



Waitemata
District Health Board

Best Care for Everyone

Community and Public Health Advisory Committees Meeting

Wednesday, 12th June 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
12th June 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 - WDHB, Chief Planning and Funding Officer
 Denis Jury - ADHB, Chief Planning and Funding Officer
 Naida Glavish – ADHB and WDHB Chief Advisor, Tikanga
 Paul Garbett - WDHB, Board Secretary

Apologies:

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

2.00pm 2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 01/05/13 1

3 DECISION ITEMS

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4 INFORMATION ITEMS

5 STANDARD MONTHLY REPORTS

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3.00pm **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 Governance Advisor – Health Vision Ltd	18/09/12

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)	✓	✓	✓					
Max Abbott (WDHB Deputy Chair)	✓	✓	✓					
Jo Agnew	✓	✓	✓					
Peter Aitken	x	✓	✓					
Judith Bassett	✓	✓	✓					
Pat Booth	✓	✓	✓					
Susan Buckland	✓	x	✓					
Chris Chambers	✓	✓	✓					
Sandra Coney	✓	✓	✓					
Rob Cooper	^	^	✓					
Robyn Northey	✓	✓	✓					
Christine Rankin	✓	✓	✓					
Allison Roe	x	✓	✓					
Gwen Tepania-Palmer	✓	x	x					
Co-opted members								
Dr Tim Jelleyman	✓	✓	x					
Eru Lyndon	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 01st May 2013

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 01st May 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 1 May 2013

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna,
commencing at 2.02p.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)
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)
Eru Lyndon (Co-opted member)

ALSO PRESENT: Debbie Holdsworth (WDHB, Chief Planning and Funding Officer)
Denis Jury (ADHB, Chief Planning and Funding Officer)
Andrew Coe (ADHB & WDHB, Group Manager Primary Care)
Ann Davis (ADHB & WDHB, Programme Manager, Primary Care)
Rachel Mattison (ADHB & WDHB, Associate Planning and Funding Manager,
Primary Care)
Janine Pratt (WDHB, Group Planning Manager)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Tim Wood (WDHB, Group Manager, Funder NGOs)
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:

Lynda Williams, Auckland Womens Health Council
Tanja Binzegger, Health Link North
Anne Curtis, Health Link North
Tracy McIntyre, Waitakere Health Link
Lorelle George, Waitemata PHO
Charlotte Harris, Auckland PHO
Brian O'Shea, ProCare
Ian Scott, Auckland PHO
Ian Snow, Auckland PHO
Barbara Stevens, Auckland PHO
Alastair Sullivan, White Cross Healthcare
Adrian Collier, Pfizer
Samuel Cho, The Asian Network Inc.

Sheryl Orton, Auckland City Plunket
Caro Watts, Waitemata Plunket
Jeremy Olds, NZ Doctor Magazine
Olivia Shivas, AUT Student

APOLOGIES: Apologies were received and accepted from Gwen Tepania-Palmer, Tim Jolleyman, Ailsa Claire and Andrew Old

WELCOME Lee Mathias welcomed those present.

KARAKIA Rob Cooper led the meeting in a karakia.

DISCLOSURE OF INTERESTS

With regard to the Interests Register, Eru Lyndon advised that he had been appointed Regional Commissioner, Social Development, Northland, Ministry of Social Development and a Director, Tamaki Development Company. He advised that the following items should be deleted from the Register: Ngati Whatua o Orakei Corporate Ltd and Te Mata a Maui Law.

With regard to the agenda for this meeting, Warren Flaunty declared an interest as a Trustee of West Auckland Hospice in Item 4.1 – Palliative Care Services in the Waitemata District – Model of Care Update. It was noted that this was an information only item and the Committee considered that there was no reason for him not to participate in consideration of the item.

PRESENTATION: CVD RISK ASSESSMENT TARGET FOR PRIMARY CARE

Andrew Coe (Group Manager Primary Care, Waitemata and Auckland DHBs) introduced the two presenters: Barbara Stevens (CEO, Auckland PHO) and Dr Charlotte Harris (Clinical Director, Auckland PHO) who would be providing the presentation on behalf of all of the PHOs in the Auckland and Waitemata DHB Districts.

Barbara Stevens and Dr Charlotte Harris provided a presentation which included the following:

- The targets of 75% of the enrolled population having CVD Risk Assessments by June 2013 and 90% by June 2014.
- The importance of the programme, with coronary and stroke deaths being by far the leading cause of death in New Zealand.
- The much higher rates of CVD deaths for Maori (27%), Pacific Islanders (29%) and South Asian (29%) than for the rest of the population.
- A year ago there had been 60,000 people needing to be screened to meet the target for Auckland DHB and 47,000 for Waitemata DHB.
- PHO performance result charts as at December 2012 and for the last two months. Currently they are reaching close to 70% and there is a level of confidence that there is a good chance of achieving the June 2013 target of 75%. The PHOs are submitting weekly data to the DHBs on performance. Barriers to be overcome and PHO strategies to achieve the target were outlined.
- A detailed explanation was provided of how risk assessments are carried out, the tools for assessing risk and the strategies used for patients who fall into the different risk categories (referring to case studies as examples).
- The PHOs' strategy to achieve the 90% goal in 13 months includes a whole of system approach (the aim being to have every eligible person who sees a health professional/service anywhere to have a CVD risk assessment completed); evaluating what worked well in achieving the 75% target; community and work place screening; systemising "doing the right thing"; and concentrating on good CVD management. The numbers to achieve the 90% target are equivalent to one assessment per practice per day.
- The ultimate goal is to manage CVD risk, however there is a need to measure that risk first.

Copies of the full presentation were circulated at the meeting and can be provided on request.

Matters covered in discussion and response to questions included:

- The PHO representatives present at the meeting were reasonably confident of meeting the 75% target. Andrew Coe noted the importance in this process of getting information quickly enough to make changes if necessary – achieving that had been one of the positive features of the process.
- General practices do their best to follow up with those patients who are identified as having a high CVD risk but don't arrive for appointments. After numerous calls, sometimes saying "this is your last chance" produces results.
- Nurses can be trained to do CVD Risk Assessments; it does not need to be a general practitioner.
- Incentive payments for CVD Risk Assessments are used in different ways. Some PHOs pay on number of assessments; others to fund particular measures, for example additional nurses to carry out assessments. The Committee requested a breakdown on the amount of money paid in incentive payments for the CVD Risk Assessment Programme at its next meeting.
- The Board Chair noted that from a report he had seen the previous day, achieving the 75% target remained a significant challenge, however definitely the trajectory towards that had changed and it was also pleasing to see a lot of good will and commitment.
- In response to a question about achieving consistent application in the approach taken to those patients identified as having high CVD risk, Dr Charlotte Harris advised that she visited peer groups, making sure that those involved are thinking clinically about how to help the people identified. It was important to look at the needs of the whole person and to ensure follow up occurs.
- In answer to a question about the possible impact of prescription charges, Barbara Stevens advised that it is of concern that the prescribing dispensing data being received from NDSA indicates that only 50 to 60% of those prescribed triple medication for CVD risk are picking up their medicines. At the moment follow up lies at practice level (normally starting with phone contact to the pharmacy) but the PHOs are now working on investigating and auditing this problem.
- The CVD Risk Assessment tool in use is highly regarded as a well based, smart tool, very successful at a number of levels. It had originated from the work of Professor Rod Jackson at the University of Auckland.
- In answer to a question about advice on lifestyle intervention, Charlotte Harris advised that the gold standard involves discussing physical activity, diet modification etc. It is very difficult to be specific about how well this is achieved and whether it always takes place.

Barbara Stevens and Charlotte Harris were thanked for their presentation.

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 20 March 2013 (agenda pages 1-9)

Resolution (Moved Judith Bassett/Seconded Jo Agnew)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 20 March 2013 be approved.

Carried

Matters Arising:

No issues were raised.

3 DECISION ITEMS

3.1 Orientation of NGO Contracts to Support Health Targets and Better Public Health Services Targets (agenda pages 10-12)

Leanne Catchpole (Team Leader Health of Older People and Healthy Lifestyles, Waitemata DHB) was present for this item. Denis Jury summarised the report.

Leanne Catchpole advised that for Waitemata DHB they had written to all of the NGO providers advising of the proposed changes and had now received the feedback from them. Some are in support, others not.

The Committee Chair noted that there is nothing exceptional in what is being proposed: as part of the Boards' smokefree and nutrition projects they would be asking for sign up from other organisations.

Denis Jury confirmed that the clauses will be non negotiable, but both DHBs will be offering support to the NGOs in these areas.

In answer to a question, Denis Jury advised that the Aged Related Residential Care Contract is a national contract which the Ministry of Health negotiates. He thought that probably more progress could be made locally with Aged Related Residential Care providers on smokefree and nutrition objectives outside the contract, rather than trying to achieve a change to the national contract.

Resolution (Moved Chris Chambers/Seconded Jo Agnew)

That it be recommended to the Auckland DHB and Waitemata DHB Boards:

That the Board approves that smokefree and nutrition clauses are inserted into all NGO contracts to support the implementation of Smokefree Aotearoa and improved nutrition environments.

Carried

4. INFORMATION ITEMS

4.1 Palliative Care Services in the Waitemata District – Model of Care Update (agenda pages 13-18)

Tim Wood (Group Manager Funder NGOs, Waitemata DHB) summarised the paper. He confirmed that John Robertson, the Chair of the Steering Group, is still in the process of working through who the membership of the group should be.

Matters covered in discussion and response to questions included:

- Irrespective of ethnicity, those people needing palliative care need the same type of service, primarily involving helping people in their own homes. In doing so it is important to respond appropriately to cultural needs. At present however different workforces are carrying out this work in different parts of the District. The development of the model of care is intended to make sure availability and type of support is consistent across the District.
- Part of this initiative is trying to work out how to use the skilled workforce more effectively. That will be a key to success.
- It is hoped to get the steering group formed and to have its first meeting soon. The first draft of the discussion document for that meeting is being finalised.

The Committee Chair asked that the Committee be kept updated on progress and Tim Wood advised that it will be possible to have a short update for the next meeting in June.

The report was received.

4.2 The International Residential Assessment Instrument – InterRAI Long Term Care Facility Tool Update (agenda pages 14-21)

Tim Wood introduced this paper, noting that there will be a more detailed report to the Auckland and Waitemata DHB Board meetings on 15 and 22 May respectively. He noted that the paper predominantly focuses on the roll-out of InterRai to Age Related Residential Care facilities and the challenging target of achieving that for 100% of those facilities in a short space of time. There is not a lot of leverage to achieve this under ARRC agreements and there are particularly difficult issues in achieving it for smaller providers.

Matters covered in discussion and response to questions included:

- The IS issues partly relate to InterRai being run from two hubs nationally, with the northern DHBs being served from Canterbury DHB. Reliance on wireless connections meant that if they go down while an assessment is taking place, all the data gathered to that point is lost. An issue with the tool itself is that data can not be saved until the assessment is completed. Assessments are reported as taking as long as three or four hours each. Another issue is non integration with the systems that ARRC providers have.
- The Board Chair commented that InterRai is quite a good tool, but the problem is that it is difficult to use. In view of the strong national commitment to it, he suggested that some thought be given to whether there is some way of getting more utility out of it. He also noted that there is an issue that when the larger ARRC facilities do train people in InterRai, they become targets for recruitment from other organisations.
- The Committee Chair noted that the report identified the problems well, but did not provide much in the way of solutions. Members hoped that the report to the Boards would develop on that.

The report was received.

5. STANDARD MONTHLY REPORTS

5.1 Planning and Funding Update (agenda pages 22-25)

Janine Pratt (Group Planning Manager, Waitemata DHB) updated the Committee on progress with the Annual Plans for 2013-14. She advised that the National Health Board has granted one week's extension to the deadline for submitting the Annual Plans, which is now 25 May. The revised Annual Plans will be considered at the DHB Board meetings on 15 and 22 May.

The Committee discussed the increased complexity of the templates and instructions for completing Annual Plans, which led to them essentially being accountability documents, with little real use as planning documents. The Board Chair advised that the DHB Chairs are highlighting this as a key issue to be addressed in advance of the 2014/15 Annual Plan process and that he had also asked the CEOs to bring it up in their forum and in the discussions that the CEOs' Forum has with the Ministry of Health. He would also see if the CEO of the National Health Board and the Director General of Health would be willing to attend a CPHAC meeting to explain their approach and discuss the Boards' concerns.

Other matters discussed included:

- With regard to cervical cancer screening (pages 23-24 of the agenda), it was noted that removal of the ethnic data disparities would not in itself increase screening participation and, as affirmed at the 20 March CPHAC meeting, there are a whole range of other measures to be pursued to improve participation.

- It was noted that the section in the report on Maori Health Gain is to recognise a gap in reporting for those members of CPHAC not members of Manawa Ora, the Maori Health Gain Advisory Committee. It is a summary of some items only and in no way a substitution for the full paper on Whanau Ora which, in addition to consideration by Manawa Ora, has or will be considered by both DHB Boards.
- With regard to the comment on this subject in the Auckland DHB section of the report, it was agreed that information on how the different agencies are working together to provide better Mental Health wraparound services for vulnerable children and youth be provided at the next meeting.

The report was received.

6. General Business

Chris Chambers raised the issue of potential changes to the legislation concerning fencing of swimming pools, on which the Clinical Director of the Emergency Department at Starship Hospital had recently commented. The Committee supported the view that this legislation has had a significant impact on reducing child deaths by drowning (and damage to children from part drowning) and that any relaxation of requirements should be firmly opposed. It was agreed that the Auckland Regional Public Health Service be requested to make a submission on this. Denis Jury advised that he would follow this up.

There was also a discussion of whether a response should be made to the Auckland Council's Draft Unitary Plan, currently out for feedback. Issues mentioned included population health, disability access, home insulation, the differing standards proposed for large and small developments and the need for more playgrounds (particularly for 8-12 year olds) in intensive developments. Janine Pratt advised the meeting that the Auckland Intersectoral Health Group, with DHB representation, is looking at the public health issues raised by the Unitary Plan with a view to making a submission. It was agreed that a copy of the proposed submission from the Auckland Intersectoral Health Group should be referred to the DHB Boards before it is submitted. The Board Chair noted the wider point of the need to engage more in the overall determinants of health.

7. Resolution to Exclude the Public (agenda page 26)

Resolution (Moved Jo Agnew/Seconded Christine Rankin)

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 item, 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 20/03/13</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) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.</p>

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>2. Presentation – Future Development</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>
<p>3. Capitation Funding</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>

Carried

3.30p.m – 4.40p.m – public excluded session.

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

The meeting concluded at 4.41 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 1 MAY 2013

CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 04th June 2013

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 01/05/13	Presentation	CVD Risk Assessments – a breakdown of incentive payments made requested for next meeting	Andrew Coe	CPHAC 12/06/13	Refer Primary Care Update Report, Section 9.
CPHAC 01/05/13	4.1	Palliative Care Services in the Waitemata District – Committee to be kept informed on progress	Tim Wood	CPHAC 24/07/13	
CPHAC 01/05/13	5.1	Planning and Funding Update (ADHB section) – information on how the different agencies are working together to provide better Mental Health wraparound services for vulnerable children and youth to be provided at the next meeting	Denis Jury	CPHAC 12/06/13	Refer report 3.1 – covers ADHB and WDHB.
CPHAC 01/05/13	General Business	Fencing of Swimming Pools Legislation – Auckland Regional Public Health Service to be asked to make a submission opposing any relaxation of requirements.	Denis Jury		
CPHAC 01/05/13	General Business	Auckland Council Unitary Plan – proposed submission by Auckland Intersectoral Health Group to be referred to the ADHB and WDHB Boards before it is submitted.	Janine Pratt		Due to timeframes this was referred to the ADHB and WDHB CEOs for review prior to submission. A copy of this submission is enclosed for Committee members under separate cover with this agenda for information.

3.1 Child and Youth Mental Health Services Update

Recommendation:

1. That the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees receive this report describing the work undertaken to date in the mental health child and youth workstream
2. That the Committees endorse the proposed approach.

Prepared by: Lee Reygate (Programme Manager Mental Health, WDHB), Vicki Scott (Programme Manager/Team Leader Youth, Oral, Child, Maternity and Mental Health (WDHB)), Jean-Marie-Bush (Programme Manager Mental Health, Asian Health, Refugee and Migrant Health Services (WDHB)), Fiona Ironside (Operations Manager Child, Youth and Family Mental Health (WDHB)), Robert Ford (Planning and Funding Manager Mental Health & Addictions (ADHB)), Hilary Carlile (Planning and Funding, Manager – Mental Health and Addictions (ADHB)), Helen Wood (General Manager, Mental Health & Addictions (WDHB/ADHB))

Glossary

AOD	– Alcohol and Other Drugs
CALS	– Child and Adolescent Liaison Service
CAMHS	– Child and Adolescent Mental Health Service
CAPA	– Choice and Partnership Approach
CYF	– Child, Youth and Family
DAP	– District Annual Plan
DHB	– District Health Board
HSG	– Health Services Group
ICSS	– Intensive Clinical Support Service
IYSS	– Incredible Years Specialist Service
MOH	– Ministry Of Health
MSD	– Ministry of Social Development
PHO	– Primary Healthcare Organisation
PM	– Prime Minister
POC	– Package of Care
WSN	– Waitemata Stakeholders Network

1. Executive Summary

Both Auckland and Waitemata DHBs have Child and Youth Mental Health workstreams. These are closely linked through the co-sponsorship of Helen Wood (General Manager, Mental Health Services and Addictions - Waitemata and Auckland DHBs). In June 2012, the Auckland DHB HSG Leadership Group recognised that the next important piece of work for mental health and addictions would be the reconfiguration and further integration of multi-agency child and youth services. To inform this piece of work, the group commissioned a Child and Youth Workstream to review current global best practice and integrate this and evidence informed practice into a new model for delivering mental health services for child and youth.

The workstream is now a substantial way through its work and a strategic plan based on it will be published later this year alongside a detailed action plan for implementation. This plan will be led by Auckland DHB but involve multi-agency engagement and service integration to improve outcomes for our children, young people, and families affected by mental health issues.

In February 2013, the Child and Youth Workstream of Waitemata Stakeholder Network (WSN) commenced the development of a Mental Health Services Implementation Plan for Improving Services for Children and Youth with Multi-agency Involvement. The purpose of this project is to highlight the key principles and actions to be taken by Waitemata DHB Mental Health and AOD services to improve service delivery and coordination for children, youth and their families/whānau who have involvement with multiple health and social services agencies. The WSN project is due to be completed by 30 June 2013.

2. Background

Auckland DHB Project

In 2010, Auckland DHB reorganised and created the Health Service Groups, which brought together clinical leaders and planners in a new structure to oversee service developments and improvements across the continuum of mental health and addiction providers.

As a result of this restructure, mental health created a series of groups to provide a governance function and to assist with advising on planning and funding service initiatives and reconfigurations across the continuum.

One of these groups, the HSG Leadership Group, provides expert and experienced guidance to the HSG Executive to inform and advise on what appropriate reconfigurations of services need to take place in order to ensure a comprehensive and high quality continuum for mental health and addictions.

As part of their commitment to review and better understand the current service spectrum and to understand what constitutes best practice within each age cohort, the HSG Leadership have decided to create workstreams. These workstreams comprise leaders and experts within their respective fields and sometimes include clinicians, consumers, families/whānau, academics, and managers.

They are tasked with reviewing the literature in a specific field of practice and commenting on the evidence base, best practice, and “ideal” models of delivery. Having considered all this information the workstream will make recommendations for new service structures, organisation, and delivery.

One such workstream is the child and youth workstream (age range 0 to 25 years to align with other sectors) that is now about three quarters of the way through its task.

Approach

The approach taken involves working through the following stages:

- Understanding current resource
- Understanding how that resource is applied across the continuum and across all providers, including other government and non-government agencies involved in child and youth work e.g. WINZ, CYFS, Education
- Identify inter-agency overlaps and connections
- Identify and understand future demand
- Evidence informed global practices
- Service redesign and reconfiguration that pools all available resources across sectors and agencies for whole continuum approach
- Understand future resource allocation needs as part of new map of delivery; working with family and whānau focus rather than service focus
- Map steps required to move to new approach

- Report to HSG Leadership for endorsement and execution of plan – includes what do we stop doing, and what do we start doing.

The following policy documents have informed the work of the work-stream:

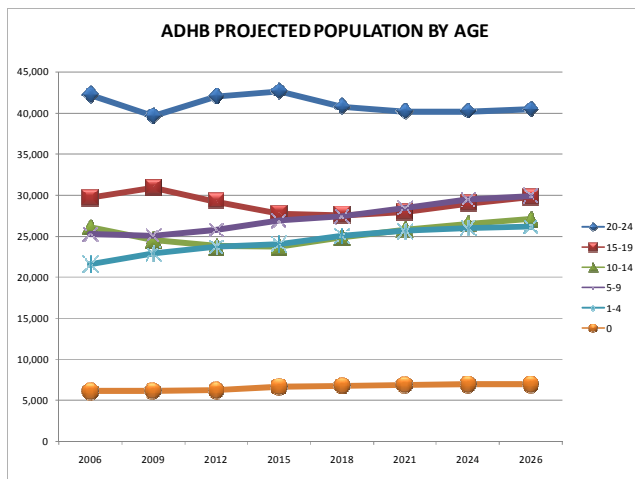
- Auckland DHB Child and Youth Improvement Plan 2012 to 2017
- Self directed care paper
- Localities approach paper
- Regional service planning
- Health Beginnings: Developing perinatal and infant mental health services in NZ 2011
- The Prime Minister’s Youth Mental Health Project 2012
- MH Commission Blueprint II 2012
- Ministry of Health ‘Rising to the Challenge: Service Development Plan’ 2013
- Whānau Ora

Auckland DHB Project Outcomes

The primary focus is to develop: a planning framework that provides sufficient detail to understand the options considered, the preferred approaches, and the steps required to achieve that desired continuum of services, including what we could stop doing to achieve the preferred outcomes.

Our findings suggest that:

- Some children and young people are facing significant challenges in terms of mental health, addiction and behavioural challenges or a combination of all three
- Within the ADHB boundaries there is not necessarily a large increase in population over the next ten years. It is the mix of ethnicity, the localities where young people and children live, and the predicted types of services that will be accessed, that gives us the challenge
- The age group for this strategy is 0-25, partly to align with our interagency partners and partly because the 18-25 years are seen to have a growing need and are dealing with transition to adulthood challenges
- Child and youth services have been developing at a slower rate than adult services because attention and resource investment have been on adult services
- The interface between the three key agencies is vital, and getting this working more effectively and in a timely way will be important: health, MSD and education.



Our focus for this work is:

- To work better to meet the needs of our diverse population and be more responsive to the needs of our Maori, Pacific, and Asian children, young people and their family or whānau between the ages of 0 to 25
- To work better with key agencies

- Intervene earlier: to ensure a more integrated and responsive system
- Design in partnership with children, youth, families, and clinicians the services that will best meet people's needs and support their recovery
- Measure and evaluate our progress

Auckland DHB Actions

The actions that Auckland DHB will take include:

- Develop a detailed action plan that is overseen by youth, families, and whānau, and the multiagency governance group, emphasising:
 - Youth, and family or whānau designed and led services for young people experiencing less severe issues for mental health and addiction
 - In partnership with clinicians, and family or whānau, designing and developing youth led services for those experiencing severe mental health and addiction issues.
 - In partnership with clinicians, and family or whānau, designing and developing child and family or whānau friendly services for children experiencing severe mental health and addiction issues.
 - Self directed care focus for family, whānau, and young person
 - Stepped care overarching approach
 - Intervene early – by collaborative and designed working with other agencies
 - Respond to the shift in need through session by session monitoring rather than routine practice
- Measure and evaluate our progress and outcomes
- Produce an online report card to track our progress

Auckland DHB approach is split into six core areas of activity which consist of:

1. Strengthening the voice
 - Authentically engage with children, young people, and their family/whānau who use our services or who may need to use our services.
2. Intervening earlier
 - This means we will look at our systems and service design so that children, young people, and their family/whānau can access services early and this will be integrated with primary care and a range of online options.
3. Addressing inequalities
 - This means listening to the Maori and Pacific voices to hear what types of services children, young people, and family/whānau would access and designing the services to meet those criteria.
4. Fostering Innovation
 - This means we have the opportunity of listening to the voice of children, young people, and their family/whānau and taking them on as partners in design and leadership to work innovatively.
 - We will do this by investigating and trying new models of care, working with young people to design services, allowing them to design and lead services for those with less severe mental distress.
 - We will develop new ways to deliver services especially developing online options. This will require us to make decisions on where to invest and where to divest resources so we live within our means.
5. Workforce
 - This means we will focus on two areas: growing and maintaining our workforce so it reflects the diversity of our population. We will also train our staff to understand the cultural diversity of the Auckland DHB population.
6. Working better together
 - This means building on the strengths of existing services and developing new services through listening to the voice of children, young people, and their family/whānau.

- Auckland DHB is committed to building on the strengths of existing services and integrating the ways in which children and young people like to work.
- We will continue to work with our colleagues across agencies to improve processes and access to the appropriate services at the right time.

Waitemata DHB Project

Context

In 2009, Waitemata DHB developed a Mental Health and Addictions Plan 2009-2015. Six focus groups contributed chapters to support the plan, detailing their key objectives and priority actions for the next five years. The Child and Youth chapter was formulated from two specific pieces of work and their subsequent documents: *The Infant, Child, Youth and Family Mental Health and Addictions Stock take* and *The Workforce Development Plan 2009-2015*.

In 2010, the Child and Youth workstream was initiated within the Waitemata Stakeholder Network (WSN) to drive and monitor the priority actions identified in the overarching Waitemata DHB Mental Health and Addictions Plan. More recently, a priority identified in the 2012/2013 District Annual Plan (DAP) was to “*Develop a multi/interagency strategy for services for high risk children and youth, to include transition, discharge and follow-up protocols, by 30 June 2013.*” This work is cognisant of and integrated with current Waitemata DHB inter-agency service provision (see Appendix 1 for a stock take of current Waitemata DHB interagency service provision).

The Prime Minister’s Youth Mental Health Initiative was launched in April 2012. The Initiative is a cross agency project to look at improving services to young people with or at risk of mild to moderate mental health problems. The specific deliverables of this initiative directly relating to the WSN project are:

- Review and improve follow-up care for those discharged from CAMHS and Youth AOD services (MOH led)
- A cross agency review of referral pathways within youth mental health services (MSD led).

Waitemata Stakeholder Network Project

In response to the DAP priority and the Prime Minister’s Youth Mental Health Initiative launched in April 2012, the Child and Youth workstream of the WSN has commenced a project to develop and implement a plan to improve services for children and youth with multiple health and social agency involvement. This project commenced in February 2013 and is on track for completion by 30 June 2013.

A plan is under development that outlines key principles and actions to be undertaken by Waitemata DHB Mental Health and AOD services to improve service delivery and coordination for children, youth and their families/whānau who have involvement with multiple health and social services agencies. The plan will include:

- High level overview of current Mental Health and AOD services activities and policies aimed at children and youth with multi-agency involvement
- Identification of key gaps in current multi-agency activities and policies within Waitemata DHB mental health and AOD services
- Key steps to address identified gaps –including opportunities for joint initiatives with other agencies
- Priorities for implementation.

The approach taken involves the following key activities:

- Develop a multi-agency reference group to guide the project
- Undertake a stock take of existing multi-agency activities and policies using a questionnaire, interviews and reference group workshops
- Finalise and release implementation plan.

WDHB Progress Update

A stock take of existing multi-agency activities and policies has been completed. Currently the draft plan is under review by the WSN reference group, with the final document due 30 June 2013.

3. Conclusion

The WSN and HSG Child and Youth projects are on track to meet their respective timeframes. On completion, each of these projects will produce a plan with a slightly different perspective. The WSN project plan will focus on improving service delivery and policy guidance, where multiple health and social services are involved. The HSG implementation plan will focus on service structures, delivery, and the continuum of care, concentrating on the integration of multi-agency child and youth work to provide better outcomes.

To achieve regional consistency of the two DHB projects, it is recommended that the outcomes of both projects are combined into a single overarching plan.

Appendix 1: Current Waitemata DHB Inter Agency Service Provision

Primary Mental Health Child and Youth Services

Waitemata DHB Youth Health Hub

During 2010, Waitemata District Health Board undertook a project to extensively review the provision of Waitemata DHB's funded youth health services. As part of this review, youth health service best practice models were considered. The outcome of this process was a decision that a number of youth health services, which included primary mental health services funded by Waitemata DHB, should be configured into a District Wide Youth Health Service (Youth Hub). Services delivered within the Youth Hub:

- Youth Engagement
- Sector Leadership
- Primary Mental Health Packages Of Care
- School Based Health Services (Alternative Education Units and Decile 1-3 schools)
- Enhanced Community Based Services (Youth Clinics)
- Clinical Liaison and Consultation.

Many of the young people accessing the Youth Hub do have involvement with multiple health and social services agencies including Schools, CYF and PHOs. A key aspect of the success of the Youth Hub is working with the young person, their family/whānau and across agencies to achieve an integrated and effective service delivery model.

Secondary Mental Health Child and Youth Services

Intensive Clinical Support Service (ICSS)

ICSS has been specifically funded to provide an innovative response to the needs of children and young people who are consumers of the Ministry of Social Development (MSD), Child, Youth and Family (CYF) and have serious mental health problems.

ICSS has a philosophy of seamless service provision and aims to minimise the number of professionals involved in each case with an emphasis on utilising the strengths of existing relationships. ICSS use the Wrap-Around Systems of Care Model. ICSS provides intensive clinical assessment and treatment services to children, adolescents and youth who have serious mental health problems and who are under the care of the MSD, CYF. The team is based at North Shore Hospital as a mobile community based service with flexible hours of operation.

The Incredible Years Specialist Service (IYSS)

IYSS provides added support and guidance to families participating in the Incredible Years parenting programmes. IYSS is run by Child and Adolescent Mental Health and primarily targets families who are referred by the Ministry of Education. This means that people from health and education work together to help children and families with their health, behaviour and learning. The programme works with the families of 5 - 8 year olds with conduct problems and derives from the Government initiatives around addressing the drivers to crime.

Child and Adolescent Liaison Service (CALs)

CALs is a small service provided to CYFS to assist them to work with children and adolescents with mental health problems that fall outside the mandate for ICSS and CAMHS. The service includes liaison, consultation and some capacity for assessment and client specific caretaker training. Following consultation clinics, which are held in CYFS offices, CALs pathways may include CALs assessment, referral for CAMHS partnership or referral to outside agencies. CALs has limited capacity to work with children and young people whom do not meet the criteria for CAMHS.

Fostering Security

Fostering Security is a training programme for parents and caregivers of children with early trauma and attachment difficulties. The programme is jointly delivered by CYF and Child Adolescent Mental Health Service staff and aims to:

- Provide caregivers with education around basic child development, and the attachment and physiological effects of early trauma, abuse and neglect
- Provide caregivers with practical management strategies
- Facilitate an integrated approach to caregiver support between CYF and Child Adolescent Mental Health Service
- Establish a support group for parents and caregivers
- Give parents and caregivers confidence to manage the challenging behaviours of their children, to develop health attachments and to sustain their placements.

A trial group is planned with the Waitakere CYFS site. With some FTE support, it could be possible to co-ordinate and roll out the programme to targeted caregivers across the Westgate, Waitakere, Takapuna and Orewa CYF sites.

School Refusal Care Bundle

Marinoto West CAMHS have worked extensively with Improving School Attendance (formerly Truancy Service) and the West Auckland Principals Association to develop a School Refusal Care Bundle. Under the CAPA model (care based around a partnership between the young person and clinicians), care bundles are a systematic way of measuring and improving clinical care processes by grouping together interventions that are more effective if given together than alone. They are an agreed set or cluster of clinical treatments that a team will provide for a particular condition, based on best practice and / or local clinical opinion. The School Refusal Care Bundle is currently being trialled by Marinoto West.

Secure Beginnings

Secure Beginnings is a 14 to 20 week individualised program designed to support a parent to recognise the strengths and struggles in their attachment relationship with their infants and pre-school aged children. After completing a comprehensive assessment, parents will be supported by a specialist in their home, using video feedback, to strengthen their ability to observe and reflect on their care-giving capacity. The programme offers parents an easy formula which they can use as a map to recognize and respond to their child's emotional needs. Secure Beginnings is a joint service between Dayspring Trust and Marinoto Child and Family Mental Health Service.

Secure Beginnings will give parents a better understanding of children's behaviours and what the behaviour is trying to achieve. Parents with infants will learn to make better sense of their infants needs. Parents with pre-school aged children will be able to better respond to their child's emotional experience and manage more challenging behaviours.

Lasting change comes from parents developing an understanding of their relationship with their child rather than learning techniques to manage behaviour. Using video review and reflective discussion, parents will be able to observe and reflect on their own individual experience. Secure Beginnings is based on the Circle of Security© program. The programme offers parents a user friendly 'map' to help recognise and respond to their child's emotional experience.

5.1 Primary Care Update Quarter 3 2013

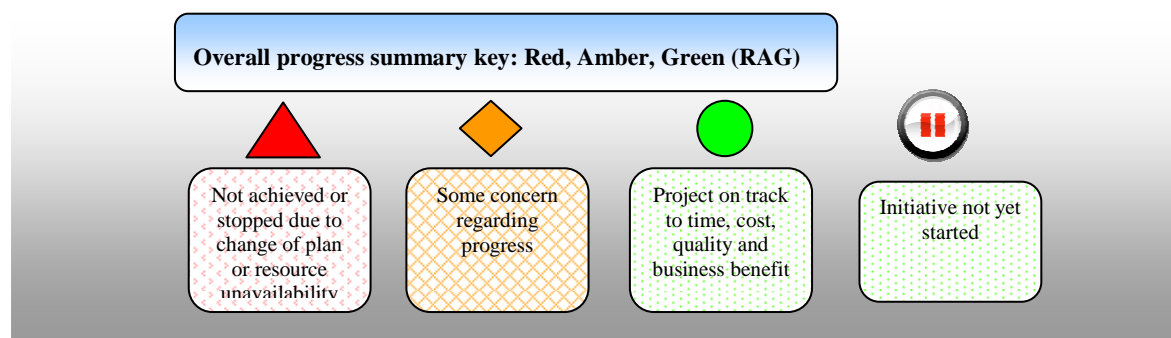
Recommendation

That the report be received.

Prepared by: Andrew Coe (Group Manager Primary Care, Waitemata and Auckland DHBs) and Stuart Jenkins (Clinical Director Primary Care, Waitemata and Auckland DHBs)

Glossary

- A&M - Accident and Medical Centre
- AH+ - Alliance Health Plus
- ALT - Alliance Leadership Team
- ARC - Aged Residential Care
- ATD - Access to Diagnostics
- BFG - Better, Sooner, More Convenient Primary Care Funding Group
- BSMC - Better, sooner, more convenient primary health care
- CAP - Community Acquired Pneumonia
- CSC - Community Services Card
- CHF - Congestive Heart Failure
- COPD - Chronic Obstructive Pulmonary Disease
- DAP - District Annual Plan
- DHB - District Health Board
- DVT - Deep Vein Thrombosis
- FFP - Flexible Funding Pool
- FSA - First Specialist Appointment
- HUHC - High User Health Card
- IFHC - Integrated Family Health Centre
- ISRW - Improving service and reducing waits
- NHC - National Hauora Coalition
- PHO - Primary Health Organisation
- PMH - Primary Mental Health
- PMS - Patient Management System
- POAC - Primary Options for Acute Care
- PPP - PHO Performance Programme
- RFP - Request for Proposals
- ROI - Registration of Interest
- TIA - Transient Ischaemic Attack
- WOC - Whānau Ora Centre



1. Summary

This report provides an update on matters relating to Primary Care for Quarter 3, 2013.

In addition, there was a request at the last CPHAC meeting to provide a high level brief overview on how funds for those activities that will now fall under the extended flexible funding pool (including SIA and Health Promotion) are currently spent. This is provided in section 8.

The committee also requested a breakdown of CVD risk assessment incentive payments to primary care and this is provided in section 9.

2. Primary Care Dashboard

The scorecard presented on the following page is a standardised performance scorecard which aligns to the overall organisational scorecard where possible. The scorecard shows how each District Health Board (DHB) is tracking against a wide range of measures. Given the DHBs focus on health targets, these are presented first in the scorecard as priority measures. Where appropriate, indicators are presented with performance by ethnicity. For each measure, the green bar reflects how well we are doing against the target for the period presented.

The progress green bar is weighted for each measure based on the degree of concern of any short fall in meeting the target. For the most part, these weightings reflect those used in the overall organisational scorecard. However, this element of the scorecard is still work in progress for some of the measures. For example, this weighting is noticeable for Health Targets where the scale is very sensitive so that any variance is deemed to be significant. If performance is achieving or better than target, the bar will display as a solid green line. Where the bar is blank, this reflects very poor performance against the target or where no data is available or no target has been set.

Summary Performance Against Targets

Priority One Targets

While the total health targets for the 'Better Help for Smokers to Quit (primary care)' and 'More Heart and Diabetes Checks' targets continue to improve each quarter, these targets remain a challenge for both DHBs. Senior management is meeting with Primary Health Organisations (PHOs) weekly to discuss health target performance and PHOs now have a plan in place to improve the 'More Health and Diabetes Checks' targets.

We do not currently have ethnicity data for the 'Better Help for Smokers to Quit' target. The smokefree target has seen a slight increase for both DHBs in the last quarter. The PHOs are in the process of developing action plans to meet the health target for 2013/14.

'More Heart and Diabetes Checks' is a new target for the 2012-13 year. Auckland DHB and Waitemata DHB are both sitting at 64% for the total population.

Service Delivery Targets

Waitemata DHB is sitting at 95% of the total PHO enrolment and 93% for Auckland DHB. Asian and Māori enrolment rates are lower than the other ethnicity groups.

Improving Māori Population Health Targets

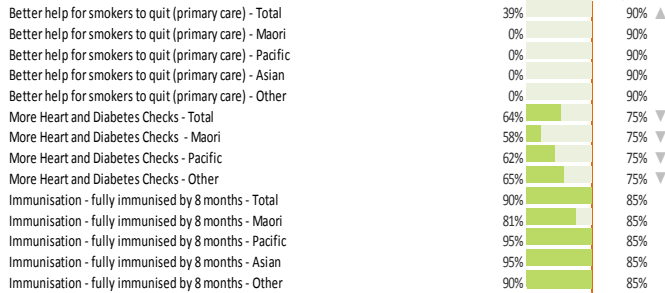
The Māori cervical screening rates remain lower than the other ethnicity groups.

Auckland and Waitemata DHB Primary Health Care Scorecard

2012/13 Q3

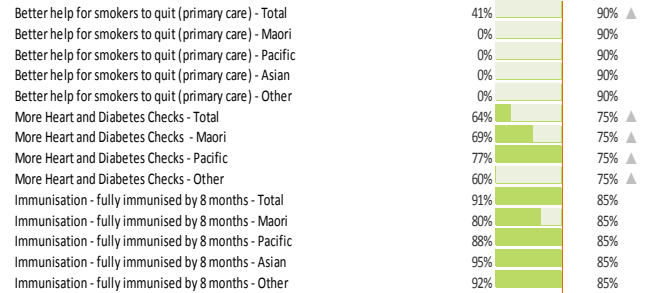
Priority One - Waitemata DHB

Health Targets



Priority One - Auckland DHB

Health Targets

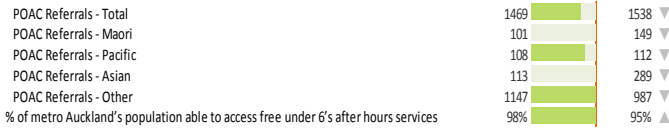


Service Delivery - Waitemata DHB

Enrolment



Acute Care



Service Delivery - Auckland DHB

Enrolment



Acute Care



Improving population health - Waitemata DHB

Key Conditions



Screening - to December 2012



Improving population health - Auckland DHB

Key Conditions



Screening - to December 2012












How to read

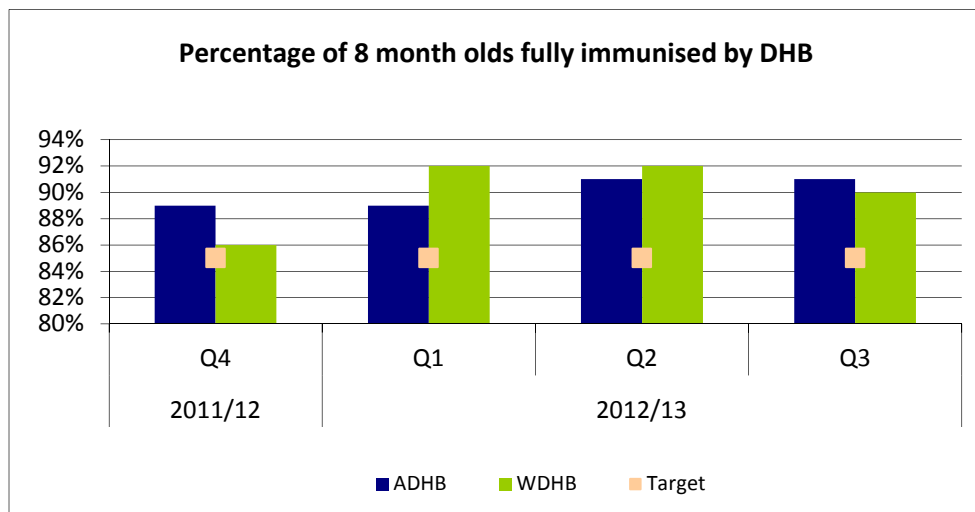
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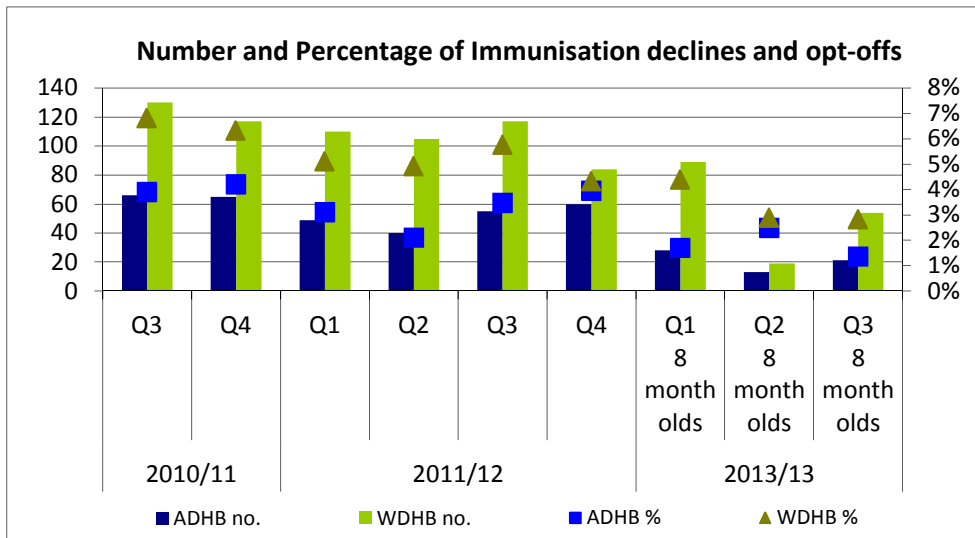
3. National Targets

Health Targets	Metro Targets 2012/13	Finalised Quarter 3 2012/13		
		Auckland DHB	Waitemata DHB	Metro
Immunisation (8-month olds)	85%	91% 	90% 	89% 
More Heart & Diabetes Checks	75%	64% 	65% 	64% 
Smoking – Brief advice	90%	41% 	39% 	42% 
Smoking- Brief advice for Maternal smokers ¹	90%	Not available	Not available	Not available

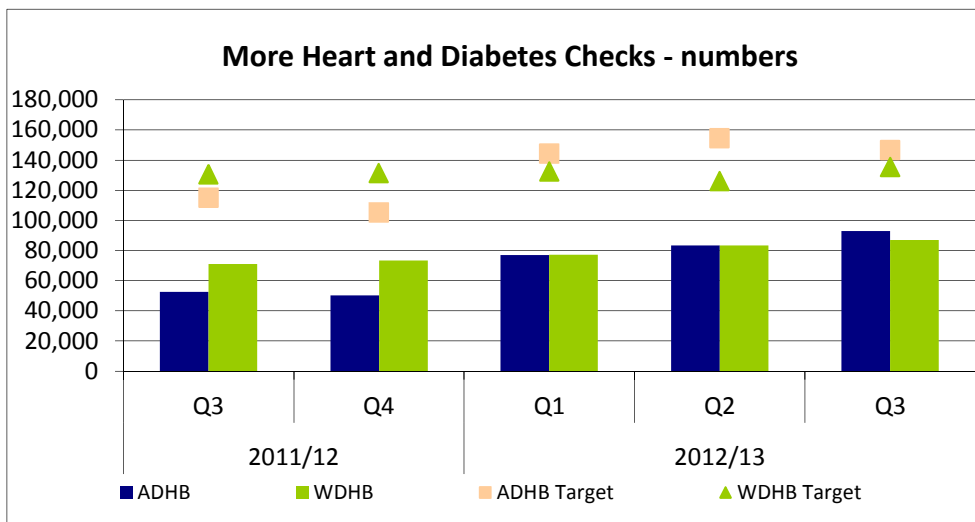
Immunisation Q3 2012/13



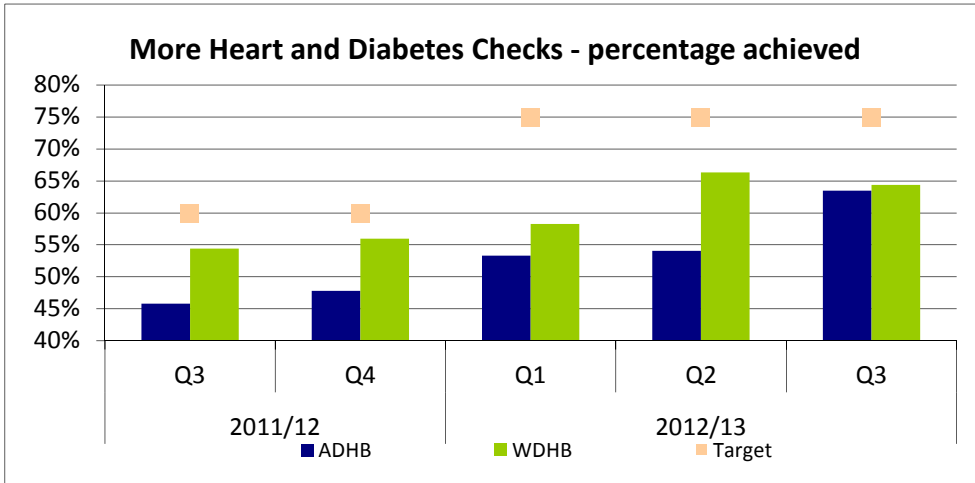
¹ There is currently no local or national system for collecting this data. The Ministry of Health is reviewing this target.



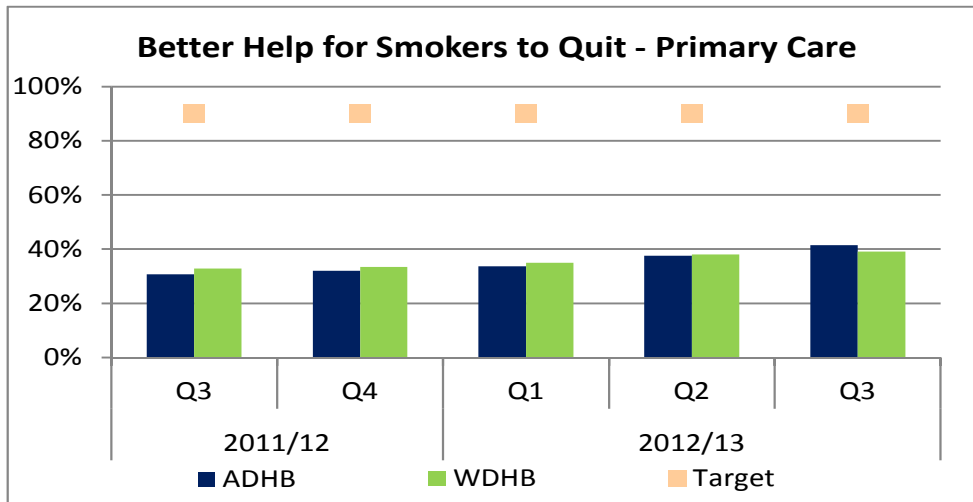
More Heart and Diabetes Checks Q3 2012/13



Please note the 'More Heart and Diabetes Checks' result is produced by the PHO Performance Programme (PPP) and is noted as the DHB level of achievement by the Ministry of Health in the DHB performance tables. The denominator for the quarter three report used by PPP was 135,141 (Waitemata DHB) and 146,518 (Auckland DHB). The shift in denominator over the last quarter was to increase Waitemata DHB denominator by 9,205 and reduce Auckland DHB denominator by 7,979. Waitemata DHB is reported to have assessed 87,091 people (64.4%). Auckland DHB is reported to have assessed 93,071 people (63.5%).






Better Help for Smokers to Quit – primary care Q3 2012/13






4. DHB Performance Measure: Policy Priority 2 (PP2) Implementation of Better, Sooner, More Convenient primary health care



There are three business cases operating in Metro Auckland; Greater Auckland Integrated Health Network (GAIHN), Alliance Health Plus (AH+) and National Hauora Coalition (NHC). The District Health Boards (DHBs) are partners within these business cases and their progress against their business case deliverables is attached in Appendix 1. The business case reports are discussed at the Better, Sooner, More Convenient Funding Group (BFG) meeting monthly and any risks identified. The table below is a DHB summary of progress to date.


Business Case	Monthly Report received	On Track	Risks and Future management	Who
GAIHN	Yes		The focus for the quarter has been on the DHB annual planning and meeting the health targets. Collaborative planning workshops with the PHOs have been used to generate content that meets both the planning guidance and letter of expectation. More importantly the process has strengthened relationships and provided a framework through which joint working will be undertaken. Moving forward GAIHN is well positioned to become the regional vehicle used to drive the implementation of enablers essential for our locality work programme.	BFG
NHC	Yes		The focus for the quarter has been on the DHB annual planning and meeting the health targets. Collaborative planning workshops have been used to generate content that meets both the planning guidance and letter of expectation. More importantly the process has strengthened relationships and provided a framework through which joint working will be undertaken.	BFG
AH+	Yes		The focus for the quarter has been on the DHB annual planning and meeting the health targets. Collaborative planning workshops have been used to generate content that meets both the planning guidance and letter of expectation. More importantly the process has strengthened relationships and provided a framework through which joint working will be undertaken. A number of practices have moved across to AH+ benefiting from the supportive infrastructure that is on offer.	BFG

5. Objectives set in our Annual Plan for this financial year


Target area	On track	Comment	Actions	Risks & future management
Diabetes		<p>Waitemata DHB The Diabetes Annual review (DAR) data for quarter three showed that 45% people with diabetes had an annual review in the year to date. ProCare Networks Limited has commenced the outcomes payment component of their Diabetes Care Improvement Package. They have not yet rolled out the package of care component of the service. The PHO has yet to produce an activity report. Waitemata PHO report that 331 people have been enrolled into the programme.</p>	<ul style="list-style-type: none"> • Quarter three reports show low numbers of people having an annual review as practices move from one service model to another. • The Planning and Funding Team met with ProCare Networks Limited on 18 April to discuss reports. These are pending. • Performance meeting with Waitemata PHO indicated that the practices are ensuring patients have access service. • Await ProCare Report to better understand how service is being implemented. 	<ul style="list-style-type: none"> • Monitor impact of Change to Diabetes Care Improvement Package.
Diabetes		<p>Auckland DHB The Diabetes Annual review (DAR) data for quarter three achieved to date is 69%. Quarterly reports have been received on time from all four PHOs. Action plans have been developed for PHOs that are identified as needing to improve performance to reach target.</p>	<ul style="list-style-type: none"> • Overall performance to date to achieve DAR is reasonable. However, there is still more work to be done in the last quarter to achieve the final target of 13922. • Auckland DHB has met with ProCare and has an action plan in place to address the remaining numbers of DAR. • Auckland DHB has implemented and conducted regular and more frequent contract meetings to monitor progress and address issues as they arise with immediate action. 	<ul style="list-style-type: none"> • Continue to support PHOs to improve diabetes care delivery.


Target area	On track	Comment	Actions	Risks & future management
Smoking		<p>Waitemata DHB The verified results for quarter three in primary care have been released with 39% for Waitemata DHB.</p>	<ul style="list-style-type: none"> • Both PHOs are continuing with the ‘catch-up’ project of phoning patients that missed receiving advice when they attended primary care. There has been a lower participation in the project from General Practices as it is competing with other priorities e.g. CVD Risk Assessments. There have also been issues with out-of-date patient phone numbers, so not as many patients are being reached as anticipated. • PHOs are continuing to identify and remedy issues with events not being recorded or reported towards this health target. Waitemata PHO is running data queries to identify patients that have been provided with advice and support to quit but it has not been captured in the coding. They are applying fixes, so that these interventions will be appropriately coded in future. • The PHOs are both running competitions throughout May in their Practices to promote World Smokefree Day on 31 May. • We are working with Maternity Services on how data collected on the ‘booking form’ can be used to measure achievement towards the Maternity ‘better help for smokers to 	<ul style="list-style-type: none"> • The phone call project has been extended through to the end of June. • The DHB is meeting with the PHOs to develop their programmes for 2013/14 with a focus on identifying data issues associated with the smokefree target and actions to resolve these issues.


Target area	On track	Comment	Actions	Risks & future management
			quit' Health Target.	
Smoking		Auckland DHB The verified results for quarter three have been released with 41.4% for Auckland DHB. This is an increase of almost 4% since the last quarter. Auckland DHB is not on track to achieve the primary care 'better help for smokers to quit' target. The PHOs have comprehensive programmes in place to achieve the target. This includes training, systems support and using DR Info to identify patients that haven't been correctly coded.	<ul style="list-style-type: none"> The DHB is meeting with the PHOs to develop their programmes for 2013/14. The focus is on identifying data issues associated with the smokefree target and actions to resolve these issues. Auckland DHB is currently in the process of recruiting a primary care/community smokefree coordinator to work in primary care and assist them in achieving the health target. 	<ul style="list-style-type: none"> The DHB will continue to meet with the PHOs monthly to monitor progress and discuss new actions to achieve the target.
More Heart and Diabetes checks		Waitemata DHB 64.4% of Auckland DHB eligible population have been assessed so far. The MOH result shows a 1.9% decrease in the Waitemata DHB assessment rate over the past quarter.	<ul style="list-style-type: none"> The DHB has extended the contracts with the PHOs to further enable them to meet the targets. Both PHOs are implementing their strategies. ProCare has increased their assessment rates through the use of agency staff. Weekly progress reports from PHOs on how additional activities are being implemented. Monitor weekly reports. Provide the CEO's with the weekly KPI report. Weekly PHO CEO and Group funding manager meetings. Continue to extend the Waitemata 	<ul style="list-style-type: none"> Waitemata DHB may not meet the Health target of 75% by 30 June 2013. Meet with PHOs CEO's in May 2013 to discuss agreements for achieving 2014 target of 90%. Provide the Senior Management Team with information about any service change and funding that the PHOs propose to meet the 90% target.

Target area	On track	Comment	Actions	Risks & future management
			DHB staff assessment options.	
More Heart and Diabetes checks		<p>Auckland DHB 63.5% of Auckland DHB eligible population have been assessed so far. MOH results show a 9.5% increase in Auckland DHB assessment rate over the past quarter.</p> <p>77% of eligible Pacific Island people have been screened in Auckland DHB (first to reach 75% target in New Zealand).</p>	<ul style="list-style-type: none"> • Performance based contracts are in place with the PHOs. • PHOs have submitted plans to show how they will achieve targets in a sustainable way. • Weekly monitoring continues. PHOs calculate that many more screens have been done but not captured in their weekly reporting - some estimating another 5% on top of their performance. This was evident with the recent MOH (PPP) results. • Workplaces (other than Auckland DHB) screening is being explored. • Acute Predict has been rolled out in Auckland DHB. • Auckland DHB staff screening underway June 2013 for three weeks. 	<ul style="list-style-type: none"> • Screening targets will be difficult to attain without screening inpatient, outpatient and workplace eligible population. PHOs are working to provide Auckland DHB with accurate data. • Some PHOs are not reporting by ethnicity weekly and others are not able to report weekly numbers therefore weekly numbers are “best estimates” at this stage.


Integration Activities



Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
Community dialysis		<p>Renal Services to</p> <ul style="list-style-type: none"> • Work with a Māori primary care provider to design, devolve and deliver Adult Haemodialysis services in a community setting. • Work with a Pacific primary care provider to design, devolve and deliver Adult Haemodialysis services in a community setting. 	<ul style="list-style-type: none"> • Partnership with a Māori provider in Glenn Innes is delayed as we need to finalise costs and funding. A potential site in Glen Innes has been identified by the Māori provider. An external project manager has been appointed, and design consultants are about to prepare documentation sufficient for a resource consent 	<ul style="list-style-type: none"> • Capacity requirements exceed speed at which new community dialysis units can be built. However the Greenlane dialysis unit refurbishment will provide a safeguard for this.




Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
		<ul style="list-style-type: none"> • Work with primary care providers to design, devolve and deliver Adult Haemodialysis for patients who are unable to home dialyse (Community Home Haemodialysis). • Implement a new model of care which will integrate kidney disease prevention, early intervention, and chronic kidney disease management services. 	<p>application for the proposed site. The Board of the Māori provider has responded positively to the proposal for an interim agreement and further meetings are planned for mid April to progress this. The architectural service fee structure is under further negotiation.</p> <ul style="list-style-type: none"> • Partnership with a Pacific provider for Dialysis unit in Onehunga is delayed as Council has declined use of the site for Community Dialysis. We are now refurbishing and reconfiguring the old Greenlane unit while investigating other options, including purchasing our own building/land in the Onehunga area. The local Pacific provider has indicated they are still keen to work with us on this option. • Draft rosters are now complete for the renal dialysis service integrating a new model of care and impact analysis is almost complete. 	
Primary Options for Acute Care (POAC)		<ul style="list-style-type: none"> • Increase the safe management in the community of people's acute care needs thus decreasing the number of avoidable Emergency Department presentations and subsequent hospital admissions. • Annual target of 23,473 POAC 	<ul style="list-style-type: none"> • 14,664 total referrals to March 2013 (87% of target). • 87% managed without admission. • 88% GP referred. • 4% Hospital referred (ED & Wards). • 8% St John referred. • Average Cost \$220.00 (including GST). 	<ul style="list-style-type: none"> • Waitemata DHB is currently exceeding target volumes. The total clinical costs will be monitored to remain within budget. • Develop criteria and/or policies for access to radiology investigations to ensure appropriate triaging of referrals and manage demand. Continue to work with the Access to




Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
		<p>referrals for 2012/13², 85% of these will avoid needing to go to hospital because of this care.</p> <ul style="list-style-type: none"> • July – March 2013 total referrals 14,664, (target 17,613). Monthly average 1,629 (target 1,956). • Counties Manukau DHB total 6,524 (target 8,721). • Auckland DHB total 3,027 (target 4,275). • Waitemata DHB total 5,113 (target 4,617). • Below target for Auckland DHB and Counties Manukau DHB. 		<p>Diagnostics project.</p> <ul style="list-style-type: none"> • IT development to improve data for detailed analysis and audit. • An evaluation of the Auckland Regional POAC service should be a focus for the 2013/14 year.
Regional after hours project		<ul style="list-style-type: none"> • A Network of at least 10 Accident and Medical (A&M) clinics open until at least 10pm, 365 days per year with reduced co-payments for under 6s, over 65s, HUHC, CSC and those living in quintile 5. 	<ul style="list-style-type: none"> • After Hours Project Partnership has agreed in principle to develop an overarching governance structure to include the Greater Auckland Integrated Health Network (GAIHN). In late January there was a strategic planning workshop for future planning for urgent care and after hours care workstreams. • Three workshops are being held in May/June 2013 between the new urgent care network (GAIHN workstream 2 and the After Hours Network). These are well attended 	<ul style="list-style-type: none"> • The After Hours Communications Sub-Group discussed the need to use the GP Liaisons from each of the DHBs to engage with the DHB communications teams in the next communications campaign to reduce pressures on the A&M clinics over holiday periods.



² The annual target is made up of: 6,150 Waitemata DHB, 5,700 Auckland DHB, and 11,623 Counties Manukau DHB.



Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			<p>by whole of sector and are expected to deliver a better whole of system urgent care model which will present better value for all parties. This is expected to be delivered by end of June.</p> <ul style="list-style-type: none"> The School of Population Health has presented the draft evaluation report at a meeting of all the sub-groups. The Auckland After Hours Network Agreement has been signed by the After Hours Consortium. The Agreement is now being signed by ProCare Networks Limited. 	
Chronic Obstructive Pulmonary Disease (COPD)		<ul style="list-style-type: none"> Deliver 120 Completed pulmonary rehab programmes in the community by June 2013: (30 in each Quarter) current baseline is approx 100 patients. Implementation of GAIHN's regional pathway for COPD by March 2013 (engage and plan Q2, implementation in Q3). 	<ul style="list-style-type: none"> It has been a successful and busy first year for our new Primary Care Partners Laura Fergusson. They have delivered stunningly well the new Community Pulmonary Rehabilitation service. This has been achieved without huge costs. A full report is available on request from Paul Birch, Specialist Physiotherapist Auckland DHB. To date > 190 patients have been triaged from the Auckland DHB waitlist (normally seen in the outpatient physiotherapy department instead of the accessible communities in which patients live). Clinical improvements as previously reported include 	<ul style="list-style-type: none"> Further work with GP engagement is essential as they are still slow to refer despite the GAIHN COPD Pathway. Work is being undertaken by GAIHN to improve uptake and use of this clinical pathway and we (physiotherapists) are applying ongoing strategies to promote and continue to engage primary care. Due to the success so far, a new three year contract has been offered to Laura Fergusson and is expected to be signed off in April.

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			<p>improvements in measurable disease specific quality of life; exercise capacity (and function); measurable and significant improvements to anxiety and depression as well as improvements to the BODE Score (predictor of mortality score) of this cohort.</p> <ul style="list-style-type: none"> Partnership between primary care and secondary care both from a physiotherapy and MDT perspective as well as GP engagement has been successful. 	
Health of Older Persons		<ul style="list-style-type: none"> Support GAIHN - 10% reduction in number of residents from Aged Residential Care (ARC) presenting to ED 2,000 bed day reduction in acute admissions from aged care sector across northern region by June 2013. 	<ul style="list-style-type: none"> GAIHN has continued to work with Auckland DHB district nursing leads, ARC facility clinical leads and managers, and Total Health Care (who will provide the service) to establish the IV pilot for ARC residents. Agreements on policies and guidelines have been reached and processes between the facilities and POAC have also been developed. KPIs for the three month report have been agreed. 	<ul style="list-style-type: none"> A communication plan and resources will be prepared. Target groups will include GPs working within ARC facilities, patients and families, and the facilities. The service is on track to be launched in April.
		<ul style="list-style-type: none"> 10% reduction of readmission rates for 75+ 	<ul style="list-style-type: none"> Auckland DHB: 13.88% against a target of 13.62% Waitemata DHB: 16.29% against a target of 15.25% 	<ul style="list-style-type: none"> The Ministry is currently reviewing the methodology used to calculate readmission rates for DHBs nationally due to there being significant data discrepancies within previous data sets. Early indications



Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
				are that both Auckland DHB and Waitemata DHB rates will be within targets for 2012/13.
Health of Older Persons (Waitemata DHB only)		<ul style="list-style-type: none"> Prevent 25% of high risk groups identified through Waitemata DHB's predictive risk model having hospital readmissions. 	<ul style="list-style-type: none"> Integrated Transition of Care Project completed the 12 month pilot phase on 31 March 2013 in accordance with the Board approved Business Plan. The outcomes evaluation analysis is due to commence, the final report will be completed by August 2013. 	<ul style="list-style-type: none"> The Business Case end date is 30 June 2013. The CEO has requested the Project continue while the interim outcomes analysis and recommendations are developed for the Waitemata DHB Board to consider.
Child Health		<ul style="list-style-type: none"> Support NHC to reduce Ambulatory Sensitive Hospitalisations (ASH) rates for under 2 year olds by 1% 	<ul style="list-style-type: none"> Monthly meetings are currently being held with NHC management and operational staff. Auckland DHB member on the NHC ALT is continuing to progress deliverables within the Annual Plan. 	<ul style="list-style-type: none"> ASH rates may not reduce. NHC may withdraw support for the Annual Plan. Continue to arrange management meetings to enhance relationships between both parties.
Sexual Health		<ul style="list-style-type: none"> Explore integrated model of care for sexual health services 	<ul style="list-style-type: none"> Work is underway to see if primary care data on sexual health services can be obtained from general practices. A proposed governance structure and engagement plan has been developed Waitemata DHB has committed to a co-design process for the development and implementation of sexual health services. At the recent PHO CEO forum, the PHOs highlighted the ongoing and 	<ul style="list-style-type: none"> Services to Improve Access (SIA) funding is currently used to deliver sexual health services to young people. The demand for sexual health services in primary care is increasing and is currently exceeding the level of SIA funding committed to sexual health service delivery. The PHOs across Auckland DHB and Waitemata DHB have different access criteria for sexual health


Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			increasing demand for sexual health services in primary care. The PHO CEOs are keen to explore how they can deliver and ensure sustainability of the required sexual health services.	services.
Radiology		<ul style="list-style-type: none"> Aligning radiology costs for POAC and Access to Diagnostics (ATD) and front line processes 	<ul style="list-style-type: none"> The ATD working group and POAC having been working on developing clinical criteria for access. There is now alignment with the agreement with providers in regards to reporting and quality requirements. Further investigation is required on aligning pricing schedules and front line processes. 	<ul style="list-style-type: none"> The main risk of aligning POAC and ADT radiology costs is a reduced service for POAC referrals as these may not be given priority by the provider as they would be paid more for the time slot allocated by a private patient. One option being considered is to have the same pricing schedule but include a surcharge for urgency.
		<ul style="list-style-type: none"> A regional target for waiting times for accepted routine community referred radiology. 	<ul style="list-style-type: none"> The Regional Target 2012/13, for waiting times for accepted routine community referred radiology is 75% of accepted referrals for scans within 6 weeks (42 days). Waitemata DHB is 51% - CT, 70% - X-ray, 56% MRI and 32% US. Auckland DHB is 66% - CT, 93% X-ray, 25% MRI and 58% US. Counties Manukau DHB is 72% - CT, 97% - X-ray, 50% MRI and 63% US. 	
High risk individuals		<ul style="list-style-type: none"> Develop avoidable admissions plan for high risk individuals identified by GAIHN predictive risk algorithm. 	<ul style="list-style-type: none"> Auckland DHB Senior Management Team agreed in early April that the GAIHN Workstream 1 prototype was a good opportunity to look at 	<ul style="list-style-type: none"> Directors for Nursing and Allied Health were interested in taking a broader locality approach. However, due to the need to move

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
		<ul style="list-style-type: none"> Set regional target for percentage decrease in growth of bed days for identified individuals. 	<p>doing things differently across a range of areas, including allied health and nursing. Directors of Nursing and Allied Health are engaged and pleased to be involved in the design. First meeting took place with two practices in the city fringe area; a ProCare practice and an Auckland PHO practice. Interventions will be discussed at a second meeting yet to be arranged</p>	<p>along the prototype this year it will involve just two practices this quarter.</p>
Non contact First Specialist Appointments (FSAs)		<ul style="list-style-type: none"> Increase non-contact FSAs by 4% each quarter. 	<ul style="list-style-type: none"> As at 31 March, non-contact FSAs have increased by 23% over 2012 volumes. The target for quarter three is 12% so the project is on track. 	
Clinical pathways (Auckland DHB only)		<ul style="list-style-type: none"> Implementation of GAIHN's regional clinical pathway for depression by June 2013. 	<ul style="list-style-type: none"> Mental health now have the detailed care pathway information for depression and have begun to break this down into the sections that are relevant for delivery in secondary and tertiary care services. We have a project group in place looking at the integration of secondary care services with primary care. This group is looking at how the depression care pathway might be implemented as part of their work. A detailed consideration of resource implications is required as part of this work. 	<ul style="list-style-type: none"> The delay is around the complexity of implementing the care pathway, the competing demands for development in primary care mental health, and the resource implications that are part of the care pathway. If the pathway is not able to be implemented fully, then an acceptable staged approach to implementation will be considered.




Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
Clinical pathways		<ul style="list-style-type: none"> A dementia pathway, which is regionally consistent wherever possible, will be developed by 30 June 2013. 	<ul style="list-style-type: none"> Auckland DHB Dementia Care Pathway Governance Group has been established and a project manager has been employed. Four workshops are scheduled with subject matter experts in May as part of the pathway development. This will align with the New Zealand Dementia Care Pathway Framework and the Regional Dementia Services Guide. The pathway will incorporate existing components of work, for example the Hospital Dementia Project, but will cross the continuum from community to aged residential care. 	
		<ul style="list-style-type: none"> A child health care pathway based on priority areas identified in the Auckland DHB / Waitemata DHB Child Health Plan by June 2013. 	<ul style="list-style-type: none"> The child health working group is refining the work plan and is looking to implement clinical skin infection pathways in the New Lynn IFHC. Practice data is being compared with hospital admissions in the Henderson cluster to identify high need practices to implement Asthma clinical pathways. 	


Primary Care Nursing

Project	On track	Comment	Actions	Risks & future management
Integrated wound care pilot		<ul style="list-style-type: none"> Pilot of an integrated model of care for complex lower leg wounds in two pilot practices in West Auckland. 	<ul style="list-style-type: none"> Meeting monthly with Practice and District Nurses, Allied Health and Shared Care Programme representative to monitor progress and ensure consistency of care between the two practices. The key nurse for the pilot in each practice is working well. Commence evaluation of the pilot. 	
Workforce development		<ul style="list-style-type: none"> Nurse Entry to Practice (NETP) Programme in Primary Health Care (PHC) settings. 	<p>Waitemata DHB</p> <ul style="list-style-type: none"> Seven PHC new graduates who started in the September 2012 intake continue in their General Practice, Hospice and Aged Residential Care (ARC) settings supported by the PHC Nurse Educators. Twelve more new graduate nurses have commenced in February 2013. These nurses have completed their first six weeks and are being supported in their Practice settings by the PHC Nurse Educators. These nurses are working in Aged Residential Care (ARC), General Practice, Hospice and Plunket settings. Two of these nurses in the ARC setting are supported with funding from a new ARC NETP programme. 	


Project	On track	Comment	Actions	Risks & future management
			<p>Auckland DHB</p> <ul style="list-style-type: none"> Four new graduate nurses commenced in general practice settings in September 2012 and four commenced in January 2013 and are supported on the NETP programme. 	
Quality Improvement Team-West Auckland Locality		<ul style="list-style-type: none"> The Quality Improvement Team will support general practices in the West Auckland locality to provide better care for people with diabetes and cardiovascular risk. 	<ul style="list-style-type: none"> Recruitment of 1.0 FTE Registered Nurse has been difficult. Currently completing a second recruitment phase. Options for secondment are being considered. 0.2 FTE General Practitioner position will be advertised shortly. 	<ul style="list-style-type: none"> Pilot funding till July 2014. Evaluation planned to understand how the service has improved the quality of diabetes care. Risk of unsuccessful recruitment of suitable candidates. Quality Improvement Nurse has been readvertised in April.




6. Locality Activities



Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
Locality Approach		<p>Locality Plans</p> <ul style="list-style-type: none"> Jointly agreed locality plan for Auckland West locality submitted to the Ministry of Health by 31 December 2012. Jointly agreed locality plans for Auckland Central and Auckland North localities submitted to the Ministry of Health by 31 March 2013. 	<ul style="list-style-type: none"> The Locality Establishment Governance Group (LEGG) was established in April. This group assumes a high level governance and monitoring role across the developing localities in the Auckland and Waitemata District. The group consists of Iwi, PHO CEO's, DHB planning and funding officers and is chaired by lead CEO of primary care. No plans will be submitted to the Ministry until agreed by the LEGG. 	<ul style="list-style-type: none"> The LEGG will provide high level leadership for the locality work. DHBs will engage with the Ministry of Health with regard to the locality plan deliverable.
Three Integrated Health Networks in place (2 in Waitemata DHB, 1 in Auckland DHB)		<ul style="list-style-type: none"> West Auckland 	<ul style="list-style-type: none"> The West Auckland Health Network (WAHN) continues to function. Waitemata DHB, ProCare and Auckland Council provided a joint update on locality planning to the West Auckland NGO forum in March. The Diabetes Quality Improvement Team roles have been advertised. 	<ul style="list-style-type: none"> The West Clinical Director maintains contact with the WAHN electronically. A face-to-face meeting will be arranged once the governance group is functioning. The Diabetes Quality Improvement role will be re-advertised. Secondment opportunities will also be explored.
		<ul style="list-style-type: none"> North Auckland 	<ul style="list-style-type: none"> The North Locality Clinical Director has been confirmed as Dr Sue Hawken. Dr Hawken will be seconded from Waitemata PHO for one day a week for an 18 month period. Sue is due to start on May 20. A working group of key 	<ul style="list-style-type: none"> The contracting process for Dr Hawken's secondment is underway. The North Locality working group is keen to obtain PHO Performance (PPP) and GP utilisation data for our localities. This data is not readily available to the DHB as some practices are reluctant to share

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			<p>stakeholders has been formed to help drive the North Auckland locality work with a particular focus on the development of the locality plan.</p> <ul style="list-style-type: none"> The group agreed the first cluster would be “Helensville, Kumeu, Huapai and Waimauku” areas in West Rodney, as this is an area of high need. A sub-group has been formed to provide a high level health needs analysis for the area. The second cluster would be the East Rodney Cluster. 	<p>identifiable data. However, we have agreement from both Waitemata PHO and ProCare to share an aggregated view of PPP data and GP utilisation data for the six practices in West Rodney in the first instance. This will be added to hospital data to provide a health needs analysis of the area.</p> <ul style="list-style-type: none"> The group will seek public health expertise in interpreting the data.
		<ul style="list-style-type: none"> Central Auckland 	<p>Local Health profiles</p> <ul style="list-style-type: none"> At the Senior Management Team (SMT) meeting in March a request was made for locality profiles to be developed. The intent is for each SMT member to sponsor activity in that area. To support that, the project team are developing Local Health Profiles for each Local Board initially developing a template for Maungakiekie-Tamaki. The Health Profiles will include basic demographic, population, geographic and transport data for each area, specific findings from the Health Needs Survey and information about providers both within DHB and others where possible. 	

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			<p>Community Engagement</p> <ul style="list-style-type: none"> The Clinical Director and Community Engagement Manager also recently visited the Local Health Partnerships (LHPs) in Glen Innes. This is made up of: The Glenn Innes Health and Wellbeing (GIHAW) group, which was re-established in August 2012 to address health priorities identified through the Tamaki Community Action Research (CAR) project. In March 2013, The LHPs in Glen Innes and the community working group identified their community and health-related priorities through a prioritisation process. The list of issues was predetermined from the CAR report and the online community health survey report for Maungakieke/Tamaki (Auckland DHB). The process was carried out by the member of the group, by placing a limited number of adhesive dots next to the items they perceived as most important. 	<p>This group is viewed as one that the Auckland DHB can engage through Locality work, in the development and improvement of health services in the Tamaki area.</p> <p>The top four areas prior to the list being validated again by the groups was</p> <ul style="list-style-type: none"> Increasing income to reduce poverty Health service information Mental health – (this also included “stress” which the members felt was important to note) Primary healthcare – quality and affordable
			<p>Mental Health</p> <ul style="list-style-type: none"> Glenn Innes did identify mental health as a priority area. There has been strong support from mental health, including Dr Ian Soosay and Molly Morris. There is a desire not 	<p>The Community Engagement Manager is planning on discussing the opportunity for a co-design process with LHP and possibility of a hui and/or involving partnership members on a mental health working group. We will</p>

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			<p>to lose that interest but understand there needs to be a process of co-designing with community.</p>	<p>also undertake a stocktake of mental health services in the area and set up a working group for a mental health project.</p>
			<p>Whānau Ora</p> <ul style="list-style-type: none"> The project team are interested in how Whānau Ora work relates to the Locality work and whether it will sit under the same Governance structure. A recent paper was submitted to the Waitemata and Auckland Boards, jointly by the Māori Health team and Primary Care, regarding a proposed plan and support for the implementation of Whānau Ora Centres. 	<ul style="list-style-type: none"> This is likely to be followed by a business case with more detail. More guidance is needed from the Governance group about the link between Locality and Whānau Ora activity.
		<ul style="list-style-type: none"> 4 clusters in place (Waitemata DHB only). 	<ul style="list-style-type: none"> Three cluster groups have been identified in the West Auckland locality: Massey, Henderson and New Lynn. Two initial clusters have been identified for North Auckland: West Rodney and East Rodney. A health needs analysis for these areas is underway. Cluster work has begun in Tamaki: Glenn Innes, Panmure and Mt Wellington, with more work planned to link Otahuhu and Onehunga. Initial work has compared GPs practices with enrolled and domiciled populations 	<ul style="list-style-type: none"> The Tamaki Cluster was identified as the first priority area for the Central Locality, due to significant community engagement that has taken place and the fact it has a high need population. Significant activity is also occurring, including

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			in Maungakieke/Tamaki to understand population movement and provider support from the local population. Next steps are to carry out the same work with Onehunga and Otahuhu and to add into the list attached PHO affiliation and any other relevant healthpoint data.	IFHC, the “Learning Hub” and Whānau ora centre discussions.
4 IFHCs operational across Auckland and Waitemata DHBs by June 2013		<ul style="list-style-type: none"> Whānau House in Henderson delivering new models of integrated care by June 2013 (engagement with surrounding practices in Q1, developing a new model of care in Q2 and implementation in Q3/4). 	<ul style="list-style-type: none"> Paediatric services continue to be delivered from Whānau House supported by Waipareira Trust’s Whānau Ora service. 	
		<ul style="list-style-type: none"> New Lynn Integrated Family Health Centre operational and delivering new models of care in line with West Auckland’s locality plan by 2013-14. 	<ul style="list-style-type: none"> New Lynn IFHC opened on April 2nd. A Paediatrician clinic along with other child health services will begin in July. 	
		<ul style="list-style-type: none"> Co-design process in place to explore new models of care within the development of Waiheke Integrated Family Health Centre by June 2013. 	<ul style="list-style-type: none"> Recent successful visits to Waiheke and Great Barrier including a co-design process to remodel service provision at the Barrier. A Health needs survey has been undertaken across localities in Auckland DHB with analysis including validation in Local Health partnerships and this is near completion. Initial work started on Local Health profiles and feedback results of the health need survey to DHB populations. 	<ul style="list-style-type: none"> Further work is identifying and establishing a Local Health Partnership and working closely with the health trusts/community and local board to do so, as well the clinical teams.

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			<ul style="list-style-type: none"> In March, the Auckland PHO CEO and Clinical Director along with the central locality community engagement manager attended the Waiheke Local Board Meeting, where the Health Needs Survey and the locality approach were discussed. 	
		<ul style="list-style-type: none"> Implementation of new models of care in collaboratively agreed priority areas within Alliance Health + Integrated Family Health Centres (engagement with surrounding practices in Q1, developing a new model of care in Q2 and implementation in Q3). 	<ul style="list-style-type: none"> Slower than planned progress due to Auckland and Waitemata DHB Pacific team merger resulting in limited capacity. Also, limited capacity to engage within Tongan Health Society due to internal changes. Concerted effort to advance implementation of new models continues with Alliance Health Plus and is a priority for the new joint Pacific Planning and Funding Manager. 	<ul style="list-style-type: none"> Slow progress – specific resource allocated to ensuring progress.
		<ul style="list-style-type: none"> Review current integrated care models being delivered in rural settings (Rodney) by December 2012 for potential networking between Integrated Family Health Centres in 2013/14. 	<ul style="list-style-type: none"> To be included in the North Locality Plan including locations for IFHCs. 	

7. Primary Care Operational Issues

Issue	Comment	Actions	Risks & future management
Contract Renewals	A number of current Non-Head Agreement PHO contracts are due to expire 30 June 2013.	<ul style="list-style-type: none"> • The primary care team are currently reviewing the PHO Non-Head Agreement contracts. • Auckland DHB has undertaken their contract review process. Agreement Review Templates were completed for all contracts expiring 30 June 2013 which included a recommendation for the future of the contract. The completed templates were then presented and discussed at the Planning and Funding Managers Meeting in April. • Commence contracting process for 2013/14 year. 	<ul style="list-style-type: none"> • Ensure PHOs are notified in a timely manner if current contracts are going to be exited or altered.
Practice/PHO movement	<p>Practice movement in 2013 Quarter 1 (January – March 2013):</p> <ul style="list-style-type: none"> • Avondale Health Centre (~5,000 enrolees) moved from ProCare to Auckland PHO. • Howick Medical Centre (~2,000 enrolees) merged with Crawford Medical Centre (~10,000 enrolees) at East Health PHO. • New Practices: <ul style="list-style-type: none"> • Bupa Care Services at NHC (62 enrolees). • Orakei Health Service at Auckland PHO (112 enrolees). • White Cross Lunn Avenue at ProCare (245 enrolees). 	<ul style="list-style-type: none"> • Practice movement continues to be monitored. 	<p>The new PHO Services Agreement is due to be implemented on 1 July 2013. The new agreement allows practices to move only once per year on 1 July with six months notice. Practices are able to move during the year but will be subject to DHB approval.</p>

Issue	Comment	Actions	Risks & future management
Audit and Compliance audits	The final Audit Report (dated 3 June 2011) from Audit & Compliance (A&C) in relation to general practices that have undergone an enrolment/capitation audit has been received. The final Audit Report includes a re-calculation of the funds recommended to be recovered. The re-calculation is in accordance with version 3.0 of the Financial, Claiming and Referred Services Audit Protocol (“New Audit Protocol”), which came into effect on 4 October 2012. It was a PHO Service Agreement Amendment Protocol Group (PSAAP) initiative and was agreed unanimously by MoH, PHO and DHB representatives.	<ul style="list-style-type: none"> Letters have been sent informing the PHOs of the new re-calculated amounts. Letters have been sent to Auckland PHO, National Hauora Coalition, ProCare and Waitemata PHO. 	<ul style="list-style-type: none"> DHBs will need to engage further with the PHOs regarding the recovery of the funds.
Annual statement of reasonable GP fee increases	The MoH has released the 2013/14 annual statement of reasonable GP fee increase. Using the same method as previously, the report states a 2.01% increase for the reasonable patient co-payment increase in 2013/14. This increase is for a practice that derives half of its income from fees and the other half from government (capitation) sources.	<ul style="list-style-type: none"> The Annual statement of reasonable fee increases has been sent to all PHOs 	<ul style="list-style-type: none"> The DHBs will continue to monitor general practice fee increases to ensure they align with the rules regarding fee increases
PHO Services Agreement and Alliance Agreement	<p>A new PHO Services Agreement and associated Alliance Agreement are being implemented from 1 July 2013. Many of the provisions of the Agreement remain unchanged, however key changes include:</p> <ul style="list-style-type: none"> A modular contract structure. Increased clarity on the roles and responsibilities of DHBs and PHOs. Updated minimum requirements of 	<ul style="list-style-type: none"> The DHBs and PHOs are working together to implement the PHO Services Agreement and Alliance Agreement. 	<ul style="list-style-type: none"> The MoH has requested the DHBs provide approval to pay in draft. This step will ensure that all the necessary administrative elements are in place while transitioning to the new Agreement. The total funding associated with the new contract is the same as current contracts so there is no financial risk associated with

Issue	Comment	Actions	Risks & future management
	<p>PHOs.</p> <ul style="list-style-type: none"> • New clauses to assist PHOs in their 'back to back' Agreements with providers, for example clarification of aspects of after hours and holiday cover responsibilities. • Increased transparency with respect to service information and the use of public funds. 		<p>payment of contracts in draft.</p>

8. Brief Overview of Current SIA and Health Promotion PHO Spend

In response to the request to provide a high level brief overview on how funds for those activities that will now fall under the extended flexible funding pool (including SIA and Health Promotion) are currently spent, the following table provides a breakdown by PHO.

	Waitemata PHO	ProCare	Alliance health +	Auckland PHO	National Hauora Coalition
Health Promotion	<p>\$410,577</p> <p>Is divided into 2 main areas</p> <p>Locality Initiatives</p> <ul style="list-style-type: none"> Physical and nutritional activity Mama, Pepi and Tamariki health Community events <p>Specific Programmes</p> <ul style="list-style-type: none"> Cervical screening for Maori Child health Push Play initiatives Smokefree PHO support Dietitian Education Service Management 	<p>\$1,980,731</p> <p>Community development</p> <ul style="list-style-type: none"> Lifestyle programmes Parish nurses Building knowledge Lifestyle coordinators ProExtra <p>Increasing uptake of services</p> <ul style="list-style-type: none"> Health promotion advisors Health promoting practices <p>Improving overall population health</p> <ul style="list-style-type: none"> Physical activity programmes (e.g.: active families, pacific nutrition) 	<p>\$2,875,842</p> <p>Health Promotion, SIA, Care Plus and Management Funding are all used in a flexible funding model.</p> <p>Flexible funding pool</p> <p>Priority areas</p> <ul style="list-style-type: none"> National Health targets Acute Demand Nurse Clinics Classification coding Practice determined indicators 	<p>\$124,125.72</p> <ul style="list-style-type: none"> Support practices to ensure increased access to targeted programmes such as influenza Development and piloting of specific programmes such as family violence intervention. 	<p>\$354,712</p> <ul style="list-style-type: none"> Breast feeding Maori Immunisation Cervical screening Maori youth access
SIA Funding activity	<p>\$579,049</p> <p>Is divided into 3 main areas</p> <p>Programme Specific</p> <ul style="list-style-type: none"> Sexual health Adolescent clinics Skin lesions Radiology Palliative Care 	<p>\$ 8,915,802.42</p> <p>ProExtra tool enables practices to access a common range of services across the whole network. The range of services is evidence based effective diagnostic, therapeutic, and pharmaceutical services to improve health outcomes and</p>	<p>A portion of the FFP will be top-sliced to fund practice related activities across the entire PHO based on practice enrolled populations. These network wide services currently include:</p>	<p>\$497,410.50</p> <ul style="list-style-type: none"> To ensure all Auckland PHO programmes are well utilised by the population groups experiencing health inequalities Contributes funds 	<p>\$3,594,741</p> <p>The funding streams to provide the greatest variation</p> <ul style="list-style-type: none"> After hours Extended hours of GP clinic Care Plus extension

	Waitemata PHO	ProCare	Alliance health +	Auckland PHO	National Hauora Coalition
	<p>Practice Claims</p> <ul style="list-style-type: none"> • Support funding for practice costs • Physiotherapy • Clinics at work sites • Home-based visits • Interpreter services <p>Population analysis</p> <ul style="list-style-type: none"> • Claims administration • Volumes analysis 	<p>reduce hospital admissions.</p> <ul style="list-style-type: none"> • Beta blocker initiation • Smoking cessation • Home visits • Flinders self management • Access to diagnostics • Spirometry • Mental health consultations 	<ul style="list-style-type: none"> • After Hours Care • Best Practice License for the suite of BPAC tools • Text-to-remind services <p>The quality payment component includes National Health targets, acute demand, nurse clinics, classification coding and practice determined indicators</p> <p>The FFP proportion is currently structured as follows:</p> <p>70% - Paid to the practices to support achievement of practice targets in the clinical framework</p> <p>20% - Paid to Practices as a quality payment subject to performance against clinical indicators</p> <p>10% - AH+ management fee</p>	<p>and support GAIHN work streams and programmes</p>	<ul style="list-style-type: none"> • Nursing outreach • Palliative Care • Sexual health consultations
Care Plus	<p>\$2,231,549 No Plan</p>	<p>\$10,533,740.89 Care Plus funding is paid on a fee for service for between 2-10% of each practice enrolled population. The balance of the funding is used to support after hours GAIHN development of clinical pathways and The Risk Stratification project and support staff to manage clinical programmes</p>		<p>\$679,655.22 100% for practice incentives</p>	<p>\$1,764,044 Care Plus funding flows through to the practices who have enrolled patients in the Care Plus service</p>

9. CVD Risk Assessment Incentive Payments

At the last meeting, the committee requested a break down of CVD risk assessment incentive payments made to primary care.

PHOs receive two funding streams to enable them to reach the health targets defined by the Ministry of Health.

1. Performance Programme Payments (PPP).
2. DHB specific contracts e.g. Auckland/Waitemata DHB CVD Agreement

9.1 PHO Performance Programme (PPP) Payment

As it is currently structured, PHOs are eligible to receive payments through the PHO Performance Programme based on their improved performance on indicators against targets. For the majority of indicators, the closer the PHO moves towards its target the greater the proportion of the payment they will receive.

The PHO Performance Management Programme has a strong focus on reducing health disparities. This is achieved through:

1. Measuring performance separately for high needs populations where appropriate
2. Weighting payments towards progress against targets, for high needs populations, and for those indicators relating to an area of health disparity.

The bi-annual payments for CVD risk assessment are \$4.00 per total population and \$6.00 per high needs population if the PHO reaches the agreed target. If targets are not achieved, the PHO only receives a percentage of the potential payment based on the formula determined by the Programme protocols. The PHO can potentially receive a maximum annual payment of \$8.00 per total population and \$12.00 for identified high needs population.

Table 1- PPP payments for PHO

PHO		Bi-annual Performance		Payment percentage	Payment Paid
		Jul-Dec 12	Jul-Dec 12	Jul - Dec 12	Jul - Dec 12
		Target	Performance		
Waitemata PHO	Total Population	67	59.43	0.56	\$7,287.29
	High Needs	67	55.21	0.26	\$3,388.06
Procare	Total Population	52.38	57.35	4	\$177,675.34
	High Needs	63.6	63.62	6	\$266,513.01
Auckland PHO	Total Population	60	63.28	4	\$11,751.26
	High Needs	66	67.01	6	\$17,626.90
AH+	Total Population	67	63.39	2.99	\$10,219.24
	High Needs	67	64.45	4.74	\$16,228.09
NHC	Total Population	67	51.84	0	\$0.00
	High Needs	67	52.92	0	\$0.00

For 13//14 the PPP will be aligned with the National Targets.

9.2 Auckland DHB CVD Agreement

An incentive payment, of up to a maximum of \$3 per enrolled eligible person for CVD risk assessment, is contracted for between Auckland DHB and its PHOs. This contract

commenced in March 2013. Milestone payments calculated based on each PHO's eligible, enrolled population at specified dates as follows:

1. On provision of an action plan by 1 April 2013. The Milestone payment is based on the eligible population (9,972) as at 1 December 2012.
2. On provision of a sustainable action plan and confirmation of achievement of the target 65% and 75% .The Milestone payment is based on the eligible population at 1 April 2013. However, for the purpose of allocated funding, this is currently estimated using the eligible population at 1 December 2012.

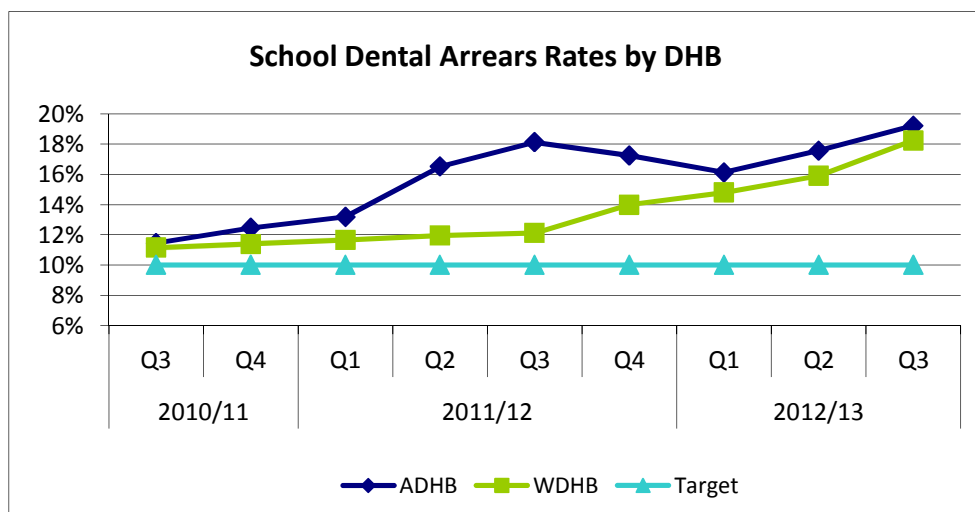
The maximum amount payable under this is \$495k.

9.3 Waitemata DHB CVD Agreement

There are two components to this agreement. The baseline amount available to each PHO is based on the number of eligible patients and is in the order of \$1m across both PHOs. Each PHO has chosen to allocate this amount differently to their practices. Procure have a \$26.67 incentive payment per high needs patient and \$17.78 per patient for other. Waitemata PHO has a flat \$26 per patient for all eligible patients. This funding is only sufficient to reach approximately 60%.

In addition to this Waitemata has provided an additional \$330k to reach the 75% target. Both PHOs have chosen a different approach to this additional funding. Procure are continuing with the incentive payments direct to the GPs as above. Waitemata PHO have invested this money into supporting infrastructure to help them achieve the target. This includes additional staff, text to remind and Dr Info.

10. Statement of forecast service performance measures



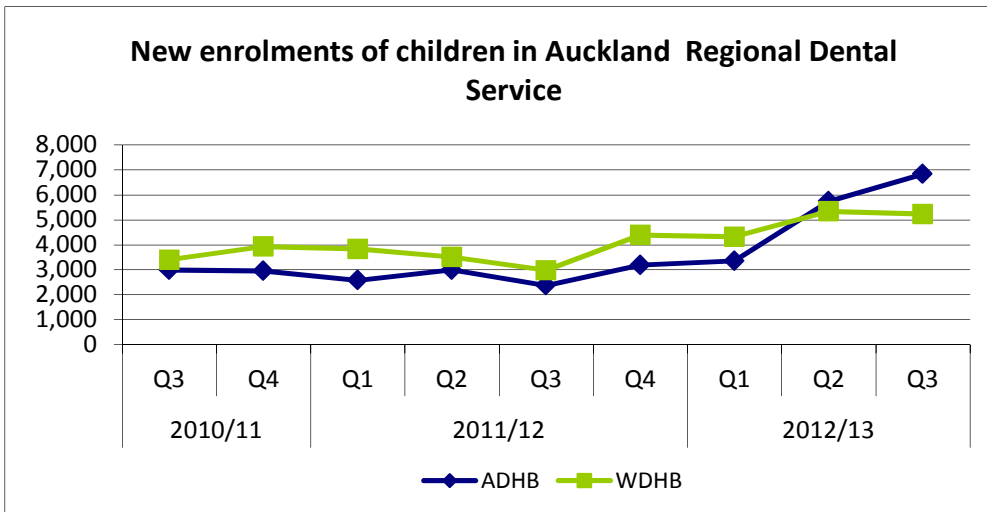
School Dental Arrears rates have increased for both Auckland and Waitemata DHBs in Q3 and are above the 10% target. The following issues have impacted the service's ability to achieve the 10% target in the past months.

1. As dental therapists continue to retire or resign, vacancies occur throughout the year. These vacancies are proving difficult to fill. Only new graduates from AUT and Otago are generally available to be recruited at the beginning of the year. Therefore vacancies during the year are not recruited until January the following year.
2. As more and more new graduates are recruited a significant number belong to the younger age group. A few have gone on maternity leave and these places are unable to be filled.
3. As more and more new graduates are recruited they need to be provided with clinical guidance and support for six months. In addition the need for staff training has significantly increased due to new facilities and equipment. Although these training sessions are essential they cause downtime leading to reduced productivity. These training sessions will continue until early next year by which time all new fixed and mobile facilities will be completed.
4. ARDS provides mentoring for AUT and Otago University students which impacts on the productivity of designated training chairs for up to 50% of the year.
5. As new clinics have been opened and old clinics closed there has been some disruption of the services in some areas causing down time and less productivity for a few days.
6. More and more preschool children are being enrolled and this boosts the number of enrolled children. In the year 2012, as per the business case, efforts are being made to enrol more adolescents in the targeted areas
7. The high DNA rate (35%) of preschool children leads to less productivity.

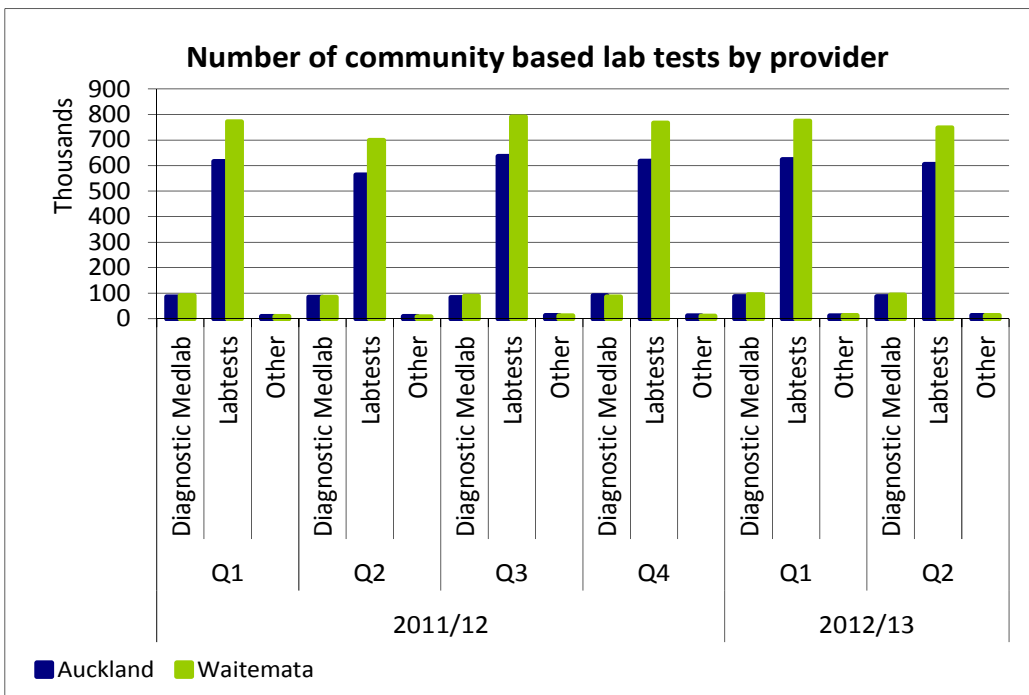
How are we working towards the target?

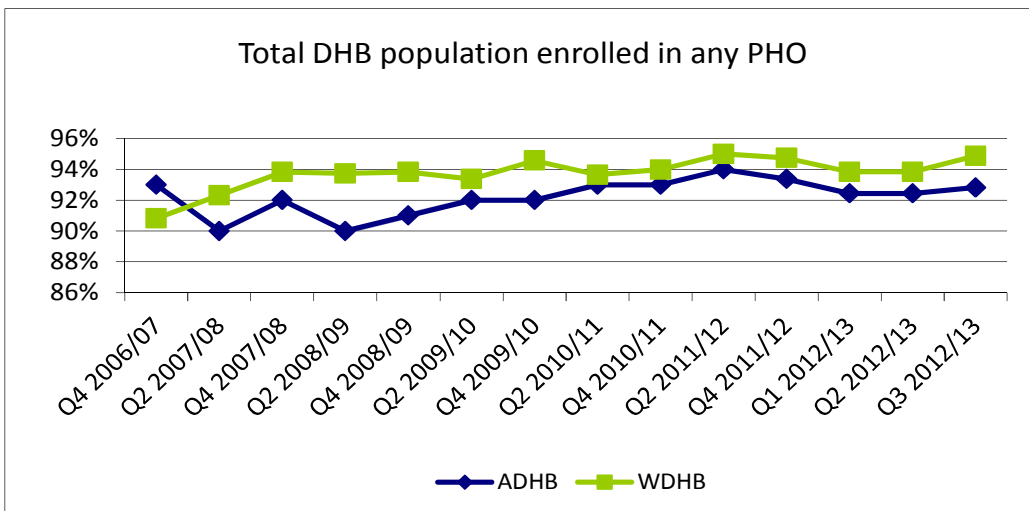
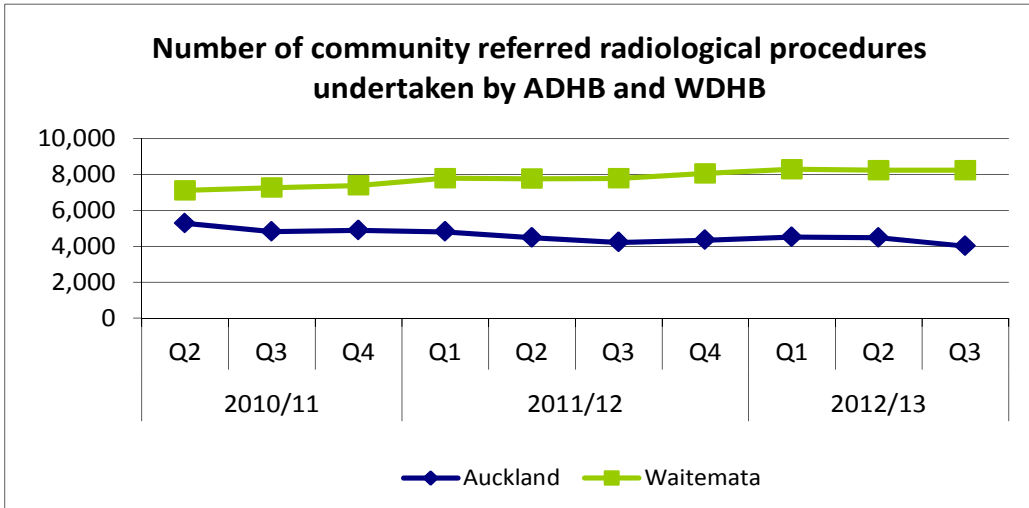
Auckland Regional Dental Service has implemented the following strategies to address the rise in arrears that has been evident during this period of change in service delivery and infrastructure.

- All team leaders are fully aware of the importance of reducing arrears and are working towards achieving the target of 10% by June 2013.
- Number of Dental assistants has increased over the period.
- Teams with high arrears are identified and necessary support and assistance is provided to achieve the target of 10%.



Enrolments continue to increase. Ministry of Health targets have been achieved for each age group. Focus is being put on enrolling 0-2 year age group.





5.2 Planning and Funding Update

Recommendation

That the report be received.

Prepared by: Denis Jury (Chief Planning and Funding Officer ADHB), Debbie Holdsworth (Chief Planning and Funding Officer WDHB), Julie Helean (Manager Planning and Service Development ADHB), Janine Pratt (Group Planning Manager WDHB), Tim Wood (Group Funding Manager WDHB), Cliff La Grange (Group Finance Manager WDHB) and Marty Rogers (Maori Health Gain Manager ADHB and WDHB)

Glossary

CPSA - National Community Pharmacy Services Agreement
DHB - District Health Board
HBSS - Home Base Support Services
LTC - Long Term Condition
NASC - Needs Assessment and Service Coordination
NGO - Non Government Organisation
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 Planning

The annual plans, Maori health plans and Northern Region Health Plan were submitted on 24 May to the National Health Board, including letters of support from the PHOs. The final versions responded to all the feedback provided by the National Health Board, however we are expecting further refinements to the plans based on the National Health Board review prior to finalisation. We are now working on the Statements of Intent with Audit NZ which are required to be submitted to the Bills Office by 28 June.

2.2 Maori Health Gain

Waitemata and Auckland DHB's Whānau ora policy position

The whānau ora approach/policy is in development. Te Rūnanga o Ngāti Whātua is leading this activity and will present and discuss the policy with Māori providers at the upcoming Māori provider forum in June 2013. A whānau ora mapping exercise that will support the policy is also underway and due for completion in June.

Support for whānau ora collectives

For 2013/14, the Ministry of Health have directed all district health boards to support the whānau ora collectives in their district.

Waitemata DHB is continuing to support Te Whānau o Waipareira whānau ora centre in Henderson. Work to integrate services within the centre is being undertaken. A joint project to develop the whānau ora workforce is underway and the first cohort of Waipareira staff members has received support from Hauora Māori funding to undertake training.

Discussions with Orakei representatives from their health clinic, corporate office and governance have occurred. The Auckland DHB is represented by members of the Māori health gain team and supported by Te Rūnanga o Ngāti Whātua. The discussions have revolved around community engagement, needs assessment and contract integration. This forum will continue to meet regularly.

Business case for a second whānau ora centre

The business case for the second whānau ora centre is currently in development. The business case proposes Maungakiekie-Tamaki as a possible site for the development of a whānau ora network, service and centre. Data is currently being analysed for the business case and a synthesised document will be circulated among stakeholders for feedback in June and presented to Manawa Ora in July. The business case is expected to be presented to the Auckland DHB Audit and Finance Committee in September.

Integrated contracts

Work to integrate contracts among Māori providers is underway. A review of contracts by the Māori health gain team has been completed. The next step is to develop and agree an outcome framework with Māori providers.

2.3 Nutrition and Healthy Lifestyle

A Nutrition Working Group has been established with representatives from Auckland DHB, Waitemata DHB Nutrition Services and ARPHS (CMDHB has also been invited to participate and will be attending the May meeting). The focus of the Group is improving DHB food environments but also establishing partnerships with other public sector settings e.g. Council, tertiary institutions etc. to facilitate changes in these settings. The Group's aim is to develop 'simple to implement' guidelines/criteria for healthier choices that can easily be picked up outside the health sector.

A nutrition clause has been developed for NGO provider contracts. Auckland DHB will include it in contracts being renewed for 2013/14. Sample policies and criteria will be available for providers via the ARPHS website.

3. Waitemata DHB Update

3.1 Home Based Support Services

Waitemata DHB's Home-based Support Services (HBSS) has remained largely unchanged since the devolution of funding to DHBs in 2003. The current model of care is outdated and is not optimal in fulfilling the DHB's commitment of 'best care for everyone'. The Planning and Funding Team has reviewed the current model of care and developed a proposal for a number of changes. The proposal includes moving to a 'Case-mix' model where clients are classified into groups based on the mix of functional needs. Providers are paid a set amount depending on the level of care required by the clients they provide services to. This model will allow flexibility for providers to customise care based on needs. It also supports a restorative and goal based approach to care whereby clients are involved in their care and are empowered to achieve optimal functioning and independence.

Another proposed change is better integration between HBSS, primary care and Waitemata DHB Needs Assessment and Service Coordination (NASC). Currently clients receive services in the community from a range of providers, however services are not as well integrated as they should be. The DHB is proposing prioritisation of services to those with higher needs to ensure the sustainability of HBSS in the district. The DHB is also proposing having Individualised Funding as an option, where clients manage their own funding and are accountable for arranging their own service.

Consultation on the proposals commenced on 27 May 2013. Key stakeholders have been informed, advertisements have gone into local papers and newsletters, and the consultation documents are available on Waitemata DHB's web site. The Planning and Funding team are available to meet with organisations / groups at their request. The consultation period will end on 24 June 2013.

The Planning and Funding team will consider all feedback and relevant information prior to making a final recommendation to the Board on the proposed model of care. The DHB will seek input from Auckland DHB under the Agreement for Bilateral Collaboration between the two DHBs. If the outcome of the consultation is a change in the model of care, the DHB will then liaise with the National Health Board regarding the service change process.

3.2 Funder Finance

The April 2013 consolidated core result for the Waitemata Funder was \$1.7M favourable to budget for the month and \$9.8M favourable to budget for the year to date.

Funder NGOs

The April 2013 core result for Funder NGO was \$1.5M favourable to budget for the month and \$5.8M favourable to budget for the year to date.

The year to date favourable position includes an upside of \$2.2M relative to PHO First Contact Capitation Services (payments based on number of PHO enrolees) and PHO Fee for Service deductions receivable. This is a net position and includes any offsetting variances in IDF caused by changes in General Practise memberships between ProCare PHO and Waitemata PHO.

Community Pharmacy continues to report a reduced level of monthly expenditure and the year to date favourable position for Funder NGO now also includes an upside in Community Pharmacy of \$1.4M. The reduced expenditure is in line with the monthly seasonal trend and is also a consequence of the user co-payment subsidy increasing from \$3 to \$5 on 1 January 2013. The year to date favourable NGO position also includes upsides resulting from Mental Health Services (\$635k) and Primary Care Demand Services (\$1.2M).

Funder IDFs

The April 2013 core result for Funder IDF was \$189k favourable to budget for the month and \$4.0M favourable to budget for the year to date. The main factor contributing to the favourable result continues to be the positive inpatient wash-up position receivable through the MOH default wash-up process. This is mostly reflective of lower acute utilisation of Auckland DHB facilities by Waitemata domiciled patients.

4. Auckland DHB Update

4.1 Immunisation

Auckland DHB continues to exceed the 85% national target for 2012/13 for immunisation of 8 month old babies with coverage at 5 May at 91% overall (Maori 79%, Pacific 88%, Asian

94%, Other 93% and NZE 94%). Coverage at age 2 as at 5 May remained at 93% (Maori 90%, Pacific 93%, Asian 95%, Other 94% and NZE 92%).

A number of strategies are being employed to increase coverage particularly of Maori including focusing on assisting practices that have a high Maori enrolment but low Maori coverage and ensuring that health professionals and parents receive consistent messages about immunising on time. Locating families is an issue and Auckland and Waitemata DHB have been advocating to the Ministry of Health over the last year unsuccessfully to date for practice level data on not fully immunised children to be available.

Other strategies under discussion include the use of incentives for families, improving access (transport, clinic times), practice staff training, in particular for receptionists, and use of the World Café methodology for engaging with large groups to explore issues and seek solutions. ADHB, WDHB and the Immunisation Advisory Centre are collaborating on the production of a DVD on dispelling common myths about contraindications for immunisation to be used in training health professionals. This should be completed in June 2013.

4.2 Rheumatic Fever

The Ministry of Health has accepted ADHB's Business Plan for the implementation of a school based sore throat swabbing programme that will have a phased rollout in 2013/14 involving 16 schools in total. The first four schools in the Glen Innes/Tamaki area will 'go live' on 5 August. Public health nurses and community health workers will visit schools three times per week and swab and child who identifies as having a sore throat. Children with a positive Group A streptococcal (GAS) result will receive antibiotic treatment. A more detailed briefing paper will be placed on the July meeting agenda.

4.3 Refugee Health

Around 30 practitioners and managers in refugee health (primary care and DHB) attended the Auckland Refugee Health Forum in April. The topic was: Transitioning from Mangere to the Community: resettlement challenges, including vaccinations. The forums are held quarterly. A training day for primary care receptionists on 'Customer Service with a cross-cultural focus' (refugee/new migrant) was held and 15 receptionists across the four PHOs participated. Feedback was very positive and the importance of listening, reflection and understanding came through strongly.

4.4 Funder Finance

For the month of April 2012 the funding accounts show a surplus of \$4.4m compared to a budget surplus of \$1.8m, a favourable variance of \$2.5m. YTD the actual surplus is \$22.6m compared to a budgeted surplus of \$11.0m, a favourable variance of \$11.6m. The YTD variance is split between a favourable variance for the "funder" of \$19.1m combined with "provider" unfavourable variance of \$5.5m.

The main features of the YTD result are a favourable budget variance in Personal Health and Med/Surg of \$15.0m, Mental Health favourable to budget by \$1.0k, Health of Older Peoples favourable to budget by \$3.2k and an unfavourable variance of \$5.5m in Provider services.