Then the process would move to the tiers below that. Ailsa Clare commented that the process has been going quite well and credit is due to both teams for keeping performing while the process is going on.

The report was received.

6. General Business

No issues were raised.

7. Resolution to Exclude the Public

Resolution (Moved Lee Mathias/Seconded Warren Flaunty)

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
<p>1. Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting with Public Excluded 24/07/13</p>	<p>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</p> <p>[NZPH&D Act 2000 Schedule 3, S.32 (a)]</p>	<p>Confirmation of Minutes</p> <p>As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.</p>
<p>2. Cash Balances</p>	<p>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</p> <p>[NZPH&D Act 2000 Schedule 3, S.32 (a)]</p>	<p>Commercial Activities</p> <p>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</p> <p>[Official Information Act 1982 S.9 (2) (i)]</p> <p>Negotiations</p> <p>The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations.</p> <p>[Official Information Act 1982 S.9 (2) (j)]</p>

3.23p.m – 3.35pm – Public excluded session.

3.35p.m – open meeting resumed.

The Committee Chair thanked those present for their participation in the meeting.

The meeting concluded at 3.35 p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT
HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 4
SEPTEMBER 2013

_____ CHAIR

**Actions Arising and Carried Forward from Meetings of the
Community and Public Health Advisory Committees as at 7th October 2013**

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 24/07/13	3.1	<u>Oral Health</u> – look at including performance results e.g. for arrears and DNA in the Primary Health Dashboard.	Tim Wood/Linda Harun		Being progressed.
CPHAC 04/09/13	2.1	<u>Review of Child Health Services</u> - engagement with Wilson Centre to occur as part of the Review - report on the Review to come to February 2014 CPHAC meeting, when a proposal is expected to be ready.	Tim Jelleyman/ Linda Harun	CPHAC 05/02/14	
CPHAC 04/09/13	4.1	<u>Health and Social Development Forum West Auckland, 2 October 2013</u> – registration form to be e-mailed to members (in case interested in attending).	Paul Garbett		Actioned – e-mailed 09/09/13

3.1 Cervical Screening Update

Recommendation:

- a) That the Committee notes that the activity under the Metropolitan Auckland Cervical Screening Governance Group (MACSGG) is progressing according to the strategic plan and notes:
- That cervical screening coverage is available to March 2013, and the three year coverage for Auckland and Waitemata DHB is stable; Auckland DHB 77.5% and Waitemata DHB 75.5%.
 - Coverage rates for priority group women remain below the national target of 80%, with the exception of Pacific women in Auckland DHB.
 - Improving overall coverage and coverage for priority group women are key drivers for MACSGG activity.
 - The focus of MACSGG to date has been three activities: addressing the data quality (the platform of which is the data-matching project), development of the Best Practice Resource and the provision of free smears to priority group women.
 - That the PHO Performance Management Programme (PPP) target will be increased from 75% to align with the national target of 80%, effective January 2014. This will require a step-change in volume of women screened in primary care, and provides an opportunity to strengthen primary care involvement in MACSGG.
- That the Committee endorses current and planned activities to be undertaken by MACSGG to improve cervical screening coverage and reduce inequalities.

Prepared by: Dr Karen Bartholomew (Public Health Physician, Waitemata DHB), Dr Sue Crengle (Public Health Physician, Waitemata DHB), Ruth Bijl (Associate Strategy and Planning Manager – Women’s and Youth Health, Auckland DHB), Stephanie Muncaster (Programme Manager Chronic and Palliative Care, Waitemata DHB), Pauline Proud (Auckland Regional Cervical Screening Project Manager, Auckland ADHB).

Glossary

ARPHS	- Auckland Regional Public Health Service
DHB	- District Health Board
DHBSS	- District Health Board Shared Services
EDAT	- Primary Care Ethnicity Data Audit Toolkit
ISP	- Independent Service Providers
KPA	- Key Performance Area
MACSGG	- Metropolitan Auckland Cervical Screening Governance Group
NCSP	- National Cervical Screening Programme
NHI	- National Health Index
NSU	- National Screening Unit
PHO	- Primary Health Organisation
PMS	- Practice Management System
PPP	- PHO Performance Management Programme
RFP	- Request for Proposals
SIA	- Services to Improve Access
WONS	- Well Women Nursing Service

1. Executive Summary

This paper is an update on efforts to improve cervical screening coverage rates in Auckland and Waitemata District Health Boards (DHBs). CPHAC was last updated on the Metropolitan Auckland Cervical Screening Governance Group (MACSGG) activities in March 2013. This current update was prompted by commentary regarding the most recent cervical screening coverage rates for priority group women presented in the Primary Care Scorecard at the CPHAC meeting in August 2013.

The most recent cervical screening coverage results available from the National Cervical Screening Programme (NCSP) are for June 2013. The three year coverage (women aged 25-69 years) for Auckland and Waitemata DHB are stable; Auckland DHB 77.5% and Waitemata DHB 75.5% towards the national target of 80%. Ethnic-specific coverage remains much lower than overall coverage.

The three metropolitan Auckland DHBs aim to improve cervical screening coverage through regional coordination activities under MACSGG, with a specific focus on priority group women. MACSGG activities align to a set of five Key Performance Areas (KPA) set out in the MACSGG Strategic Plan, which was presented to CPHAC in March 2013. The KPAs are:

1. Governance, leadership and monitoring
2. Quality information and data
3. Improved access and reduced barriers
4. Primary care delivery
5. System organisation and design that works for women.

The establishment phase of MACSGG has involved the employment of a regional coordinator (in position for approximately ten months) and prioritisation of activities under the Strategic Plan. The three activities prioritised by MACSGG have been improving data quality (KPA 2), systems support for primary care (KPA 4) and the provision of free smears through primary care (KPA 3). These activities were prioritised as necessary platforms to work with primary care towards coverage improvement.

Data quality has been assessed through the MACSGG Technical Group and a range of solutions identified. Data-matching between primary care and the NCSP-register is considered to be the fundamental platform for improvements to cervical screening coverage. A two phase project has been established to a) develop regular automated data-matching with the NCSP and b) work with primary care on the optimal way to package and communicate the data-matched results in order to screen more women. As a result of the analytical work undertaken by the technical group, the National Screening Unit (NSU) agreed at the last MACSGG meeting to participate in addressing data integrity issues at a national level. This was a significant step forward.

The second focus of MACSGG activity has been the development of a Best Practice Resource for primary care. This Best Practice Resource is similar to that developed for immunisation, and seeks to support primary care at a systems level. It has been developed by the regional coordinator collaboratively with a range of practices. It is currently out for consultation and will then be implemented through the MACSGG Operations Group.

The third focus of MACSGG activity has been the additional funding of free smears for priority group women, over and above the small volumes contracted by the NSU. The volumes

contracted for 2013-2014 for Auckland DHB is 2,265 and Waitemata DHB is 2,200. PHOs are also able to use their flexible funding pool to support free smears at the practice level. MACSGG will continue to work with primary care on the maximisation of available resource to reduce the financial barrier to cervical screening.

Implementing the current MACSGG activities (and planned future activities) to achieve improvements in coverage will require sustained primary care involvement and practice level action. This is an opportune time to strengthen primary care involvement in MACSGG because a change is planned by the Ministry of Health to the PHO Performance Management Programme (PPP) cervical screening target. This will increase from 75% to reflect the national target of 80% in January 2014. PHO achievement of this new target will require a step-change in the volume of women screened. The additional numbers of women to be screened to reach the 80% target is approximately 3,500 for Auckland DHB and 6,400 for Waitemata DHB.

2. Introduction

Cervical screening coverage is an important indicator for DHBs, is a key health priority for DHB Māori Health Plans, and is reported in the PPP Improving Population Health indicators. The national target for cervical screening coverage (three year coverage for women aged 25-69 years) is 80% for all women.¹ The national target was increased from 75% to 80% in 2011.

The NSU administers the NCSP for the Ministry of Health. Smear taking is not funded nationally and it involves a cost to women. Cost is a well established barrier in cervical screening,² and the NCSP is the only New Zealand screening programme that involves a cost to participate. NCSP funds regional register activities,³ Independent Service Providers (ISPs),⁴ smear taker training, small volumes of free smears for priority group women, and regional coordination in some District Health Boards (DHBs). Regional coordination has been recently established (under MACSGG) for the metropolitan Auckland DHBs.

Unlike other programmes such as breast screening or immunisation, women do not have a 'nominated provider' of smears but are able to choose their smear taker. Cervical screening is, however, fundamentally a primary care activity. Less than 5% of cervical screens in the metropolitan Auckland region are delivered by the centrally funded Family Planning Association or the ISPs. The metropolitan Auckland region covers approximately 600 practices where approximately 10,000 smear takers are registered.

¹ The national target is calculated using the NCSP register record of cervical smears for the hysterectomy-adjusted 2006 census DHB population. Hysterectomy adjustment is an estimate of women who are no longer eligible for cervical screening (that is, can safely be excluded) due to hysterectomy. This calculation is not based on actual numbers of hysterectomies in the region. The hysterectomy adjustor calculation was changed in 2012 and is no longer ethnic-specific. This change in reporting impacted on ethnic specific coverage in March 2012 (previously reported to CPHAC in the March 2013 cervical screening update paper).

² Lovell S, Kearns RA. Sociocultural barriers to cervical screening in South Auckland, New Zealand. *Social Science & Medicine*. 2007;65(1):138-50.

³ The register records smear results and treatment for women enrolled in the programme. Register activities include the provision of overdue and recall reports, maintaining the register, providing information and tracking results.

⁴ There are seven ISPs nationally, four in the metropolitan Auckland region – two Māori providers, one Pacific provider and the Well Women Nursing Service (WONS). The NSU centrally funds the variable services provided by the ISPs, however they deliver relatively small volumes of cervical screens. The DHBs do not currently have visibility of these contracts, however MACSGG is working towards improved integration with ISPs.

DHB activities to improve coverage are currently directed through MACSGG and the regional coordination service. These activities are designed to coordinate, support and improve primary care cervical screening coverage. The ability for Auckland and Waitemata DHBs to reach the coverage target of 80% is dependent on primary care action to screen women. PHO activity is aligned to the cervical screening PPP targets. The PPP target for cervical screening coverage is currently 75%⁵ (not 80%), and the interim targets are set to incentivise small incremental increases in coverage. In addition to the difference between the PPP target and the national target, primary care has been focused on the delivery of other priority programmes including health targets.

The PPP target will be increased from 75% to 80% in January 2014. This is an opportunity to improve MACSGG primary care engagement in achieving the new target, as this will require a step-change in volume over the current baseline screening in the order of tens of thousands of women screened (see section 4 below). This will require concerted practice level action with PHO and MACSGG support towards the national target.

3. Coverage data

There are persistent issues with the timeliness of coverage data from the NCSP. The latest June 2013 coverage data was received in late September. The timeliness issue is understood to be a combination of technical problems with the now extremely delayed NCSP-register upgrade project (including the building of a new data warehouse for reporting) and the requirements of the National Kaitiaki Group⁶ review for routine coverage reporting. The problematic nature of this lack of timely coverage data in terms of DHB planning and monitoring has been raised repeatedly with the NSU at a number of levels.

The three year coverage rates for the most recent data available, to June 2013, are presented in Table 1 for the metropolitan Auckland region. The table includes a retrospective data coverage correction released by the NSU which has altered historical comparator coverage rates (March 2012), particularly for priority ethnic groups.

⁵ The PPP indicator is calculated differently than the NSU reported DHB coverage.

PPP cervical screening coverage is calculated using NCSP-register record of cervical smears for the hysterectomy-adjusted practice/PHO enrolled eligible women. The PPP cervical screening indicator is reported at aggregate level by practice and by PHO, and can be presented at DHB level. There is therefore a difference in denominator between the NSU coverage and the PPP coverage at a DHB level. PPP is calculated for total population and for high needs women. The high needs definition in PPP is Māori, Pacific and Quintile 5. However the NCSP definition for priority group women is Māori, Pacific, Asian, under-screened and unscreened.

⁶ The National Kaitiaki Group has been established since 1995 under the National Kaitiaki Regulations under Part 4A of the Health Act. Their role is the review of aggregate Māori women's data from the NCSP register including routine coverage and monitoring data.

**Table 1. Cervical screening three year coverage (25-69 years, target 80%)
showing March 2012 – June 2013. Source: NSU**

DHB	March 2012* NSU revised figures	December 2012	March 2013	June 2013
Total				
National	76.7%	77.2%	76.9%	76.8%
Auckland	76.2%	77.5%	77.3%	77.5%
Counties Manukau	69.3%	69.7%	69.4%	69.3%
Waitemata	75.4%	75.7%	75.6%	75.5%
Māori				
National	61.2%	62.9%	63.0%	63.1%
Auckland	55.6%	57.1%	57.1%	57.4%
Counties Manukau	59.3%	60.6%	60.1%	59.9%
Waitemata	51.7%	52.5%	52.7%	52.8%
Pacific				
National	66.9%	69.5%	69.4%	69.3%
Auckland	79.6%	86.1%	86.9%	87.2%
Counties Manukau	61.5%	63.7%	63.7%	63.3%
Waitemata	64.2%	65.2%	65.2%	65.8%
Asian				
National	59.8%	62.8%	63.2%	63.6%
Auckland	57.3%	61.1%	61.5%	61.6%
Counties Manukau	57.6%	59.7%	59.9%	60.4%
Waitemata	55.2%	58.7%	59.5%	60.3%
European/Other				
National	83.4%	83.2%	82.8%	82.5%
Auckland	89.2%	88.3%	87.7%	87.9%
Counties Manukau	82.6%	81.2%	80.6%	80.4%
Waitemata	85.3%	84.7%	84.2%	83.9%

* Corrected data supplied by the NSU includes the new hysterectomy adjustor and three NHI ethnicity matches, as well as more women on the register (personal communication, Ivan Rowe, NSU).

Table 1 shows that June 2013 coverage is relatively stable, with a small improvement for Asian women in both Auckland and Waitemata DHB. The exception to this is coverage for Pacific women in Auckland DHB which demonstrates a sustained improvement. Investigation into the improvement for Pacific is being undertaken through MACSGG, and any learnings will be shared back through this forum. Table 1 also shows that while coverage for European/Other women has dropped slightly in March 2013, overall the coverage for this group consistently exceed the coverage target in all DHBs.

What the three yearly coverage proportions presented in Table 1 do not show is the associated volumes. With the new PPP coverage target, consideration of volumes required to achieve 80% coverage is critical for planning activities to support this, particularly for priority group women which is a focus for MACSGG. Table 2 presents the current increase in volume of women screened to reach the 80% target.

Table 2. Metropolitan Auckland cervical screening coverage volume increases required to reach coverage target of 80% Source: NSU

Region/DHB	Current 3 year coverage 25-69 years March 2013	Current 3 year coverage volume 25-69 years	Volume of women required to reach 80% target*	Increased volume to reach 80% target*
Metro Auckland	74.2%	299,327	322,690	23,363
Auckland	77.5%	101,705	105,017	3,312
Counties Manukau	69.3%	88,457	102,060	13,603
Waitemata	75.5%	109,165	115,614	6,449

* Increase in volume required from baseline of June 2013

Overall improvement in coverage could be achieved with minimal ethnic-specific coverage improvements which would increase inequities. MACSGG is focused on overall coverage improvements as well as improvements for priority group women, including unscreened and under-screened women. Table 3 shows an analysis of the volume of additional screens required for Māori women to achieve the 80% target.

Table 3 Metropolitan Auckland Māori cervical screening coverage volume increases required to reach coverage target of 80%. Source: NSU

Region/DHB	Current 3 year coverage 25-69 years March 2013	Current 3 year coverage volume 25-69 years	Volume of women required to reach 80% target*	Increased volume to reach 80% target*
Metro Auckland	57.2%	22,317	31,223	8,906
Auckland	57.4%	5,246	7,306	2,060
Counties Manukau	59.9%	10,859	14,510	3,651
Waitemata	52.8%	6,212	9,406	3,194

* Increase in volume required from baseline of June 2013

4. Progress/Achievements/Activity

The majority of DHB activity related to cervical screening is directed through MACSGG. Further Planning and Funding activity related to specific projects is being developed with the Māori Health Gain Team and with the MACSGG Asian health representative.

4.1 The Metropolitan Auckland Cervical Screening Governance Group

MACSGG was established in 2011 in response to a NSU contract aimed at improving cervical screening coverage through regional (metropolitan Auckland) coordination, although the NSU contract implementation was delayed. MACSGG is an advisory group that includes

representation from planning and funding for the three metropolitan Auckland DHBs; public health, screening and clinical expertise; Māori, Pacific and Asian representation; PHO, general practice and nursing members; and consumer representation. Members of the NSU also sit on MACSGG in order to facilitate a two way communication between the regional and national levels.

The MACSGG contract with the NSU is for a three year period. The NSU have indicated that they will fund a further year of activities for 2014-2015. The first two years of the contract are complete. To date the service has established the MACSGG group and sub-groups, development of the strategic plan and creation of the regional coordination service currently employing one project manager. The MACSGG strategic plan has five KPAs that were presented at the March 2013 CPHAC meeting. While the focus of the MACSGG group overall has been on improving participation and coverage for cervical screening, the regional coordination service has a broader focus on improvements to all aspects of the screening pathway in the region.

MACSGG will undertake an external review of its establishment phase by December 2013 (as indicated in the Strategic plan) with a view to making any improvements to the MACSGG group, the strategic plan or the regional coordination service within the next year. The review will also be used to further develop planned activities for the subsequent 18 months.

The strategic plan for MACSGG outlines five Key Performance Areas (KPAs). These were presented in the March 2013 CPHAC update paper but activity towards these is briefly outlined in Table 4 below.

Table 4 MACSGG regional strategy key performance areas for improving cervical screening coverage

KPA	Key area	Activities
1	Governance, leadership and monitoring	<ul style="list-style-type: none"> • Establishment of regional coordination service, which has been operational for nearly a year • Establishment of MACSGG with bi-monthly multidisciplinary advisory meetings • Establishment of the MACSGG Technical Group, development of the work programme and support for the platform data-matching project • Recent establishment of a regional planning and funding MACSGG sub-group • Regular interaction with the NSU ISPs
2	Quality information and data	<ul style="list-style-type: none"> • The basis of the MACSGG Technical Group work programme including: <ul style="list-style-type: none"> – The data-matching automation project – The parallel project to improving practice communications regarding data-matching – Technical support for the Waitemata DHB ethnicity misclassification project • Planned activity after the data-match project is established includes: <ul style="list-style-type: none"> – Investigation of exclusions in primary care – Investigation of hysterectomy information on the NCSP-register and in primary care – Investigation of inaccurate addresses

KPA	Key area	Activities
3	Improved access and reduced barriers	<ul style="list-style-type: none"> • Cost barriers - provision of funding for free smears in addition to the small volumes provided by the NSU, delivered in primary care and targeted for priority group women • Provider barriers - work with PHOs to identify practices with low coverage and work with individual practices on improvement activities – implementation through Best Practice Resource • Cultural barriers - range of culturally appropriate activities as identified in the regional strategy including discussion and presentation at a range of specific fora, for example at The Asian Network (TANI) and with the Pacific Parish Nursing service
4	Primary care delivery	<ul style="list-style-type: none"> • Development of a Best Practice Resource for primary care to support systematic improvements from invitation and recall across the screening pathway <ul style="list-style-type: none"> – Currently out for consultation – Implementation planning underway via the Operations Group • Financial support for smear taker training <ul style="list-style-type: none"> – Successful training of 20 additional smear takers • The MACSGG Technical Group data-matching project, particularly the practice communication phase which is being developed currently
5	System organisation and design that works for women	<ul style="list-style-type: none"> • Improving awareness and experience <ul style="list-style-type: none"> – Ongoing health promotion activity including alignment with the regional arm of the NSU social marketing activities⁷ – Promoting alternate smear providers where appropriate – Working with ISPs, with a focus for the next 18 months on improving the integration of ISP activities into alignment with MACSGG and DHB funded services – Consideration of ‘opportunistic screening’ in primary care in the Best Practice Manual

⁷ The NSU is no longer funding central social marketing campaigns (such as the television advertising) but has elected to have a smaller regional focus. The regional coordinator is working on improved communication with the social marketing agency on coordinating activities with primary care.

4.2 The Regional Coordination Service

The regional coordination project manager has been undertaking activities across the screening pathway as it relates to the MACSGG strategic plan, and reporting on these to MACSGG. Many of these activities are covered in Table 5.

Specific activities include:

- Development of a Best Practice Resource to support practices in developing systems to improve cervical screening from invitation and recall throughout the pathway. This has been a collaborative effort between the project manager and primary care (PHOs and practices) to share the learnings, particularly from practices who have good coverage with high proportions of enrolled priority group women. Development of this manual has facilitated positive relationships between primary care and the regional coordination service.
- Development of a regional cervical screening scorecard with indicators from across the screening pathway. This was developed with a MACSGG sub-group and includes a range of high level indicators developed to provide context for the primary focus of MACSGG which is improving coverage. The scorecard will be presented formally at the next MACSGG meeting.
- Coordination, support and leadership of the MACSGG Operations Group (currently on hold) and the Technical Group (see below). The Operations Group may be re-established with the implementation of the Best Practice Resource and the data-matching projects that require specific operational input.
- Presentation, discussion awareness-raising in a number of different fora including the NCSP Advisory Group, cultural advisory groups and primary care network meetings (eg practice nurses, practice managers).

4.3 Technical Group

The Technical Group sits under MACSGG to concentrate on KPA 2 improving data quality. The Technical Group has been a very successful collaboration between interested PHO technical staff, the NCSP regional register, public health and regional coordination. The activities undertaken by the Technical Group are outlined in the Appendix.

4.4 Operations Group

This group, comprised of primary care representatives, will be responsible for the implementation of the Best Practice Resource which is currently out for consultation.

4.5 Planned work

The focus for the remainder of the current MACSGG contract (to June 2014) includes rolling out the Best Practice Resource in primary care and the implementation of the data-matching project. An external review will be conducted as indicated in the Strategic Plan by December 2013 in order to inform the workplan for the next 18 months, and strengthen MACSGG.

A range of other projects are currently being considered and prioritised by the MACSGG sub-group of regional planning and funding members and will then presented to the NSU and MACSGG. The projects under consideration are likely to have an ethnic-specific focus, and may include work on co-design with specified practices which will better help us understand the non-financial barriers women face in accessing cervical screening.

A strong focus on ensuring clarity of roles nationally, regionally and at DHB and PHO levels will continue.

5. Risks/Issues

The timeliness of regular NCSP coverage data remains problematic. The NSU indicates that the NCSP-register will be functional from February 2014; however this date has already been extended multiple times. MACSGG is working with the NSU to ensure that when the new data warehouse reporting function of the NCSP-register is complete that it is able to support the regional data requests in a timely way.

Improvements in coverage require primary care momentum and sustained activity, where primary care is currently focused on other activities, including towards health targets. The change in the PPP coverage target will require a substantial increase on current screening volumes. This is an opportunity to build on the momentum gained through MACSGG and Technical Group in order to facilitate PHO and MACSGG engagement at a practice level.

The regional MACSGG contract with the NSU will be complete on 30 June 2014, with an assurance of funding for the 2014-2015 year. A prioritisation process will be underway shortly to review the potential projects for the remaining MACSGG resource. In addition an external review is currently being commissioned to inform the maximal opportunity to utilise MACSGG and primary care resource to improve coverage going forward. MACSGG is committed to sustainable and long term improvements in cervical screening coverage.

6. Conclusion

Waitemata and Auckland DHBs are progressing a range of activities designed to improve cervical screening coverage and reduce inequalities. Improving cervical screening coverage is challenging, with regional coordination only recently being established. It is an opportune time with the change to align PPP coverage with the national coverage to strengthen primary care engagement in MACSGG and continue to progress prioritised activities to address total coverage, coverage for priority group women, as well as a range of issues across the whole cervical screening pathway.

Appendix: Metropolitan Auckland Cervical Screening Governance Group - Technical Group Activities

Collaboration within the Technical Group has resulted in a detailed understanding of the practice level issues related to cervical screening including ethnicity data transfer errors, exclusions applied in primary care, and the incomplete NCSP-register recording of hysterectomy data. Sustained commitment and contribution has been received from Waitemata PHO and Procure representatives. The Technical Group is gaining momentum and has recently expanded its membership to include all of the regional PHOs, and all have expressed their appreciation for the data-matching project to support their work with practices.

The Technical Group has developed a white paper describing the identified issues and providing recommendations for further investigation. The work programme developed out of this white paper, with a decision to focus on establishment of the platform activity which is the data-matching project (see below). The other identified issues will have specific projects developed around them after the data-matching project is underway, and these projects will be presented to MACSGG.

The regional data-matching project

The data-matching project is the platform activity on the Technical Group work programme, and is a priority project for MACSGG. The Technical Group and MACSGG consider this project to be critical to any coverage improvements in the region, particularly to support primary care activity towards the new 80% PPP target in 2014. The following is a brief description of the data-matching project and current progress.

The Auckland regional cervical screening register (based at Auckland Regional Public Health Service; ARPHS) has been providing a data-matching audit service to interested PHOs and practices. Data-matching involves practices/PHOs identifying their eligible population (women aged 20-69 years) and providing this list to the regional register to match against the NCSP-register. This is similar to other ad hoc data-matching carried out by cervical screening regional coordinators throughout the country, and to activities coordinated by breast screening lead providers for the BreastScreen Aotearoa programme.

A data-match process has the following benefits:

- Identifies never screened women (the only way to do so as the NCSP-register is not a population-based register).
- Identifies women overdue and assists in prioritisation of overdue lists, for example by differentiating women with a history of a high grade lesion and therefore at high clinical risk.
- Identifies under-screened women. These women are no longer contacted by the NCSP-register and may no longer be contacted by the practice (these are women who have 'fallen off' the recall lists).¹ Some may be up to 10 years overdue.
- Assists practice efforts to improve participation in cervical screening by using the lists as the basis of practice activities eg invitation drives, recall letters and practice nurse contacts.

¹ The NCSP does produce regular monthly reports, providing a list of nearly due or overdue women to practices who subscribe to this service. The overdue reports list women with Normal History overdue by 6 months and women with Abnormal History overdue by 3 months. Overdue women 'fall off' the list after three consecutive reports over the period of three consecutive months. Overdue lists are to aid recall activities; this is not a data-match with primary care so can't identify never screened women. In addition primary care have noted that the reports are problematic because the difference in recall dates and hysterectomy information causes significant practice frustration, and practices are able to opt off receiving the lists.

Some PHOs have used Services to Improve Access (SIA) funding to support this additional activity.

- Practices can use the lists to feed information back to the regional register to improve the quality of information on the NCSP-register, for example hysterectomy status.

The current data-matching process has been small scale until relatively recently due to the manual nature of the task and capacity issues at the regional register. Over the last several months this process has been scaled up; however this level of manual activity is not sustainable in the long term due to the scale of the eligible population in the metropolitan Auckland region.

The regional coordination project manager has completed the data collection for a case study of successful data-matching and resulting practice action. This case study is for a group of three practices with high Asian enrolment who do not undertake their own internal audit processes for cervical screening. The data-matching process identified women that were contacted by the practice champion (receptionist) who arranged smear taking clinics in conjunction with a local ISP. This has resulted in approximately 30% increase in coverage across the three practices. This case study is being written up with the intention to publish.

The regional register and Waitemata PHO have now matched approximately 23,000 women (about 1/3 of their eligible population). In order to support the case for data-matching Waitemata PHO have provided the DHB a report on their manual data-match. This report demonstrates that:

- 15% of eligible women matched were not on the register:
 - Asian, 'Other,' Pacific and Maori women were overrepresented.
 - Very young women, and women >55years were also over-represented (particularly women aged 60-69 years).
- 28% of women were overdue. Of the overdue women:
 - 11% had a history of a high grade lesion.
 - 7% had a history of a low grade lesion.
 - Maori, Pacific and Asian women were overrepresented
- Only 3% had a hysterectomy confirmed by the register to be safely excluded from the programme.

Waitemata PHO plan to repeat the audit to review the practice activity that has been undertaken. Anecdotal reports from practices indicate that some practices have found the lists very useful and have actioned them, while others have expressed concern about the quality of register data, particularly around hysterectomy, smear history and recall dates. These findings have led to the development of a parallel project on practice level communications relating to data-matching (see below).

The Technical Group is now progressing two separate projects in relation to data-matching. Both are necessary for successful action to identify and screen individual women in primary care.

1. Automated data-matching:

- Automation of the current manual process using 'single source of truth' data.
- DHB Shared Services (DHBSS) is the only organisation to hold (and have the mandate to hold) both sources of data currently. DHBSS holds and matches this data in order to calculate PPP coverage, but only at an aggregate level. In addition DHBSS have the most secure method for large scale data transfer (Connex, the National Health IT Board recommended method).

- Work is underway with DHBSS and the NSU on whether the following substantial increases to the scope related to DHBSS reporting activity could be employed to facilitate national data-matching.
 - Provide PHOs with individual level data for cervical screening per practice.
 - Include (conduit to PHOs but not analyse at DHBSS level) limited clinical information to assist with prioritisation of the lists for practice activity (as per the data available with the current manual match: date of last smear, date next smear due, last results, smear history).
 - The Technical Group is providing a briefing paper for DHBSS to support their discussions with the Ministry of Health on this issue.
 - The discussions with DHBSS and the NSU will centre on whether the increase in scope for DHBSS is feasible (particularly within the current tightened DHBSS remit), acceptable and secure.
 - Consideration will be given to the resourcing of this activity, particularly as it has moved from a regional solution to a national one. It is too early yet to size the resource requirements.
2. Practice communication improvement project regarding data-matching:
- MACSGG to resource a small project to examine in depth, with a small number of practices:
 - The variation in current invitation/recall/audit process across a range of practice configurations and enrolment profiles.
 - Investigate the utility of data-matched lists and the prioritisation information in them.
 - How the lists could be optimally packaged and prioritised to facility practice action.
 - What level of support for increased activity based on the lists would be valued (for example alteration to free smear contract to be based on the data-matched lists).
 - This project has proceeded through the FAST quality improvement training process at Waitemata DHB and will be supported in an ongoing manner with quality improvement expertise.
 - The Technical Group is currently developing project documentation and resource requirements to present to MACSGG, alongside sourcing interested and relevant practices.
 - Early stage discussions with the Māori Health Team and the MACSGG Asian health representative to look at the project from a priority group women perspective.

Waitemata DHB Ethnicity Data Quality Improvement Project

The purpose and methods of this project were outlined in the March 2013 CPHAC report. In brief the project has involved contacting women identified in an audit in 2012 as having discrepancies in the ethnicity recorded in the PHO register, the NCSP-register and the NHI. This misclassification affects coverage and makes it problematic to identify and target resource to priority group women.

The contacting of women for this project is complete for Waitemata PHO (via the PHO-led process), and nearly complete for Procure PHO (the DHB-led process). Delayed timelines for the DHB-led process have been the result of the requirement for individual practice agreement for the project, as well as the scale of the extraction of up-to-date contact details for women.

The final results are not yet available. Early analysis of the PHO-led process shows that of the 850 women contacted changes in the primary care register have resulted in changes to the classification of women: a 34% increase for Māori, 9% increase for Pacific and 17% increase for Asian women (with a consequent reduction in European/Other). Early results for the DHB-led process are of a similar magnitude. The project is being independently evaluated, with a focus on the success factors in each process. The evaluation results will inform consideration of project implementation across Auckland DHB.

The process to update the NCSP-register has been approved by the National Kaitiaki Group and the NSU. A small number of NHI ethnicity records will also be updated, and permission has been granted by the Ministry of Health for this. The changes to these records have not yet been made therefore the small increase in coverage anticipated for these results will not yet be reflected, although we estimate that the approximately 30% increase in Māori women will result in about a 3% increase in DHB coverage.

In addition to the improvements for cervical screening this project has led to good working relationships with the two Waitemata DHB PHOs regarding ethnicity data. These relationships have facilitated the positive discussions about implementation of the broader Primary Care Ethnicity Data Audit Toolkit (EDAT) which is being led by the Māori Health Gain Team and the Primary Care Team for both Auckland and Waitemata DHBs. In addition the learnings from this project have specifically informed the shape and presentation of the EDAT Request for Proposals (RFP) response to the Ministry of Health.

5.1 Planning and Funding Update

Recommendation:

That the report be received.

Prepared by: Sue Waters (Acting Chief Planning and Funding Officer ADHB), Debbie Holdsworth (Director Funding WDHB/ADHB), Julie Helean (Manager Planning and Service Development ADHB), Wendy Bennett (Manager Planning and Health Intelligence WDHB/ADHB), Tim Wood (Funding and Development Manager Primary Care WDHB/ADHB), Cliff La Grange (Manager Finance and Support Services WDHB/ADHB) and Marty Rogers (Maori Health Gain Manager ADHB/WDHB)

Glossary

DHB - District Health Board
GAS - Group A Streptococcus
PHO - Primary Health Organisation

1. Summary

This report updates the Committees on Auckland and Waitemata DHBs' Planning and Funding activity.

2. Summary of activities in common

2.1 ADHB and WDHB Planning, Funding and Outcomes Collaboration

A Project Director for the programme has now been appointed and work has begun at both DHBs on the next stage of transition activity. Her current priorities include:

- Finalising a plan for the transition, with proposed timelines agreed and shared with the teams
- Working with both DHBs' HR, IS and Facilities teams to ensure a trouble free transition to the new shared facility at the Shea Terrace site
- Working with the Planning and Funding workstream leaders to develop an effective combined structure at Tier 4 and 5 to support the outcomes required to achieve both DHBs Annual Plans

The following appointments have been made at Tier 3 to the Planning, Funding and Outcomes team and all the individuals will be in these positions by 14 October 2013:

- Funding and Development Manager Primary Care - Tim Wood
- Funding and Development Manager, Women's, Child and Youth Health – Ruth Bijl
- Funding and Development Manager, Health of Older People – Kate Sladden
- Finance Manager - Cliff La Grange
- Manager Planning and Health Intelligence - Wendy Bennett

2.2 Planning

As reported to the last meeting the Auckland and Waitemata DHBs' Annual Plans for 2013-14 were approved by the Minister of Health and are on the ADHB and WDHB websites respectively. The draft 2014/15 Annual Planning guidance has recently been released by the Ministry of Health for DHB review and input.

Two business plans are now being developed, one for the Funder and one for the Provider. The business plans assign names to each of the Annual Plan deliverables, and this helps senior management track progress.

The Annual Report 2012/13 is currently in the last stages of audit and development and a near final, audited version will be provided to the next Audit and Finance Committee meeting.

2.3 Primary Care

PHO Agreements

As a result of the new PHO agreement which came into effect on 1 July 2013, the Ministry of Health has developed a proposed template for the Back to Back Agreements between the PHO and the general practices. The template is not mandatory, however there are clauses within the template that are mandatory and which must be used in a Back to Back Agreement.

Auckland and Waitemata DHBs are discussing with the PHOs the possibility of having a consistent Back to Back Agreement across all of the practices in the Auckland and Waitemata areas.

Alliance Agreements

The transitional Alliance Agreement with Waitemata PHO has been prepared and is in the process of being finalised with the PHO.

The framework to progress the Alliance Agreement needs to be developed in order to move forward the dialogue and collaboration on the overarching Alliance Agreement. In addition, the development of a strategic direction for primary care will commence shortly.

The Alliance Agreement through GAIHN, and the Agreement prepared with Waitemata PHO originally had end dates of 30 September 2013. As the overarching Alliance Agreement is still in development, the existing Alliance arrangements will need to continue.

The DHBs and the PHOs have indicated a desire that business as usual processes, such as the annual plan, health targets and the progression of the Back to Back Agreement, occur through the Alliance approach.

Review Clinical Governance

The Primary Care Team continue to work with Dr Allan Moffitt on the review of clinical governance arrangements.

Localities

The 'Health and Healthcare Where It Matters' locality approach document is being presented to the Localities Establishment Governance Group (LEGG) for final approval at the meeting on Tuesday 8th October 2013.

2.4 Maori Health Gain

Ethnicity Audit rollout

This is a key activity in the 2013-2014 Maori Health Plan. We are continuing to work with the PHOs across both DHB regions to determine a process, timeline and monitoring framework.

Maori Provider Development and Support

Good progress has been made on the development of integrated contracts for each of the providers. We still expect this to be completed by 31 December 2013. Work continues on identifying opportunities for new service modelling, co-location of services and a reinvestment of funding.

Whanau Ora

Waitemata DHB has been leading the Whanau Ora Policy Framework for Te Tumu Whakaraae. This work is nearing completion and is expected to be signed off at the national Hui in October. Once this has been done it will be submitted to the national DHB CEO forum for endorsement and work will be completed in partnership with the MOU partners on the Auckland and Waitemata District Health Board (DHB) model.

Rheumatic Fever

A key focus of the Maori Health Gain participation in this mahi has been to ensure that planning is responsive to Maori communities and that Maori are included in the decision making process. This has been particularly successful at Waitemata; however work is still required for the Auckland developments.

Primary Care

Relationships with the PHOs across the Waitemata and ADHB areas have been gaining momentum, with engagement on a number of projects being positive and fruitful. These include the Cervical Screening ethnicity audit programme, the development of the Ethnicity Data Audit Tool RFP development, Whanau Ora discussions, and a range of other initiatives focussed on improving access.

2.5 Community Pharmacy

The third phase of the national Community Pharmacy Services Agreement (CPSA) commenced on 1 August 2013. This included a Long-Term Conditions (LTC) Service Fee increase and introduction of an Interim Core Payment. The objective of the CPSA is to manage the transition to more patient-focused pharmacy services to support patients to manage their medications more effectively. Auckland and Waitemata DHBs have helped community pharmacy providers to understand the new funding and service model; this has been a challenge because of the large number of providers and new pharmacies opening regularly. Engagement with primary care and secondary care services to support implementation is progressing, as per Northern Region Health Plan 2013/14 targets.

During May 2013, Auckland and Waitemata DHBs, in conjunction with Counties Manukau DHB, sought feedback on a proposal to create a Metro Auckland Pharmacy Advisory Group to replace the three existing Metro Auckland DHB Pharmacy Advisory Groups and Northern Region Pharmacy Leadership and Advisory Group. The drivers for creating a single group included closer collaboration between Auckland and Waitemata DHBs' primary care and pharmacy work streams, and Metro DHBs working together to support CPSA implementation. A call for nominations for community pharmacist representatives closed on 4 October 2013; the first meeting is scheduled for November.

Auckland and Waitemata DHBs are currently inviting applications for new providers of the Community Pharmacy Anti-coagulation Management Service (CPAMS) following a nationally agreed process. CPAMS involves point-of-care testing and adjustment of warfarin (a blood thinning agent) doses by community pharmacists, with the aid of a computerised decision support system. The existing number of agreements is consistent with national volumes (Auckland DHB, 4; Waitemata DHB, 8). Additional agreements, if entered into, will come into effect during February 2014.

3. Waitemata DHB Update

3.1 Rheumatic Fever

Waitemata DHB is developing and implementing an integrated programme for Group A Streptococcus (GAS) identification and treatment that strongly targets high risk individuals and communities. Initially the focus has been on implementation of a school-based throat swabbing programme (intensive three times per week programme in selected highest risk schools). The school-based programme is currently being extended to include opportunistic swabbing across high-medium risk schools and/or geographic locations, primarily in secondary schools that have existing nursing services.

The Rapid Response component of the programme is a hybrid model which includes *sentinel GP clinics* (to provide cover in key geographic locations across the district) alongside *Maori, Pacific and other primary care providers and Child and Family Service partnership/s* to provide primary care outreach services working with Community Health Workers in a further 14 medium to high risk West Auckland schools. The matrix of schools will be aligned with community-based outreach swabbing, home visiting/follow-up and community-based drop-in clinics. This ensures the model is building on existing providers and infrastructure. **Please note this partnership model has been agreed at a high level and work to confirm the detail is underway and will be modified in collaboration with providers as required.** In summary, timely identification and treatment of GAS across Waitemata DHB is planned to be achieved through the following integrated initiatives:

- Encouragement and support for primary care to follow the Heart Foundation guidelines and develop low/no cost models of swabbing/treatment, particularly in selected high risk geographic locations
- Intensive school-based swabbing in high risk schools
- Opportunistic school-based swabbing (use of existing school nurses in Decile 1-3 high schools, support for nursing in high-medium risk Decile 4 high schools, targeted health promotion/health literacy in schools)
- **Rapid Response** through a 12- to 18-month trial of a hybrid model which includes:
 - 1. Sentinel General Practitioner (GP) clinics** to operate in areas to provide extended access and to support the school based model and in areas to provide access where a school and community based model is not available.
 - 2. Maori and Pacific Provider and Child and Family Service partnership/s** to undertake school-based/primary care outreach swabbing in a further 14 medium to high risk West Auckland schools. Working together with existing primary care infrastructure with strong community facilitation linkages.

- Community-based outreach swabbing, working with providers who work with high needs families (Te Whānau o Waipareira Trust, and to be confirmed, HealthWest and Te Ha Oranga).
- Health promotion/literacy with and through all providers.

3.2 Immunisation

Waitemata DHB continues to exceed the 90% national target for 2013/14 for immunisation of 8 month old babies with coverage at 1 September at 91%, a 1% drop from June 2013 (Maori 82%, Pacific 96% a 2% increase since June, Asian 97%, Other 87% and NZE 91%). Coverage at age 2 as at 1 September is 91%, a 1% drop since June (Maori 92%, a 2% increase since June, Pacific 95%, Asian 96%, Other 87% and NZE 90%). The combined decline/opt off rate remains high at 5.7%.

A video addressing Clinical Myths was launched in September. Research with both parents and health professionals has demonstrated a gap in knowledge regarding genuine contraindications for immunisation. In many cases premature babies or children with mild illness have scheduled immunisation events delayed, for no genuine clinical reason. This video will provide health professionals with the clarity and confidence to discuss common concerns and reassure parents and caregivers when it is alright for their child to be immunised.

3.3 Hospice West Auckland inpatient beds open

Prime Minister John Key opened Hospice West Auckland's Kowhai Unit on Friday 4 October 2013. The Kowhai Unit is an inpatient specialist palliative care service. The opening was attended by Dr Lester Levy, Dr Dale Bramley, Dr Debbie Holdsworth and Stephanie Muncaster. The hospice staff welcomed the Prime Minister and guests including a number of volunteers to the unit. Dr Levy spoke on behalf of the Board.

The inclusion of an inpatient unit in West Auckland has been achieved through the on going support of the Waitemata DHB Board and the Waitakere community. This completes the four year project to meet the Board's commitment to fund inpatient beds in West Auckland. The two beds in Beach Road, Te Atatu Peninsula will increase the number of inpatient palliative care beds funded by Waitemata DHB to 15.

The addition of this unit in West Auckland will assist with the continuity of care for people receiving community services from Hospice West Auckland. Patients will be admitted for respite, pain and symptom control and end of life care. The patients' family/Whanau will have the use of quiet spaces within the inpatient unit to be with their loved one. The community and inpatient teams will work together to ensure the needs of their patient and families/whanau receive specialist palliative care.

3.4 Funder Finance

The August 2013 consolidated core result for the Waitemata Funder was \$4k favourable to budget for the month and \$27k adverse to budget for the year to date.

Funder NGOs

The August 2013 core result for Funder NGO was \$41k favourable to budget for the month and \$48k favourable to budget for the year to date. The favourable net year to date position includes an adverse variance of \$296k in Oral Health services which is in part a result of the nationally agreed additional price increase for this service.

Funder IDFs

The August 2013 core result for Funder IDF was \$37k adverse to budget for the month and \$75k adverse to budget for the year to date. This variance results from a delay at Auckland DHB in having an agreed IDF service change formally authorised. This is now authorised and the related variance will reverse in the September month. The impact of the national inpatient wash-up position receivable/payable through the MOH process has not yet been accounted for because of the lead time required for discharges to be coded and submitted.

4. Auckland DHB Update

4.1 Immunisation

Auckland DHB continues to exceed the 90% national target for 2013/14 for immunisation of 8 month old babies with coverage at 1 September at 93% overall (Maori 86%, a 6% increase over the previous month, Pacific 92%, Asian 97%, Other 91% and NZE 92%). Coverage at age 2 as at 1 September increased to 95% (Maori 93%, a 5% increase since June, Pacific 97%, a 4% increase since June, Asian 97%, Other 94% and NZE 94%).

4.2 Rheumatic Fever

Implementation of the School based sore throat swabbing programme is now underway. Public health nurses and community health workers visit schools three times per week and swab any child who identifies as having a sore throat. Children with a positive result for Group A streptococcal (GAS) receive antibiotic treatment. The Minister's Office has indicated that the Minister wishes to attend the next planned school roll out event which is likely to be at the Ruapotaka Marae in late October.

The target for the primary care 'rapid response' programme for those not in school or during school holidays is to "reach" 80% of Auckland DHB Maori, Pacific and quintile 5 children and young people. Alliance Health + is the primary provider for this programme.

A housing advice and referral 'hub' serving the three Auckland DHBs is being developed. Families will be assessed and referred for free home insulation, free curtains, draught stoppers etc. as indicated. Auckland DHB is undertaking work to ensure referral pathways are in place in its clinical settings. Alliance Health + and the National Hauora Coalition will provide this programme under contract with the Ministry of Health. This will be in place by 1 October 2013.

Alliance Health + will also provide the Pacific Engagement programme under a contract with the Ministry of Health.

4.3 Oral Health

The Greenlane dental clinic will have extended hours fortnightly on Thursdays from 4.30pm to 6pm. The extended hours will help to increase access for our community and will reduce the currently high arrears rate. Ten sterilising machines (SciCan Statim 5000) have been ordered and are expected to be delivered and installed in October.

4.4 Funder Finance

For the month of August 2013 the funding accounts show a deficit of \$3.7m compared to a budget deficit of \$4.7m, a favourable variance of \$1.0m. The variance is split between a favourable variance for the "funder" of \$1.0m combined with a "provider" favourable variance of \$0.0m.

YTD the funding accounts show a deficit of \$5.2m compared to a budget deficit of \$7.9m, a favourable variance of \$2.7m. The variance is split between a favourable variance for the “funder” of \$2.6m combined with a “provider” favourable variance of \$0.1m.

The main features of the YTD result are a favourable budget variance in Personal Health and Med/Surg of \$2.3m, Mental Health favourable to budget by \$0.0k, Health of Older Peoples favourable to budget by \$0.3, a favourable variance of \$0.1m in Provider services. Most Personal Health costs are not significantly different from the budget although some late project starts are giving a favourable variance in other expenditure as well as an accounting error in PHO Capitation payments which will correct next month.

Health of Older People is favourable for the YTD by \$0.3m. The main variance is an unfavourable variance in Home Based Support of \$240k which is offset by a favourable variance in other expenditure, which is an amalgamation across many cost codes. All targets in the Business Transformation Project have been achieved in August and YTD.