# Community and Public Health Advisory Committee Meeting

## Wednesday 17 February 2010

## 2:00pm

## Marie Hosking Room
## Level 7, Building 14
## Greenlane Clinical Centre
## Greenlane

*Hei Oranga Tika Mo Te Iti Me Te Rahi*
*Healthy Communities, Quality Healthcare*

# Community and Public Health Advisory Committee

## For discussion with Board

| CPHAC Meeting Date: | |
|---|---|
| Feedback By: | |
| **DAP** | |
| **RECOMMENDATIONS** | |
| 1. | |
| 2. | |
| **NOTING** | |
| 1. | |
| 2. | |
| **KPIs** | |
| **RECOMMENDATIONS** | |
| 1. | |
| 2. | |
| **NOTING** | |
| 1. | |
| 2. | |
| **RISKS** | |
| **RECOMMENDATIONS** | |
| 1. | |
| 2. | |
| **NOTING** | |
| 1. | |
| 2. | |
| 3. | |

# Community and Public Health Advisory Committee
# Action Points

| MEETING DETAILS | |
|---|---|
| Date and Time | |

| Agenda Item | Detail | Responsibility | Action |
|---|---|---|---|
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# 1

# KARAKIA

## 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.

# *2*

# ATTENDANCE AND APOLOGIES

# 3

# CONFLICTS OF INTEREST

# Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An “interest” can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction.
- Having a financial interest in another party to a transaction.
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it.
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction.
- Being otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

**IMPORTANT**

If in doubt – declare.
Ensure the full nature of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legisaltion.govt.nz) and “Managing Conflicts of Interest – Guidance for Public Entities” (www.oag.govt.nz ).

**Date:** 10/02/2010

# ADHB BOARD
# INTERESTS REGISTER

| NAME OF BOARD MEMBER | ORGANISATION | ROLE | FINANCIAL INTEREST | NATURE OF INTEREST | DATE OF LATEST DISCLOSURE |
|---|---|---|---|---|---|
| **Pat SNEDDEN (Chair)** | 1. Ngati Whatua o Orakei Maori Trust Board<br>2. Watercare Services Limited<br>3. Housing New Zealand<br>4. Tamaki Establishment Board<br>5. Quality Improvement Committee<br>6. Chief Crown Negotiator Ngati Kahu Claim<br>7. Chief Crown Negotiator Muriwhenua Forum | Consultant<br>Director<br>Chair<br>Chair<br>Chair<br>Consultant<br>Consultant | Hourly consulting rate<br>Fee<br>Fee<br>Fee via HNZC<br>Fee<br>Fee<br>Fee | Member of Treaty Negotiation Team in respect of Claim 388 register with Waitangi Tribunal<br>Wholesale supplier of water and waste water services to the Auckland region<br>Has a joint multi-million Healthy Housing programme with Health Board<br>Investigating a comprehensive cross agency intervention related to the Tamaki area including ADHB<br>Oversees implementation of quality programmes in DHB nationwide<br>Crown Negotiator Ngati Kahu Treaty of Waitangi Claim<br>Crown Negotiator Muriwhenua Treaty of Waitangi Claim | 3 September 2008 |

**Date:** 10/02/2010

| NAME OF BOARD MEMBER | ORGANISATION | ROLE | FINANCIAL INTEREST | NATURE OF INTEREST | DATE OF LATEST DISCLOSURE |
|---|---|---|---|---|---|
| **Harry BURKHARDT (Deputy Chair)** | 1. Replas Ltd | Owner/Managing Director. | Salary | Plastics Manufacturing Company | 6 August 2009 |
| | 2. Matta Products Ltd | Owner/Director. | | Plastics Manufacturing Company | |
| | 3. Remat Group Ltd | Shareholder/Director | | Plastics Manufacturing Holding Company | |
| | 4. Burkhardt Investments Ltd | Shareholder/Director | | | |
| | 5. Burris Ltd | Shareholder/Director | | | |
| | 6. Reco Ltd | Director | Fee | | |
| | 7. ADHB Charitable Trust | Trustee | | | |
| | 8. New Zealand Maori Arts and Craft Institute | Chairman | | Government owned Maori Tourist operation | |
| | 9. Matt I Ltd | Shareholder/Director | | Plastics Manufacturing Holding Company | |
| | 10. Matta LLC | Trustee | | Plastics Distribution Company USA | |
| | 11. Deputy Chair and Negotiator Ngati Kuri o te Iwi | Consultant | Fee | Negotiator for Ngati Kuri o te Iwi Treaty of Waitangi claim | |
| | 12. Packaging Council of New Zealand | Executive Board Member | | | |
| **Jo AGNEW** | 1. Senior Lecturer Nursing Auckland University | | Salary | | 4 February 2009 |

**Date:** 10/02/2010

| NAME OF BOARD MEMBER | ORGANISATION | ROLE | FINANCIAL INTEREST | NATURE OF INTEREST | DATE OF LATEST DISCLOSURE |
|---|---|---|---|---|---|
| **Susan BUCKLAND** | 1. Writing, editing and public relations services<br>2. Medical Council of NZ<br>3. Occupational Therapy Board | Self-employed<br>Professional Conduct Committee member<br>Professional Conduct Committee member | Fees<br>Hourly fee<br>Hourly fee | Writer, editor and public relations services<br>Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes<br>Lay member of PCC to assess complaints and determine outcomes | 7 August 2009 |
| **Dr Chris CHAMBERS** | 1. Employee, Auckland District Health Board<br>2. Wife employed by Safekids<br>3. Associate, Epsom Anaesthetic Group<br>4. Member, ASMS<br>5. Shareholder, Ormiston Surgical<br>6. Credentialing Committee for Ormiston private hospital<br>7. Surveyor Quality Healthcare NZ | | | | 3 February 2010 |

**Date:** 10/02/2010

| NAME OF BOARD MEMBER | ORGANISATION | ROLE | FINANCIAL INTEREST | NATURE OF INTEREST | DATE OF LATEST DISCLOSURE |
|---|---|---|---|---|---|
| **Rob COOPER** | 1. Ngati Hine Health Trust | Chief Executive | Salary | Management of a Health, Disabilities, Social & Education Services Trust | 1 September 2009 |
| | 2. New Zealand Research Centre for Growth and Development | Board Member | Fee (to Ngati Hine Health Trust | Governs a leading health sciences research centre | |
| | 3. James Henare Research Centre, University of Auckland | Advisory Board Member | Fee (to Ngati Hine Health Trust | Advises U o A on Maori research in Northland | |
| | 4. Manaia PHO, Whangarei | Shareholder | Fee (to Ngati Hine Health Trust | Governs a Whangarei based PHO | |
| | 5. Whanau Ora Task Force | Member | Fee (to Ngati Hine Health Trust | Assists in the development of Government's Whanau Ora policy | |
| **Dr Brian FERGUS** | 1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland | | | | 15 July 2009 |
| **Dr Ian SCOTT** | 1. Shareholder Chair Auckland PHO | Chair | Meeting fee | | 27 January 2010 |
| | 2. Locum GP | | Contract rate | | |
| | 3. Waiheke "Integrated Family Health Centre" Steering Group | Member | | | |
| **Bob TIZARD** | 1. Nil | | | | 27 February 2008 |

**Date:** 10/02/2010

| NAME OF BOARD MEMBER | ORGANISATION | ROLE | FINANCIAL INTEREST | NATURE OF INTEREST | DATE OF LATEST DISCLOSURE |
|---|---|---|---|---|---|
| **Seiuli Dr Juliet WALKER** | 1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procare | Self employed contractor | Contract hourly rate | General practitioner services | 1 November 2009 |
| | 2. Member, National Breast Screening Advisory Committee | Member | Fee | Consultant Pacific Advisor | |
| | 3. Facilitator, RNZCGP General Practice Education Programme Stage II | Contractor | Contracted monthly fee | Educational Support and Training | |
| | 4. ADHB Employee: contracted roster Doctor for Pohutukawa | Contractor | Hourly rate | Forensic sexual assault examinations | |
| **Ian WARD** | 1. Chair, Advisory Board, Healthvision Limited | | Fee | | 3 February 2010 |
| | 2. Principal/Director C -4 Consulting Limited | | | Tender to National Shared Services | |

**Date:** 10/02/2010

| NAME OF MEMBER | ORGANISATION | ROLE | FINANCIAL INTEREST | NATURE OF INTEREST | DATE OF LATEST DISCLOSURE |
|---|---|---|---|---|---|
| **Rev Alfred NGARO** | 1. **4pm Group Ltd**<br>2. Pacific Advisory Committee, PHAC<br>CPHAC member<br>3. National Task Force for Family Violence MSD<br>4. Family and Community Services national advisory group<br>5. Auckland Safer Communities<br>6. Tamaki Achievement Pathways Schooling improvement<br>7. Tamaki College Board of Trustees<br>8. Tamaki Community Development Trust | Consultant<br>Chair<br>Member<br>Task Force member<br>Advisory Member<br>Executive member<br>Chair<br>Elected Trustee<br>Member | Salary<br>Fee<br>Fee<br>Fee<br>Voluntary<br>Voluntary<br>Fee<br>Voluntary | Community Development<br>Pacific Advisory for ADHB<br>PHAC representative<br>Representative from Family and Community Services national advisory group<br>Development and implementation of a comprehensive social intervention logic for supporting families nationally<br>Development of Auckland Safer City plans<br>Chair management committee for cluster of 13 schools in management improvement initiative<br>Disciplinary and property Committee<br>NGO delivering social services within the Tamaki area | 11 May 2009 |
| **Farida SULTANA** | 1. Nil | | | | 6 August 2008 |

**Date:** 10/02/2010

| NAME OF MEMBER | ORGANISATION | ROLE | FINANCIAL INTEREST | NATURE OF INTEREST | DATE OF LATEST DISCLOSURE |
|---|---|---|---|---|---|
| **Lynda WILLIAMS** | 1. Maternity Services Consumer Council<br>2. Auckland Women's Health Council<br>3. Member National Antenatal HIV Screening Implementation Advisory Group<br>4. Chair Postnatal Distress Support Network Trust Board<br>5. ADHB Primary Maternity Services Steering Committee | Employee<br><br>Employee | Salary<br><br>Salary | | 4 August 2008 |
| **Iain MARTIN** | 1. University of Auckland | Employee | Salary | | 26 June 2008 |
| **Anne KOLBE** | 1. Private Paediatric Surgical Practice<br>2. Employee Communio NZ<br>3. Head, Auckland Clinical School, School of Medicine, University of Auckland<br>4. Husband: Employee University of Auckland<br>5. Member Risk and Audit Committee Whanganui District Health Board | | | | 12 December 2008 |

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# CONFIRMATION OF MINUTES

# - 27 JANUARY 2010

# Community and Public Health Advisory Committee
# Minutes

| MEETING DETAILS | |
|---|---|
| Time and Date | 2:00pm, Wednesday, 27 January 2010 |
| Venue | Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom |

| | |
|---|---|
| **1** | **KARAKIA** |
| | Puawai Rameka opened the meeting with a karakia. |
| **2** | **ATTENDANCE AND APOLOGIES** |
| | **Committee Members**<br>Dr Brian Fergus (Chair)<br>Susan Buckland<br>Dr Chris Chambers<br>Pat Snedden<br>Seiuli Dr Juliet Walker<br>Rev Alfred Ngaro<br>Jo Agnew<br>Harry Burkhardt<br>Dr Ian Scott<br>Rt Hon Bob Tizard<br>Ian Ward<br>Lynda Williams<br>**Maori Health Advisory Committee Members**<br>Liz Mitchelson<br>Puawai Rameka<br>**Pacific Health Advisory Committee Members**<br>Tafilelea Fa'avae Gagamoe<br>Aufa'amulia Asenati Lole–Taylor<br>Latoatama Halatau<br>Melino Maka<br>**Management in Attendance**<br>Garry Smith – Chief Executive<br>Dr Denis Jury – Chief Planning & Funding Officer<br>Taima Campbell – Executive Director Nursing<br>Hilda Fa'asalele – General Manager Pacific Health<br>Aroha Haggie – Maori Health Gain Manager<br>Janice Mueller – Director Allied Health<br>Ian Bell – Board Administrator<br>**Apologies**<br>The Chair declared the meeting open at 2:00pm.<br>Apologies had been received from Rob Cooper, Farida Sultana, Tepania Kingi and Naida Glavish. |
| **3** | **CONFLICTS OF INTEREST** |
| | There were no notifications of conflicts of interest for any item on the agenda. Ian Scott and Ian Ward advised of amendments to the interests register. |
| **4** | **CONFIRMATION OF MINUTES 18 NOVEMBER 2009** |
| | Moved Ian Scott; seconded Bob Tizard<br>*That the minutes of the Community and Public Health Advisory Committee meeting held on 18 November 2009 be confirmed as a true and correct record.*<br>Carried |

| 5 | **ACTION POINTS 18 NOVEMBER 2009** |
|---|---|
| | The action points were noted. |
| 5.1 | **Eating Disorders Services Update** |
| | Ian McKenzie, Regional Director, Mental Health and Addiction Services, NDSA and Deidre Maxwell were in attendance.<br>The government had provided funds to develop Eating Disorder Services with most of the money coming to the North for both the Northern and Midland regions. The project was now in the implementation stage of the services with under 15s to Starship in-patients and over 15 new facilities in the community together with DHB capacity. This is an expansion of the Eating Disorder Services for a robust continuum of care. The project was going well. Some of the challenges are the scale of growth of services particularly in recruiting specialist staff and the timing of opening of facilities, funding and establishing contracts. NDSA had a funding management role and there was a clear regional governance structure and problems could be escalated to the regional CEOs. ADHB had shown leadership and support.<br>Funding was designated for four years so there was a risk further out and a back to back agreement for the funding going to NDSA is in place. The parents group that had presented to the Board had been engaged as stakeholders and it was suggested that one of their representatives be on the regional governance group.<br>It was suggested that there needed to be a general discussion on governance of regional structures and networks. |
| 5.2 | **Timetable for January, February, March, DAP and SOI** |
| | The schedule showing the sequence of events was noted. The Board would consider holding a strategic planning day in association with the Strategic Plan development. |
| 6 | **PLANNING AND FUNDING PERFORMANCE** |
| 6.1 | **Planning and Funding Summary Report** |
| | The report was noted. The Auckland Sexual Abuse Foundation had secured a package of funding for another 12 months. With the health of older people home based support services contracts three providers had agreed to the model of care and funding with one other querying the funding which appeared to be a manoeuvre to obtain a bigger share of the market. They had been advised to accept the model. The InterRIA standard assessment tool was used nationally. |
| 6.2 | **Planning and Funding Indicators List and Exception Report** |
| | It was noted the number of other (non TB) disease investigations was increasing and the strategy to address this was to promote immunisation. The immunisation rate was close to the national target and would be met within the year. |
| 7 | **IMPROVEMENT ACTIVITIES** |
| 7.1 | **DAP Projects Report** |
| | The goal diagram for 2009/2010 did not distinguish disability and this would be considered in developing the 2010/2011 District Annual Plan.<br>It was noted that there were no projects under goal 3. The objective to increase Maori access to services was challenging in relation to resources and changing behaviours to address DNA. DNA had not reduced by the aimed 5% but in fact in the last year had increased. The project had presented to the Clinical Advisory Board and would present to the next Maori Health Advisory Committee.<br>Pacific were progressing building on the summit health last year using Healthy Village Action |

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| | Zones and on the improved immunisation rates.<br>While funding had been withdrawn by the Ministry for the devolution of secondary care services this was being picked up in the EOI process. |
| **8.2** | **DAP and SOI Update** |
| | There had been considerable work in January and progress made on the District Annual Plan. The Minister's Letter of Expectations had not yet been received. The Ministry had reduced the amount of reporting to the six health targets and another thirteen. The whole document would be coming to the next CPHAC meeting and would be approximately 80 pages long.<br>The Summary of Objectives was contained in section 5 and members were invited to email comments. Concern was expressed that the increasing number and demand by older people may put pressure on funding to children and there was a need to protect that as well as gains for Maori and Pacific.<br>Of the funding increase of $46m, $27m was for ADHB's population and this meant the budget would be tight against costs as while there was a zero ER national strategy steps within Meca's will increased costs. The transparent Health Sector Relationship process may assist.<br>The national/regional shared services would be stated the same in each DHBs DAP. New national prices were based on national average costs with an uplift from 18 months ago and would be different from the funding. There were stronger budget directions to a cost target rather than revenue with a strong focus on cost and volume management. |
| **8.3** | **Youth Health Improvement Plan** |
| | The Youth Health Improvement Plan had been out for public consultation then reviewed with some alterations as a result of the feedback. There was value in having a plan which showed direction acknowledging the present constraints on implementation. Youth Health would be in the prioritisation for funds process.<br>Moved Ian Scott; seconded Ian Ward<br>*That the Committee approves the finalisation and dissemination of the ADHB Youth Health Improvement Plan.*<br>Carried |
| **8.1** | **Primary Care Business Cases** |
| | **1. National Maori PHO Coalition.**<br>Simon Royal presented to the Committee on the National Maori PHO Coalition Whanau Ora business case which included eleven PHOs with an enrolled population of 250,000 with a focus on building pathways for whanau ora with an initial proof of concept through defining the system, identifying how to reorientate systems of care and identifying efficient use of health and social resources to improve outcomes. It was dependent on aligning investment to get the outcomes. The aim was vertical and horizontal integration of services and government departments.<br>The coalition was working with GAIHN and other groups. KPIs for outcomes would be developed and there was continual strategic review to avoid replication or silo development.<br>**2. Alliance Health+**<br>Winston Timaloa and Olo Elise Puni presented to the Committee. The aims of the first year were to enhance primary care and navigation through the health system of appointments and follow-ups through community support and out reach services including extended hours and access to labs and radiology together with referral management. Transformational change was consolidation of the three PHOs into one with consequential savings. 70% of the enrolled population were high health needs and they would be following the whanau ora approach with wrap around care for families. Issues were business rules for enrolled/non enrolled, regional approach, clinician networks and IT platforms and they would be cooperating and supporting the Maori and GAIHNs proposals. |

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| | **3. Greater Auckland Integrated Health Network (GAIHN)**<br>Paul Roseman presented to the Committee. The focus was on reducing health inequalities using the whole system with measurable goals and outcome measures. The aim was changes in patients' experience and clinical quality, consistency and best practice, transform productivity and patient care and improve equity and enhance whanau ora through matching resources to influence. There would be transparent measures of performance on health outcomes, patients' experiences and financial performance with regional care pathways. There would be models of care for long term conditions, GP access to diagnostic tests, radiology, improved POAK and regionalisation, addressing inequality including whanau ora and use of clinical audit tools. The goals would need to be agreed regionally and through a charter be part of DHBs DAP.<br>An aligned view and priorities across metropolitan Auckland DHBs was tabled providing a Board checklist and assessment criteria for the business cases.<br>Moved Pat Snedden; seconded Ian Scott<br>*That the Committee supports in principle the PHO primary care business cases to be developed to the guidelines and criteria.*<br>Carried |
| **8.4** | **Review of Funding contracts Using the Results Framework** |
| | The paper was noted and while it was important to have prioritisation framework care needed being taken to maintain the Maori and Pacific gains that had been achieved. |
| | **PUBLIC EXCLUSION** |
| | Moved Ian Scott; seconded Jo Agnew<br>*That in accordance with provisions of Schedule 3, clauses 32 and 33 of the New Zealand Public Health Disability Act 2000 public be excluded for consideration of items 8.5 and 8.6.*<br>*The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:*<br>*General subject of each matter to be considered: Health Select Committee Response and Auckland Regional Public Health Services Funding*<br>*Reason for passing this resolution in relation to each matter: To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)*<br>*Ground(s) under clause 34 for the passing of this resolution: That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.*<br>Carried<br>Moved Brian Fergus; seconded Pat Snedden<br>*That the Community and Public Health Advisory Committee resume in public meeting.*<br>Carried |

| | **NEXT MEETING** |
|---|---|
| | The meeting closed at 5:50pm<br><br>The next meeting is scheduled for<br>2:00pm, Wednesday 17 February 2010<br>Marie Hosking Room<br>Level 7, Building 14<br>Greenlane Clinical Centre |

**CONFIRMED**

**CHAIR: DATE:**

# 5

## ACTION POINTS

## - 27 JANUARY 2010

**Community and Public Health Advisory Committee**
**Action Points from the meeting on Wednesday 27 January 2010**

| Item | Detail | Designated | Action |
|---|---|---|---|
| Carried forward | Treatment of Dementia to be discussion CPHAC March 2010 | Denis Jury | |
| Carried forward | The Committee asked for DNA rates being reported back to the Maori Health Advisory Committee be compared with Counties Manukau rates and national rates | Denis Jury<br>Naida Glavish | Note report to MHAC |
| 5.1 | There needed to be a general discussion on governance of regional structures and networks. | Garry Smith | |

# 6

# PLANNING AND FUNDING PERFORMANCE

**6.1 Planning and Funding Summary Report**

**6.2 Planning and Funding Indicators List and Exception Report**

**6.3 Planning and Funding Indicators (Full set)**

## 6.1 Planning & Funding Summary Report

## Planning and Funding Functional Group

## Summary Report

### 1. Lifting the Health of people in Auckland City

#### Oral Health

Our first two mobile dental units have been completed and delivered. Staff training has been organised. The service will commence 8 February 2010. Resource and building consent has been obtained for Sylvia Park and Point England Clinics. Tender documents were issued for these clinics and have now closed.

#### Emergency/Pandemic Management

Pandemic planning activity continues, with key priority being ARPHS' organisational readiness for an expected "new pandemic wave" of H1N1. Main planning activities involve refining emergency activation plans, activation scenario training for ARPHS staff, and the reviewing of operational processes and procedures. ARPHS is coordinating pandemic planning activities with the regional Health Coordinating Executive Group (HCEG) and the regional HCEG Pandemic Working Group (HCEG PWG).

### 2. Performanc e Improvement

#### Pharmacy

The Community Pharmacy Agreement has been established for an eighteen month period. This time period was determined to ensure that both the sector and DHBs put energy into the creation of the new contract funding mechanism for the future.

The four northern DHBs will continue to work collaboratively and collectively on community pharmacy in three key areas:

1. relationship development
2. contract review, and
3. e-prescribing

#### After Hours Services

Whitecross and ADHB met to clarify expectations of the service provided. A new agreement has been drafted to incorporate clarification. The service is as specified previously, however there have been changes made to opening hours in a number of clinics moving the close time back to 8pm, with changes in the funding to reflect this. The overnight arrangement is unchanged.

A number of meetings have been held with GP practices across the Central Auckland region who currently provide after hours services to understand the nature of the existing after hour service provision and where things could be improved for the future.

Contracts are in place with each PHO to enable them to purchase face- to- face clinical services for their high needs populations at White Cross Ascot Accident and Medical Clinic between the hours of 10pm and 8am 7 days per week.

### 3. Live Within Our Means

#### Auckland Sexual Abuse Help Foundation (ASAH)

The project to seek intersectoral commitment to a one-off emergency funding package to compensate for the ACC funding ($361,000 p.a.) withdrawn as of 31 January 2010 for ASAH was successful. Commitment was achieved from NZ Police, CYF, Ministry of Health and ADHB (Mental Health). A proposal for an intersectoral long term funding framework was forwarded to the Ministry of Justice for consideration by the Taskforce for Action on Sexual Violence. The interim funding package will allow ASAH to continue to provide services at the current level pending decisions on a long term funding model.

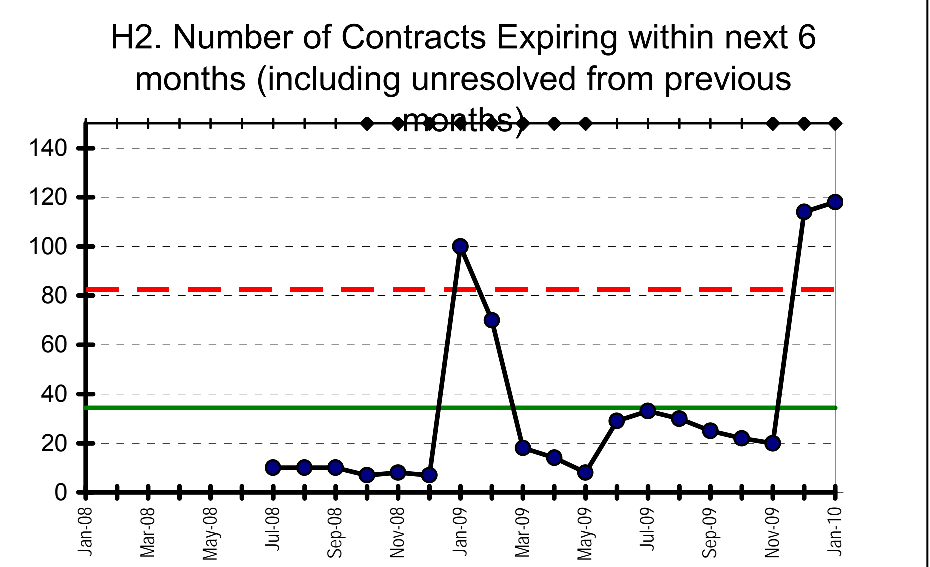
#### Immunisation

A draft Immunisation Strategy for ADHB has been developed and it is intended to seek regional commitment to at least some over arching principles and objectives. Discussion has begun with Northland, Counties Manukau and Waitemata DHBs regarding the Ministry directive for a regional immunisation strategy for 2010/11. A submission to the Health Select Committee "Inquiry into how to improve completion rates of childhood immunisation" is being prepared (due 12 February).

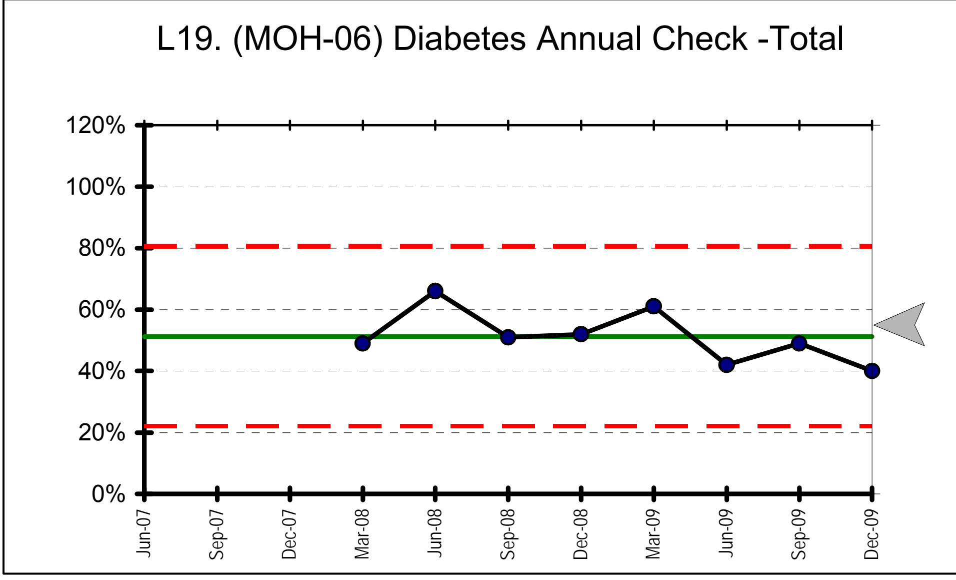
## 6.2 Planning & Funding Indicators List & Exception Report

## Planning and Funding Indicators Exception Report

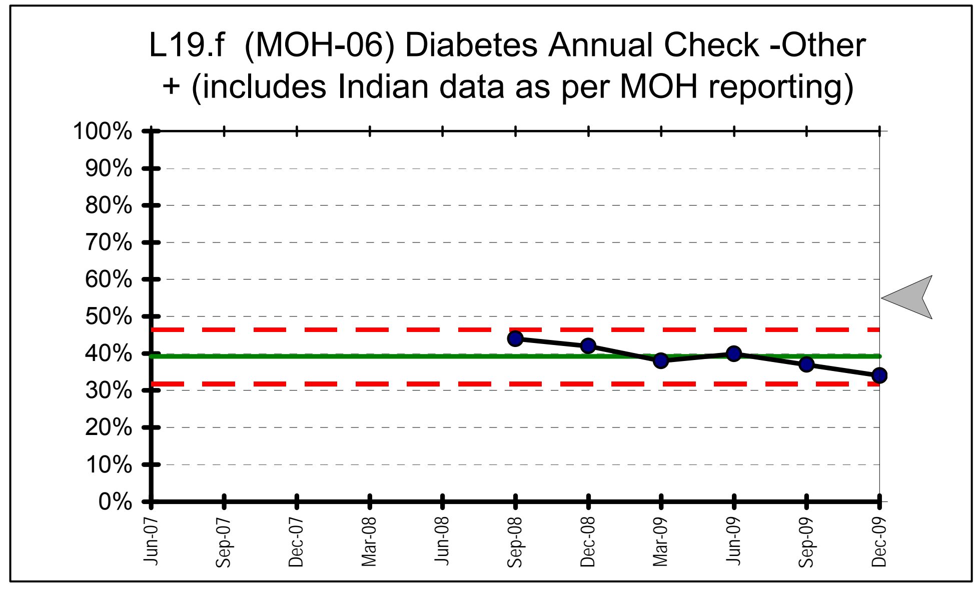
**Jan 2010**

| **Exceptions this month** | |
|---|---|
| The figure for January includes a number of Agreements expiring towards the end of the 09/10 financial year. The P&F Managers for these services will be review their Agreements as per the Value for Money review process initiated by P&F during the 4th Quarter. The results will determine the ongoing status of the Agreements and the service term. |  |

The ADHB PHO's overall are performing poorly in the use of Diabetes Get Checked, which is the indirect measure for assessing the management of diabetes. This has a direct impact on the reported performance. Of note, the PHO performance programme reports for Q3 & Q4 (2008/2009) show a moderately higher achievement for both total population (50.3%) and for the for high needs (61.7%). The data for Q1 and 2 2009/2010 is not yet available. The programme does not however, break down the data into ethnicity. Therefore, it is likely that the DGC data is reporting less than the true picture.



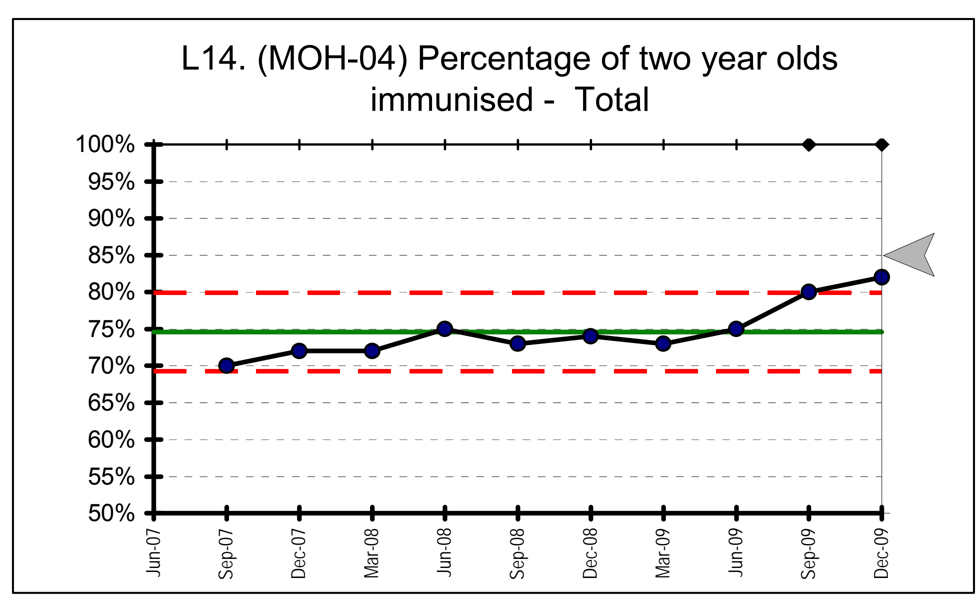

See Above



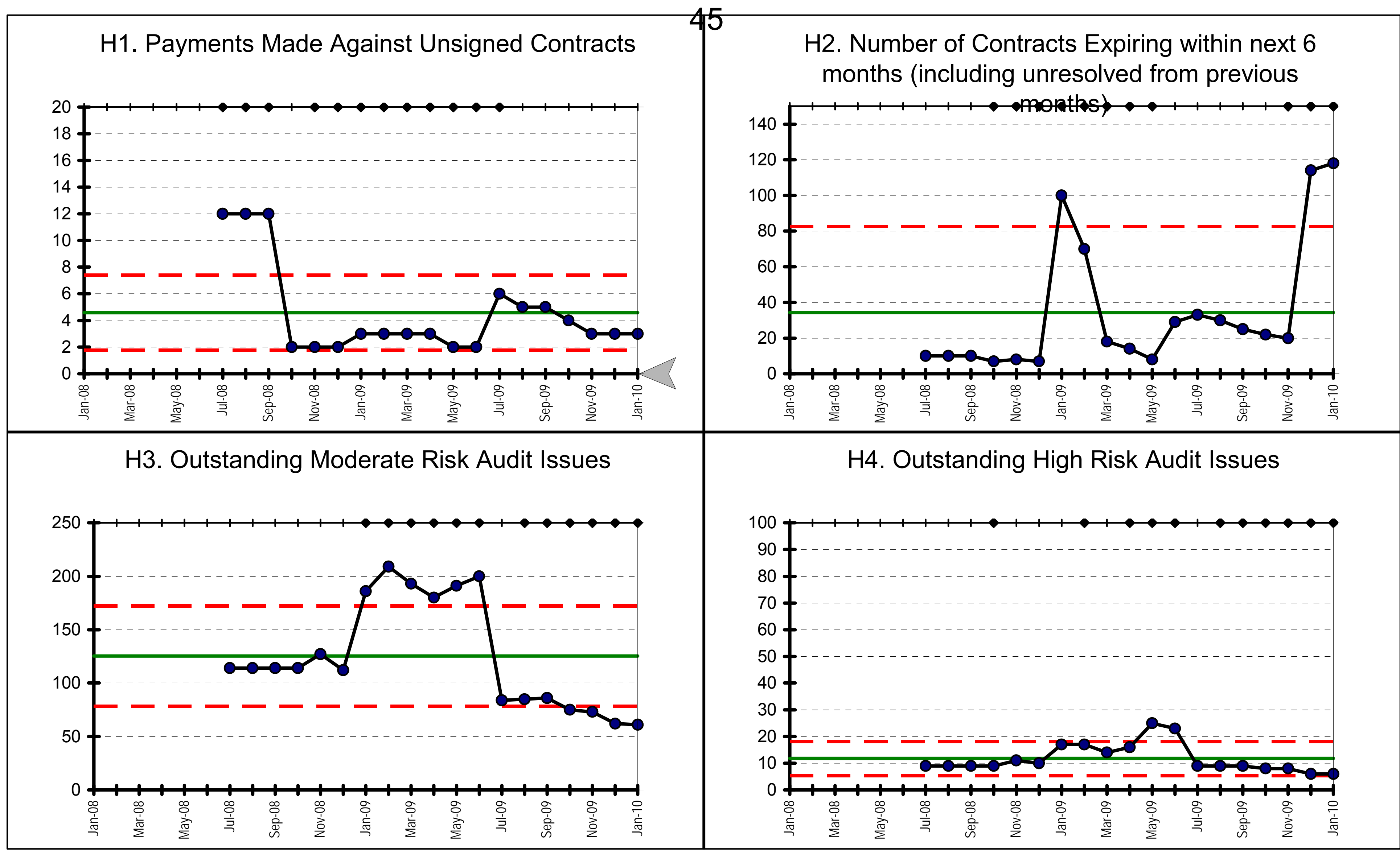
## Comments on Financial Performance and HR

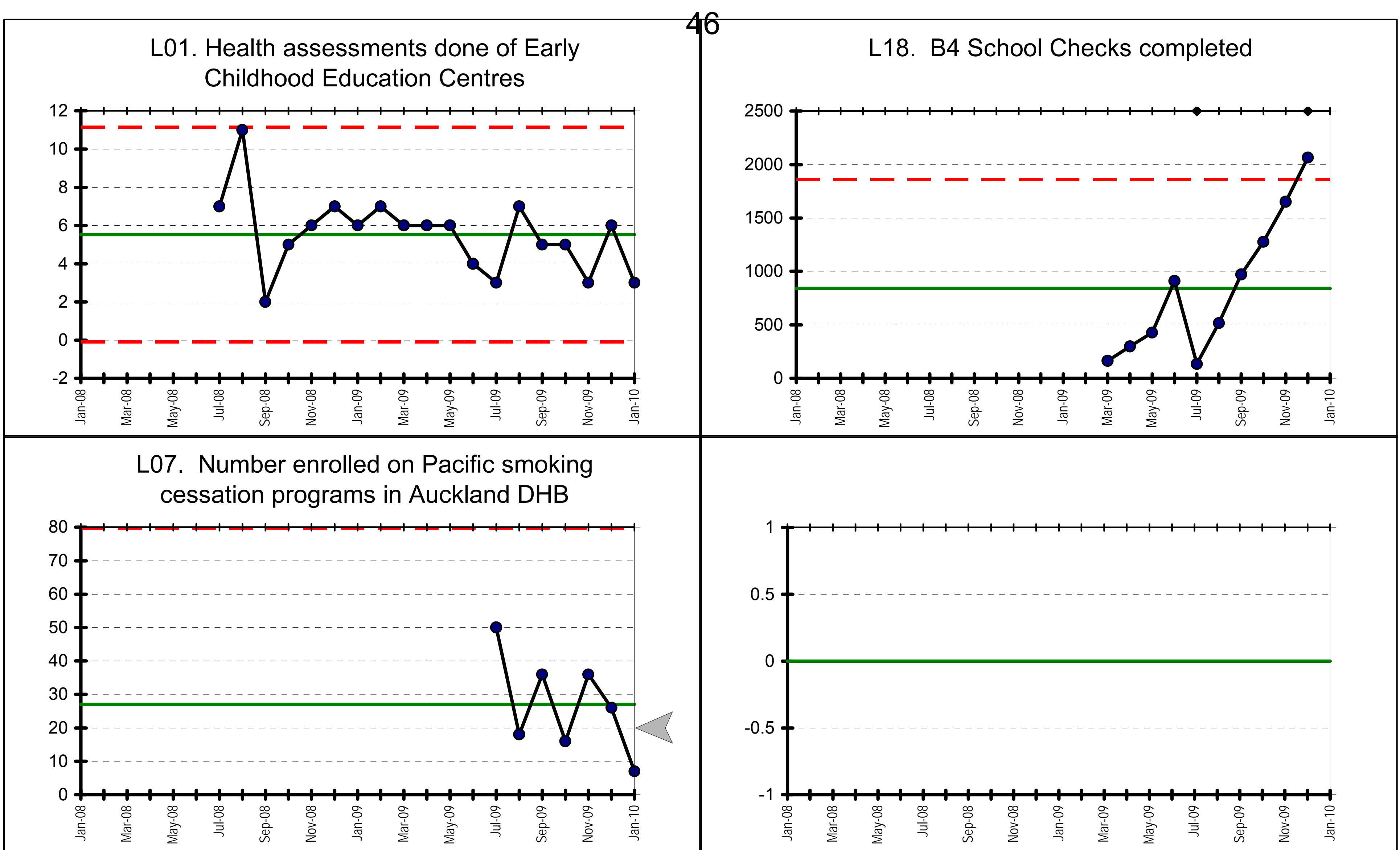
No comments

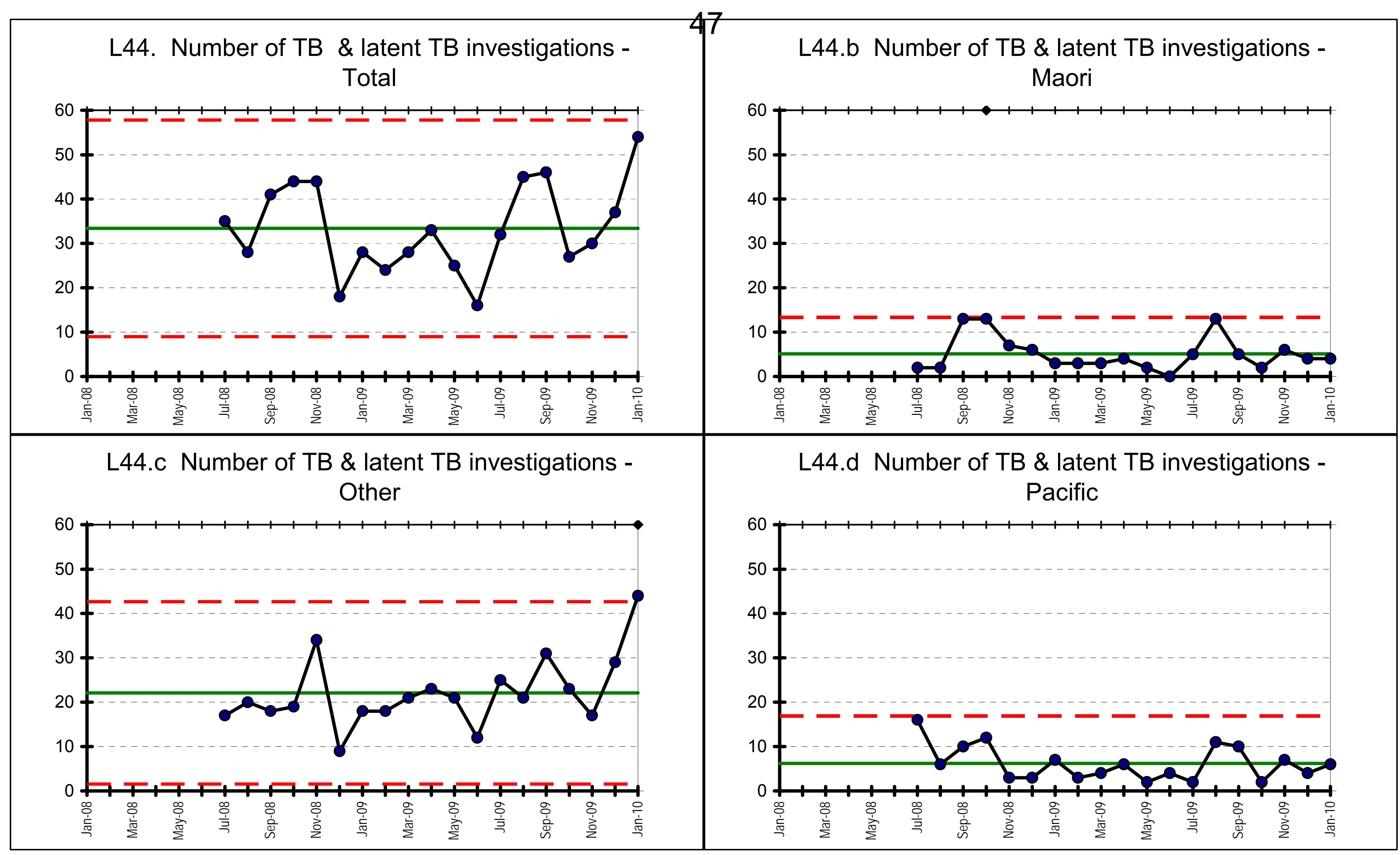
## KPI's for Review this month



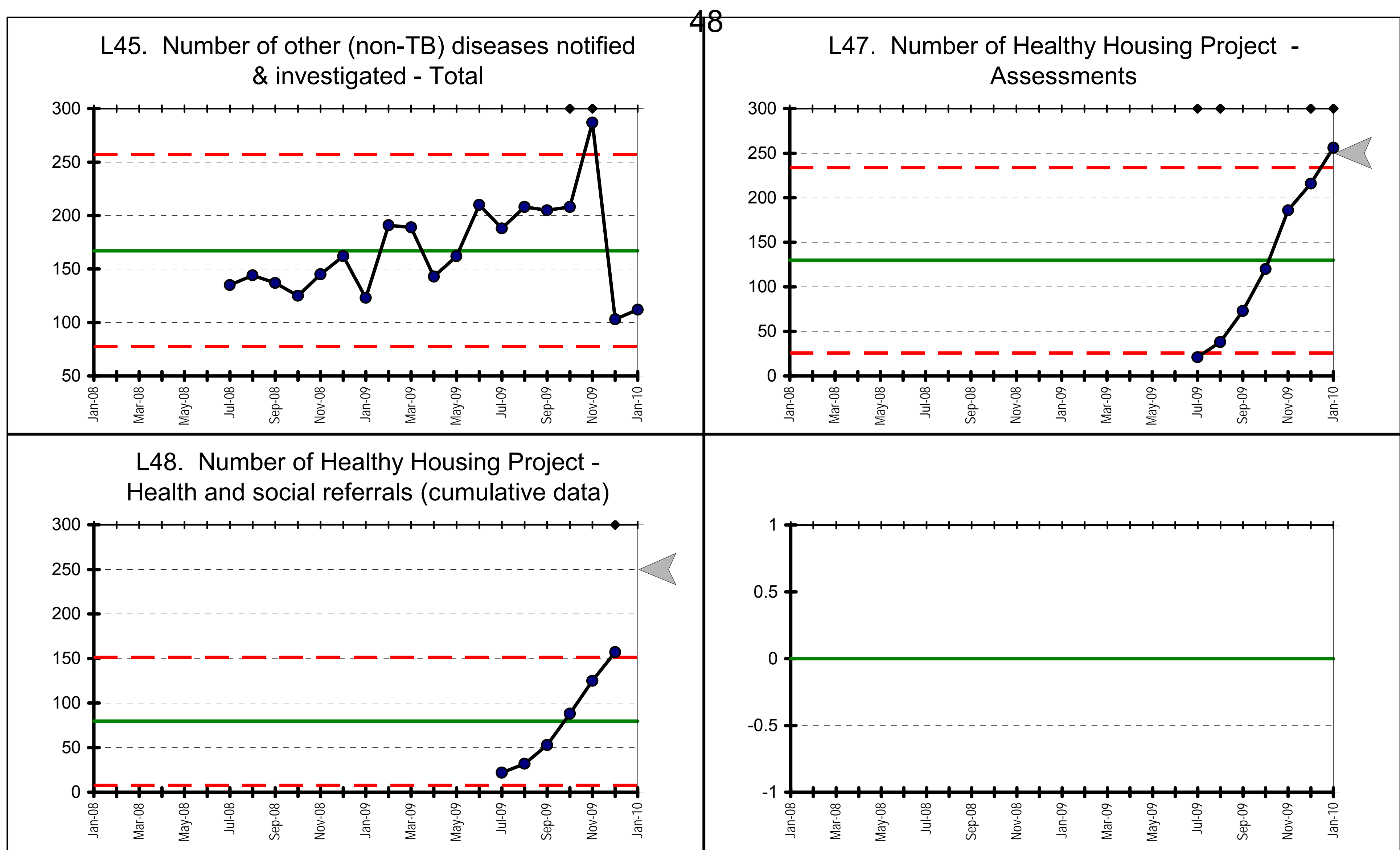
## 6.3 Planning & Funding Indicators (Full Set)

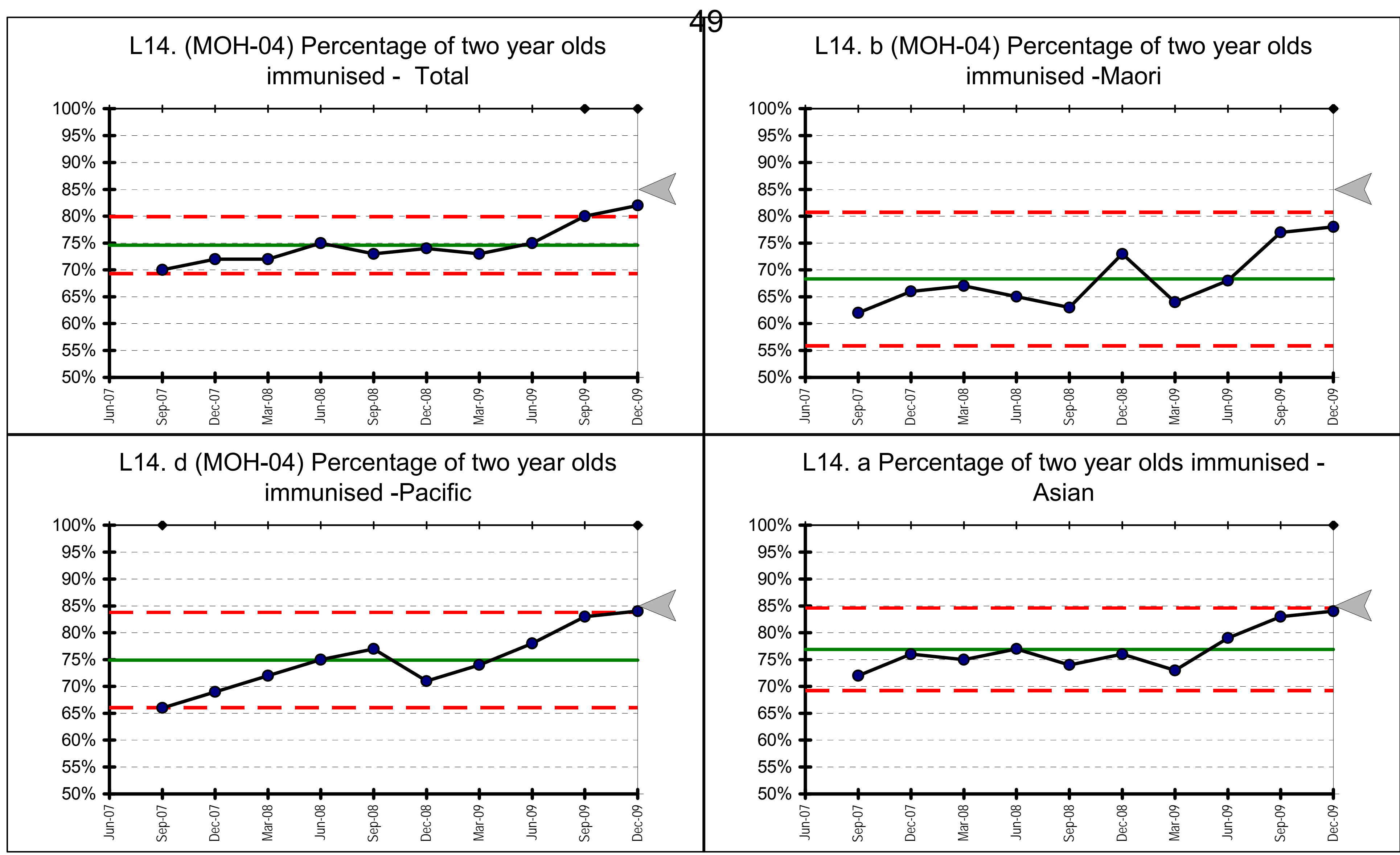

H1. Payments Made Against Unsigned Contracts
H2. Number of Contracts Expiring within next 6 months (including unresolved from previous months)
H3. Outstanding Moderate Risk Audit Issues
H4. Outstanding High Risk Audit Issues
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10


L01. Health assessments done of Early Childhood Education Centres
L18. B4 School Checks completed
L07. Number enrolled on Pacific smoking cessation programs in Auckland DHB
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10

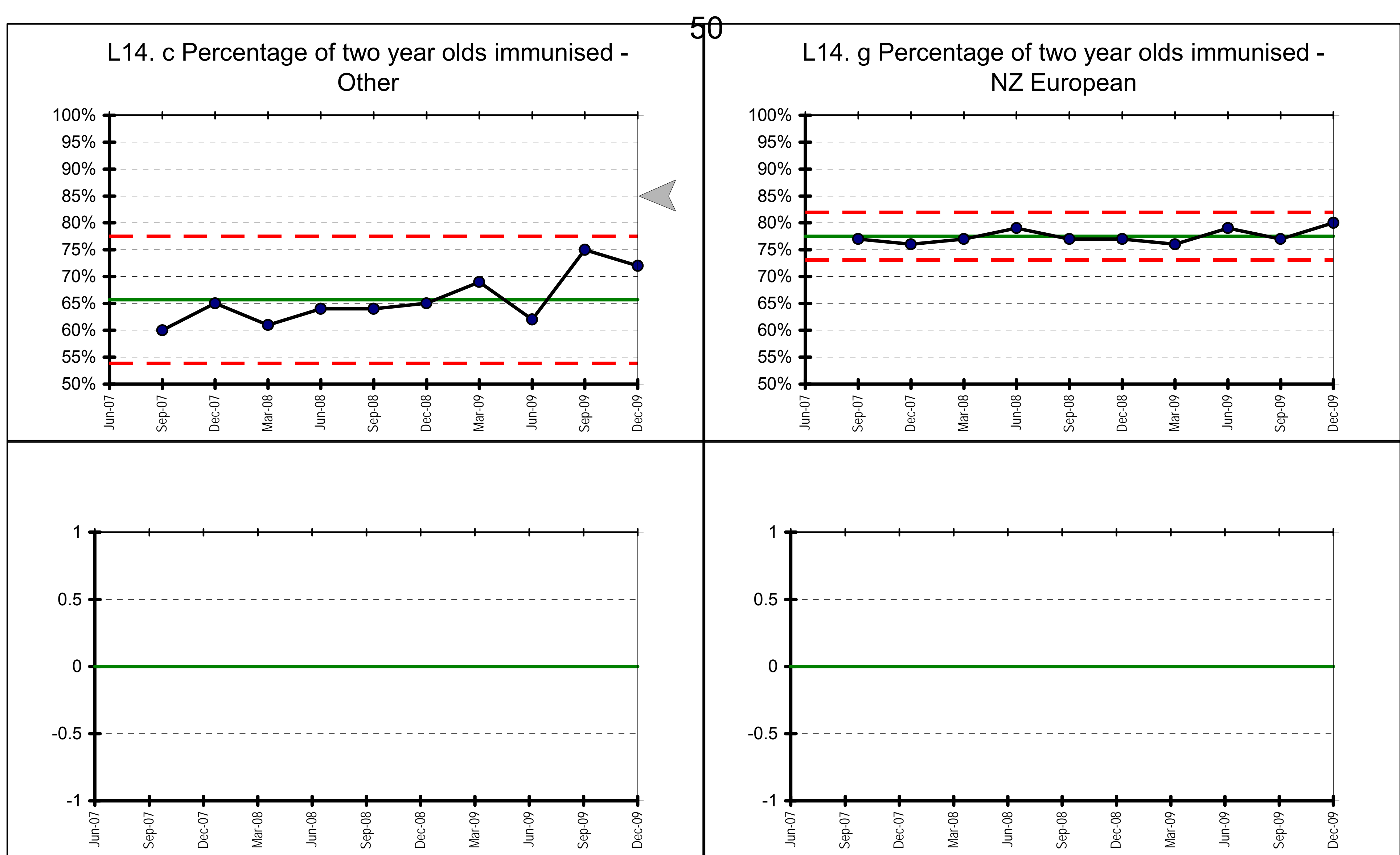


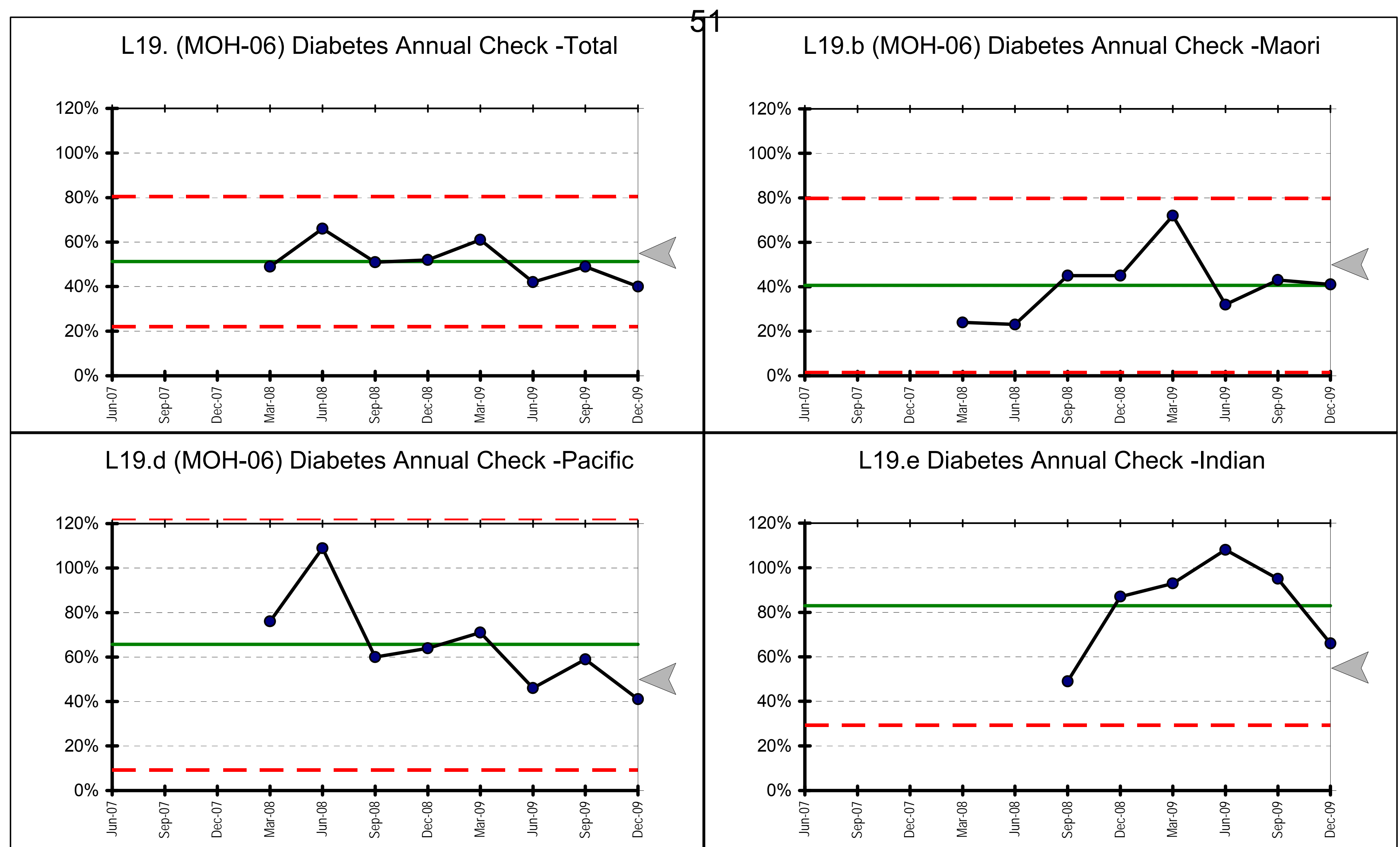
L44. Number of TB & latent TB investigations - Total
L44.b Number of TB & latent TB investigations - Maori
L44.c Number of TB & latent TB investigations - Other
L44.d Number of TB & latent TB investigations - Pacific
60
50
40
30
20
10
0
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10


L45. Number of other (non-TB) diseases notified & investigated - Total
300
250
200
150
100
50
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10
L47. Number of Healthy Housing Project - Assessments
300
250
200
150
100
50
0
L48. Number of Healthy Housing Project - Health and social referrals (cumulative data)
1
0.5
0
-0.5
-1

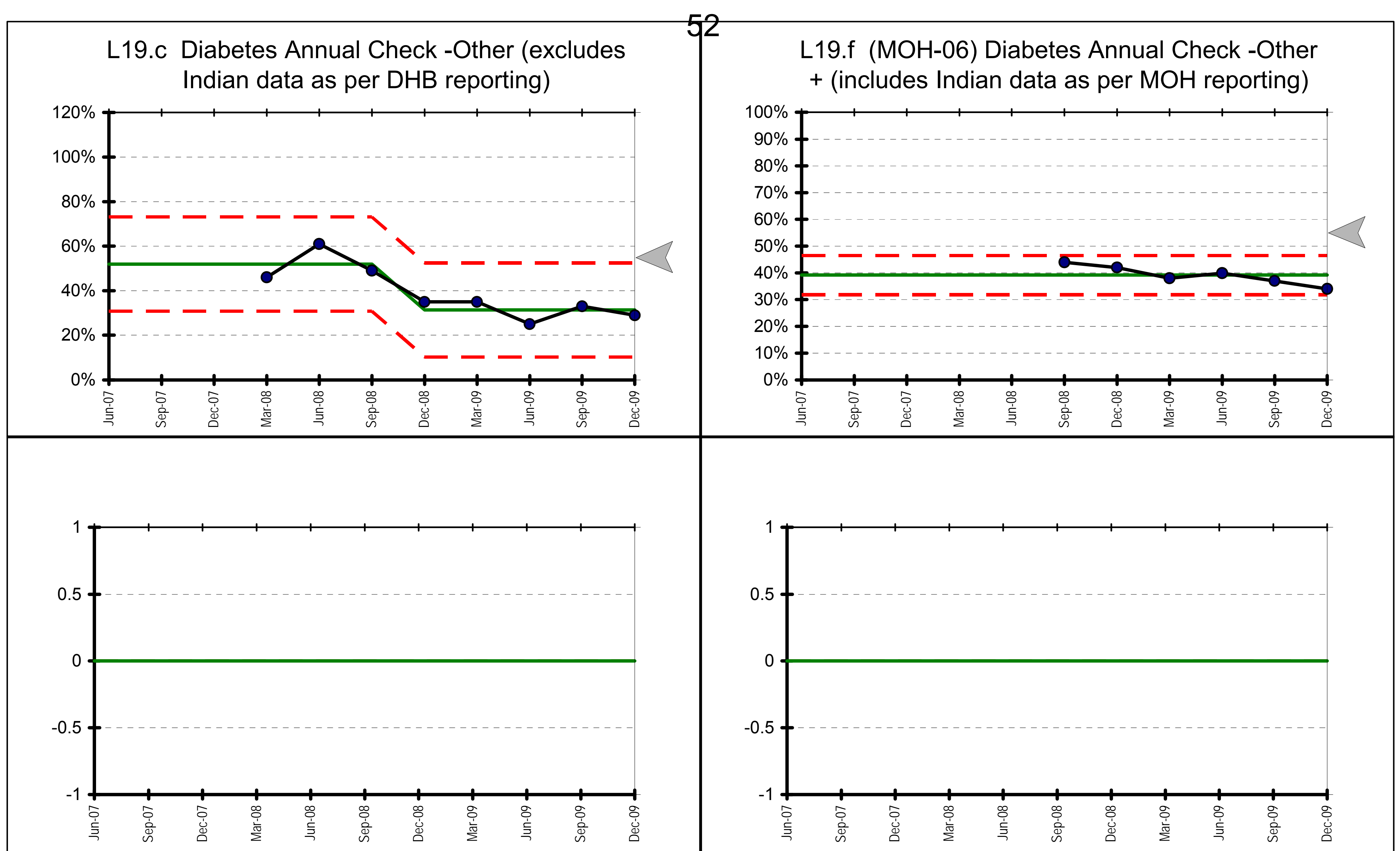


L14. (MOH-04) Percentage of two year olds immunised - Total
L14. b (MOH-04) Percentage of two year olds immunised -Maori
L14. d (MOH-04) Percentage of two year olds immunised -Pacific
L14. a Percentage of two year olds immunised - Asian
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09

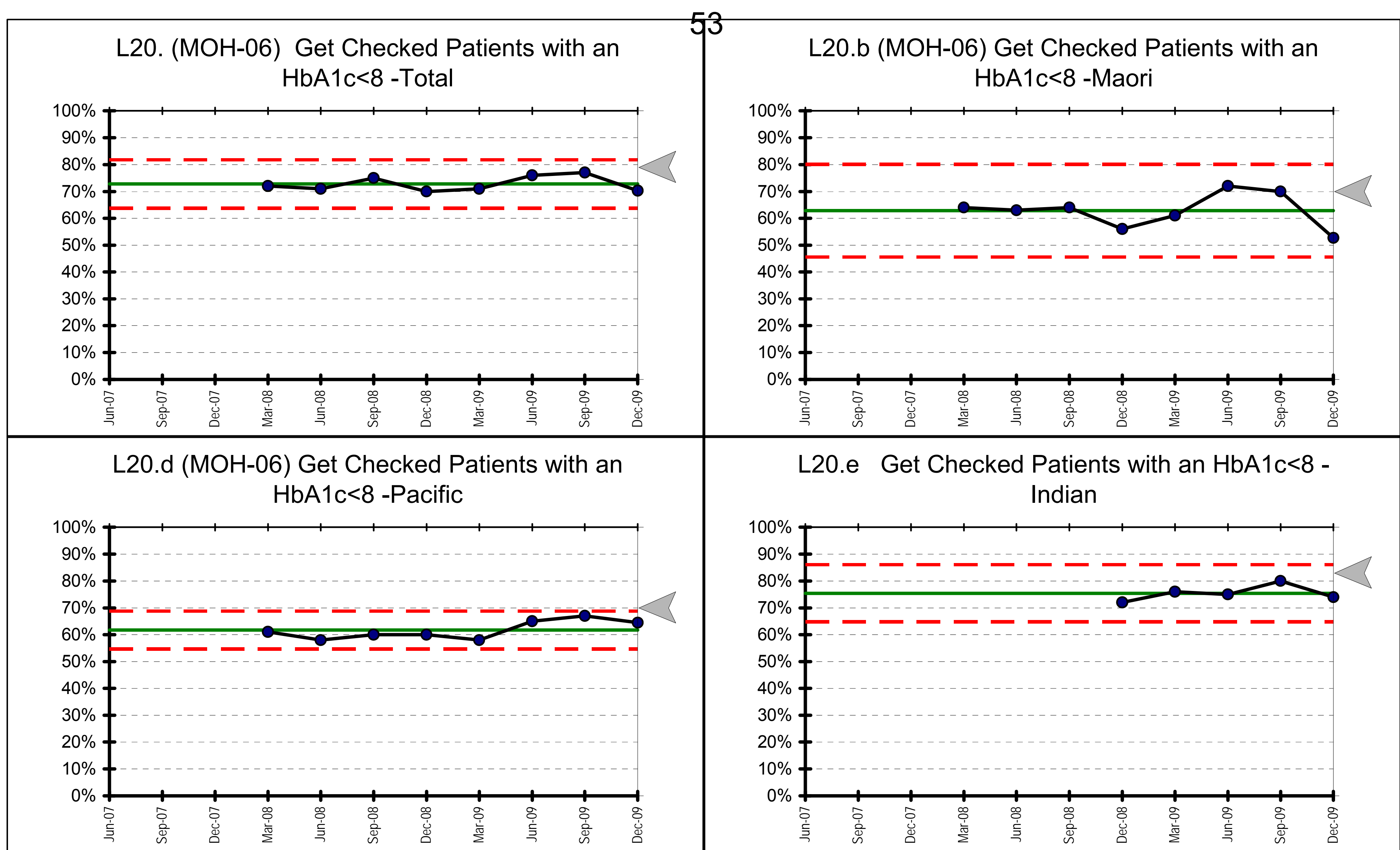

L14. c Percentage of two year olds immunised - Other
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09
L14. g Percentage of two year olds immunised - NZ European
1
0.5
0
-0.5
-1

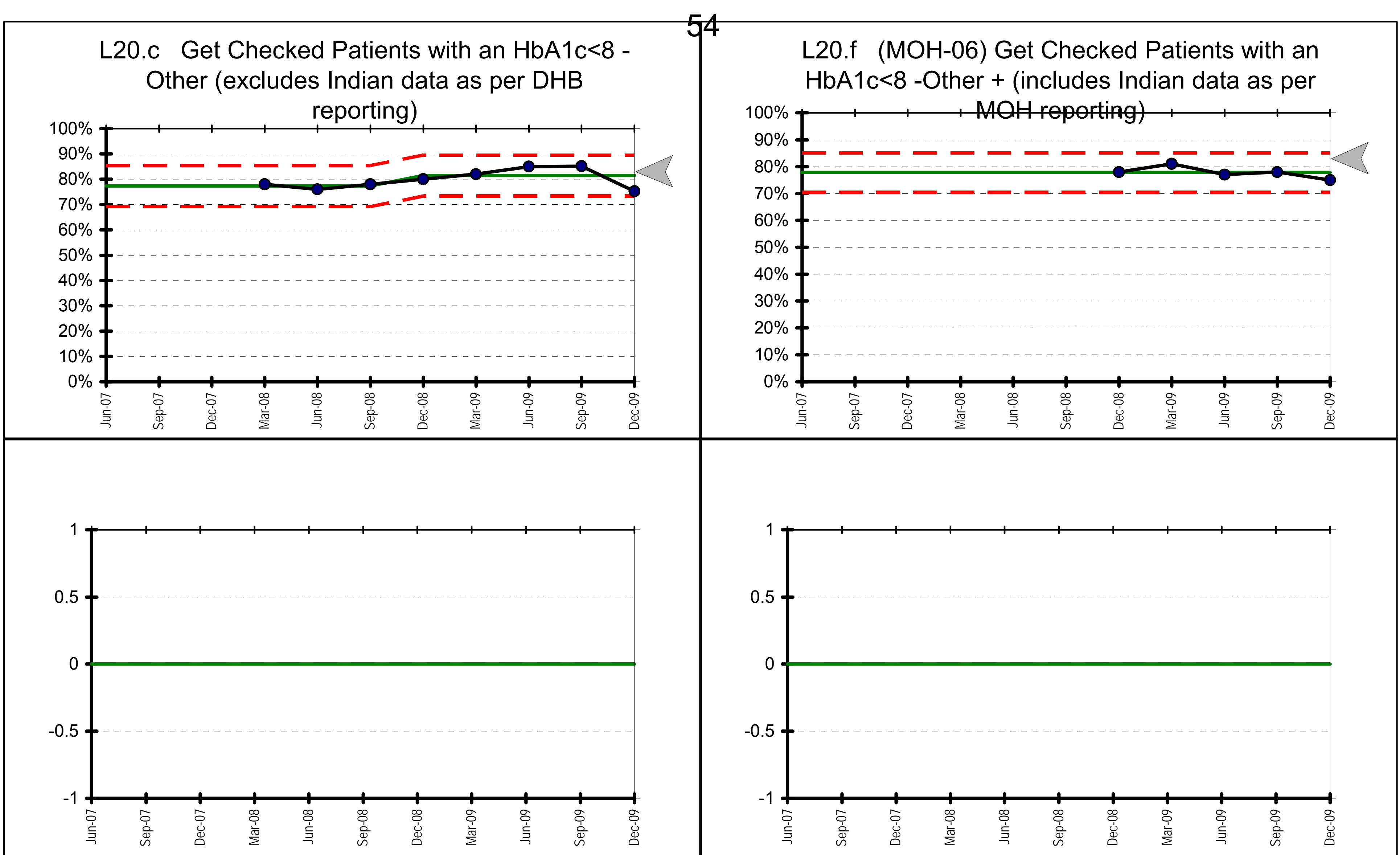


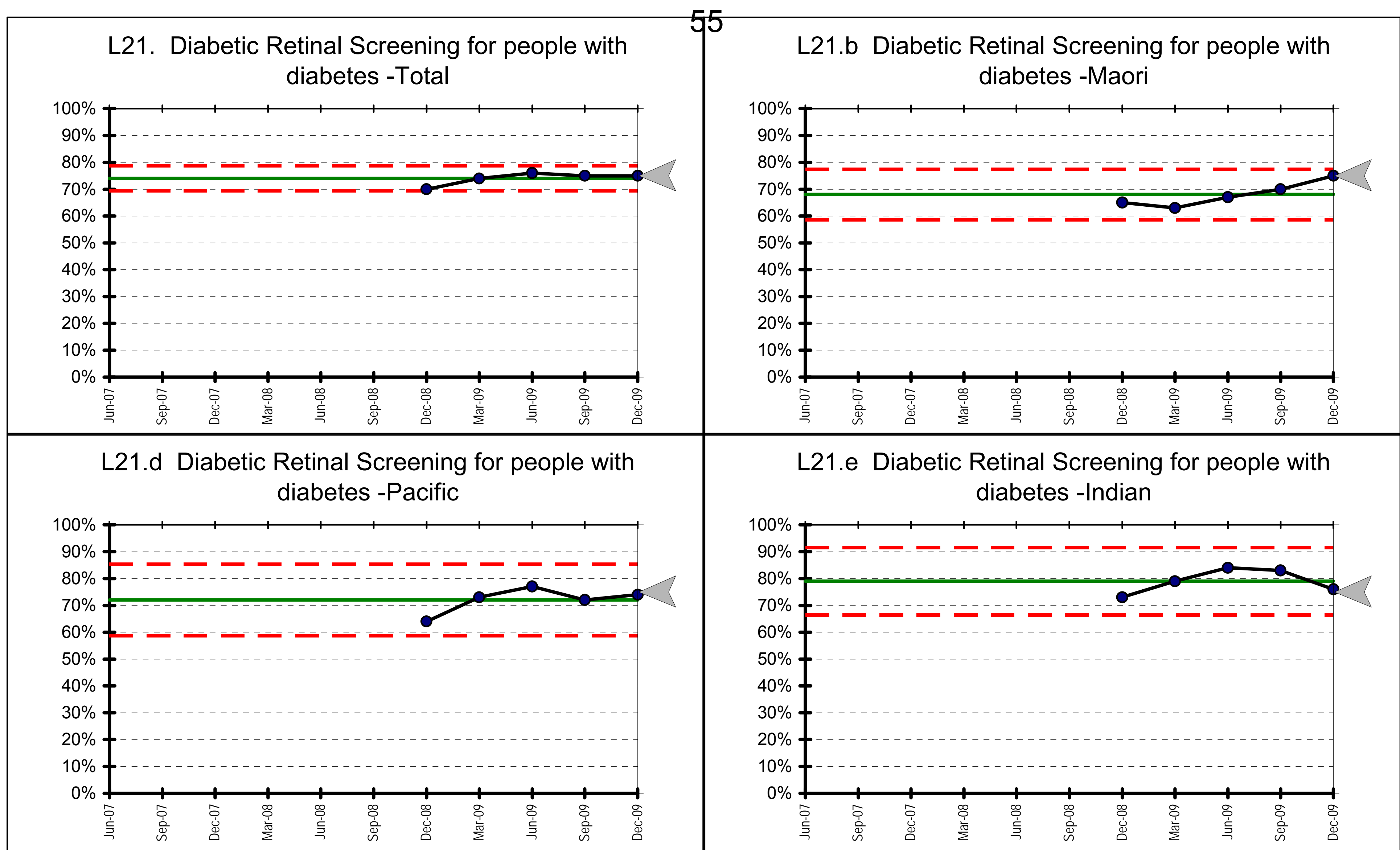
L19. (MOH-06) Diabetes Annual Check -Total
L19.b (MOH-06) Diabetes Annual Check -Maori
L19.d (MOH-06) Diabetes Annual Check -Pacific
L19.e Diabetes Annual Check -Indian
120%
100%
80%
60%
40%
20%
0%
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09



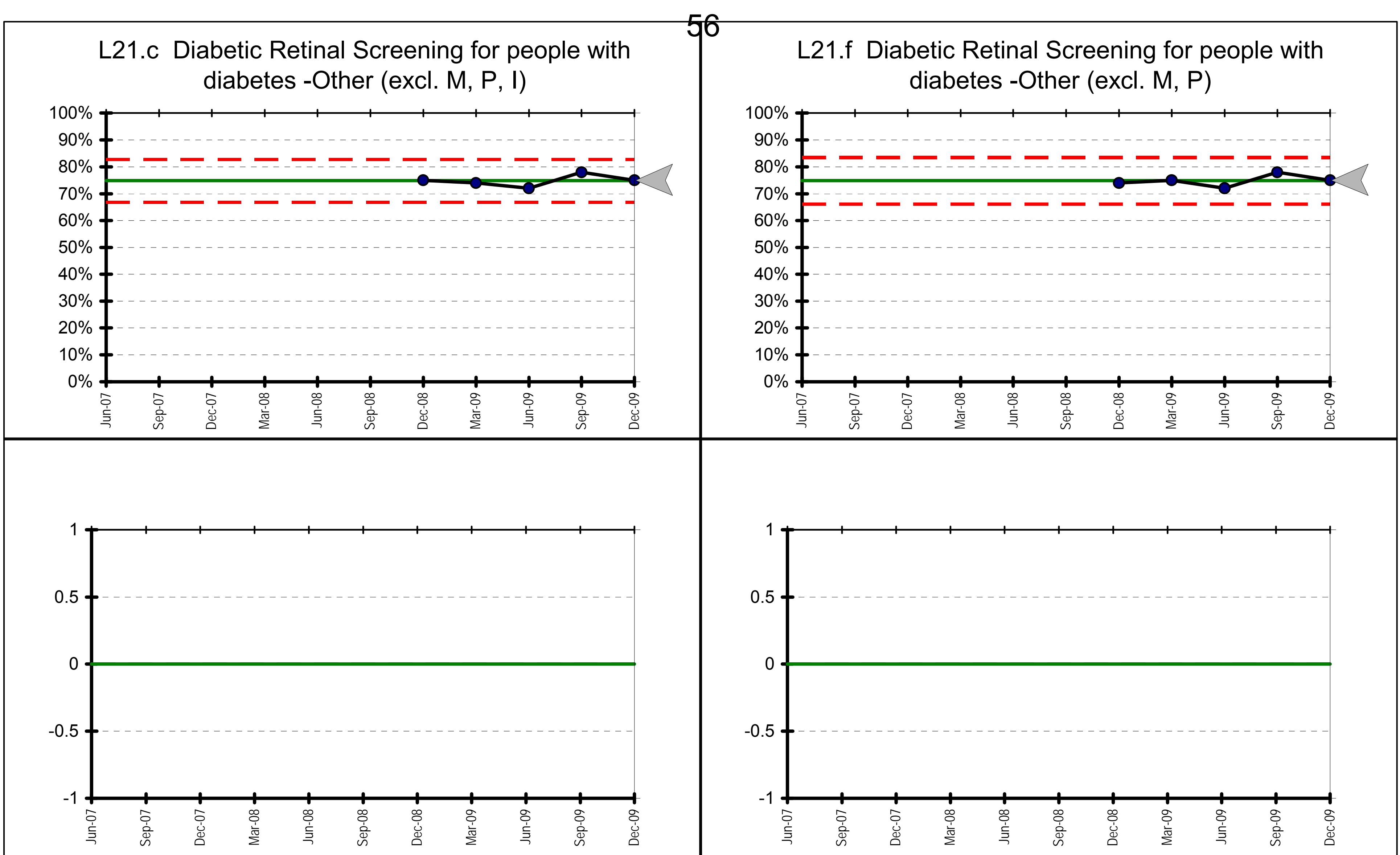
L19.c Diabetes Annual Check -Other (excludes Indian data as per DHB reporting)
120%
100%
80%
60%
40%
20%
0%
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09
L19.f (MOH-06) Diabetes Annual Check -Other + (includes Indian data as per MOH reporting)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1
0.5
0
-0.5
-1


L20. (MOH-06) Get Checked Patients with an HbA1c<8 -Total
L20.b (MOH-06) Get Checked Patients with an HbA1c<8 -Maori
L20.d (MOH-06) Get Checked Patients with an HbA1c<8 -Pacific
L20.e Get Checked Patients with an HbA1c<8 - Indian
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09

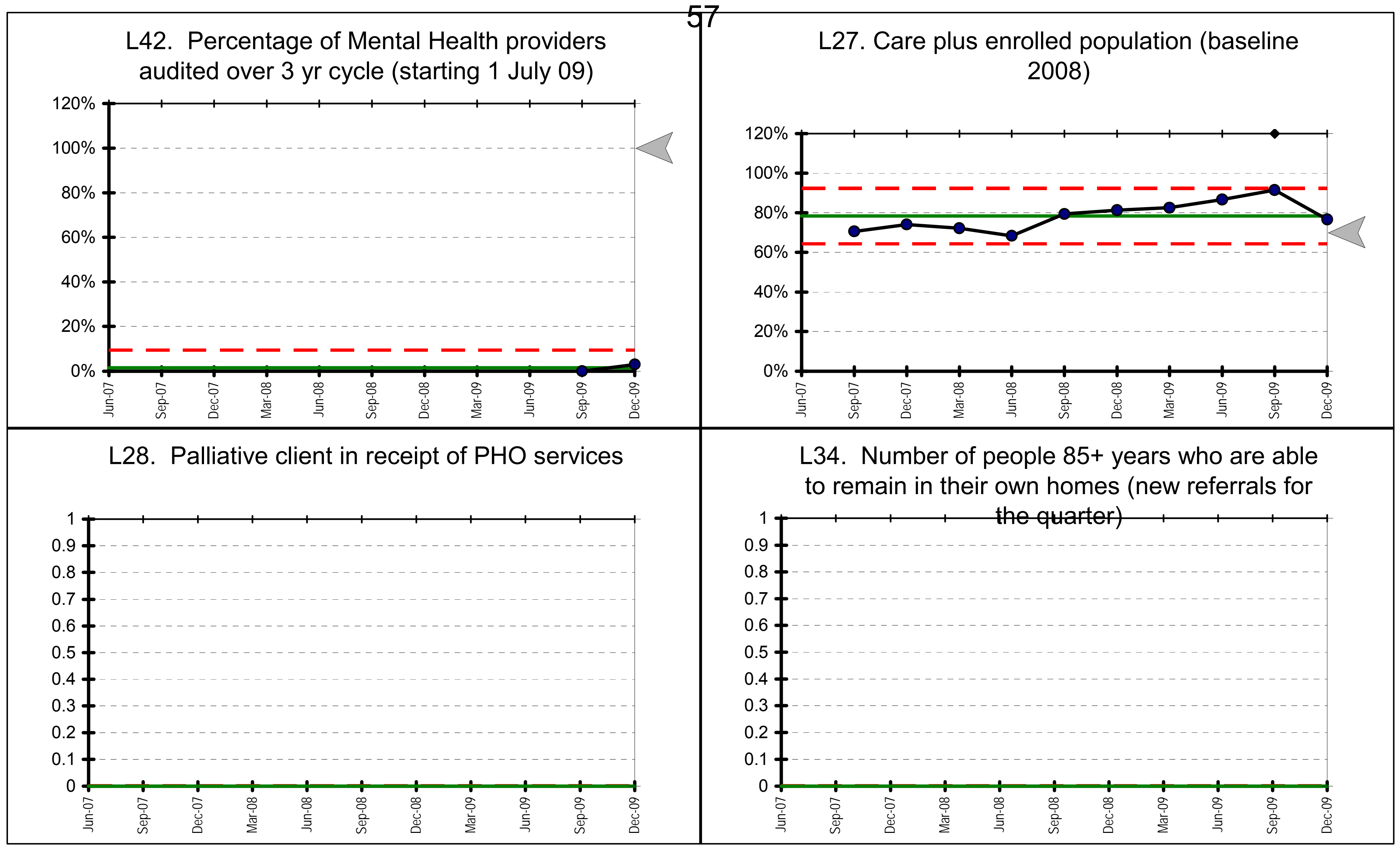

L20.c Get Checked Patients with an HbA1c<8 - Other (excludes Indian data as per DHB reporting)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09
L20.f (MOH-06) Get Checked Patients with an HbA1c<8 -Other + (includes Indian data as per MOH reporting)
1
0.5
0
-0.5
-1

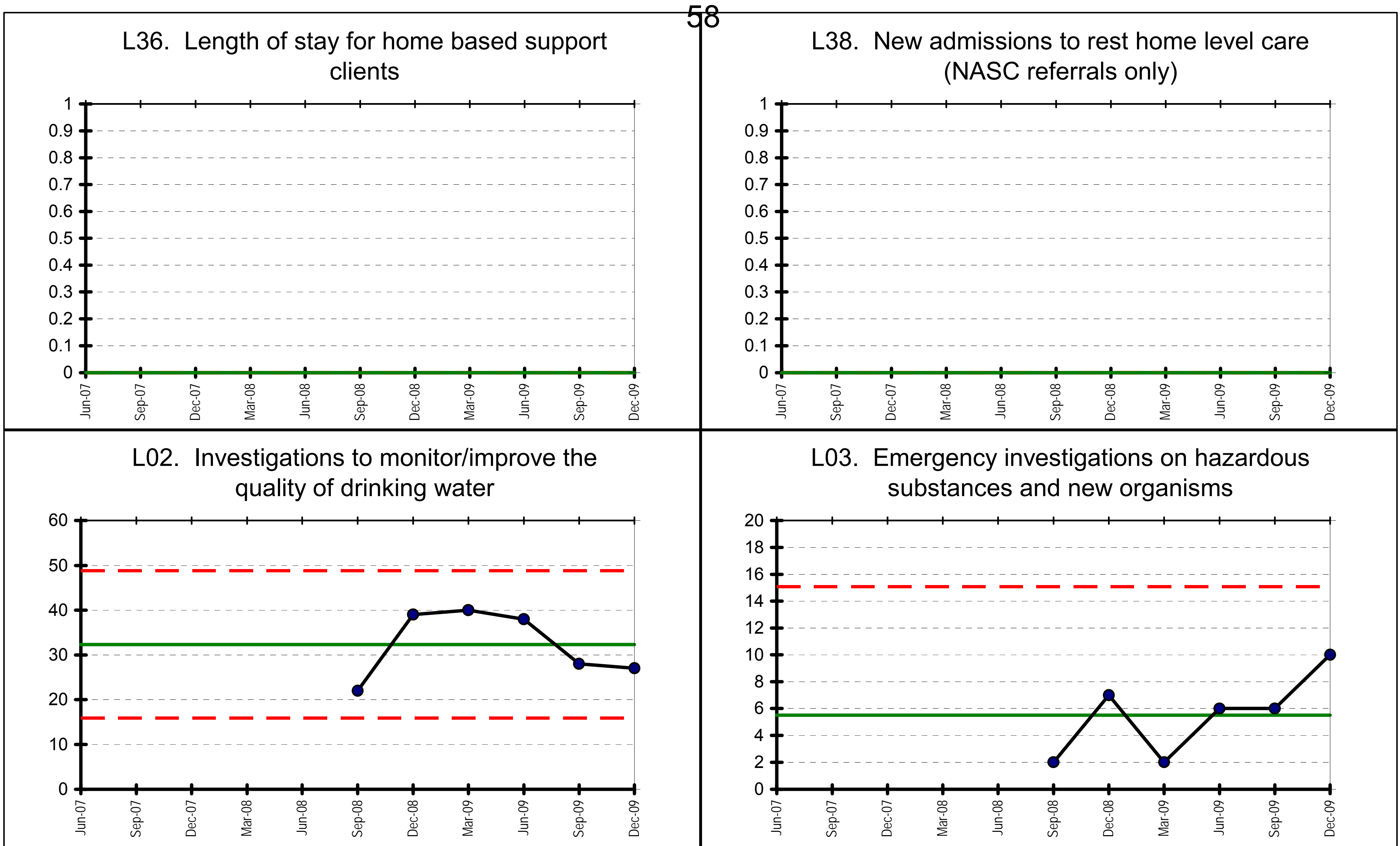


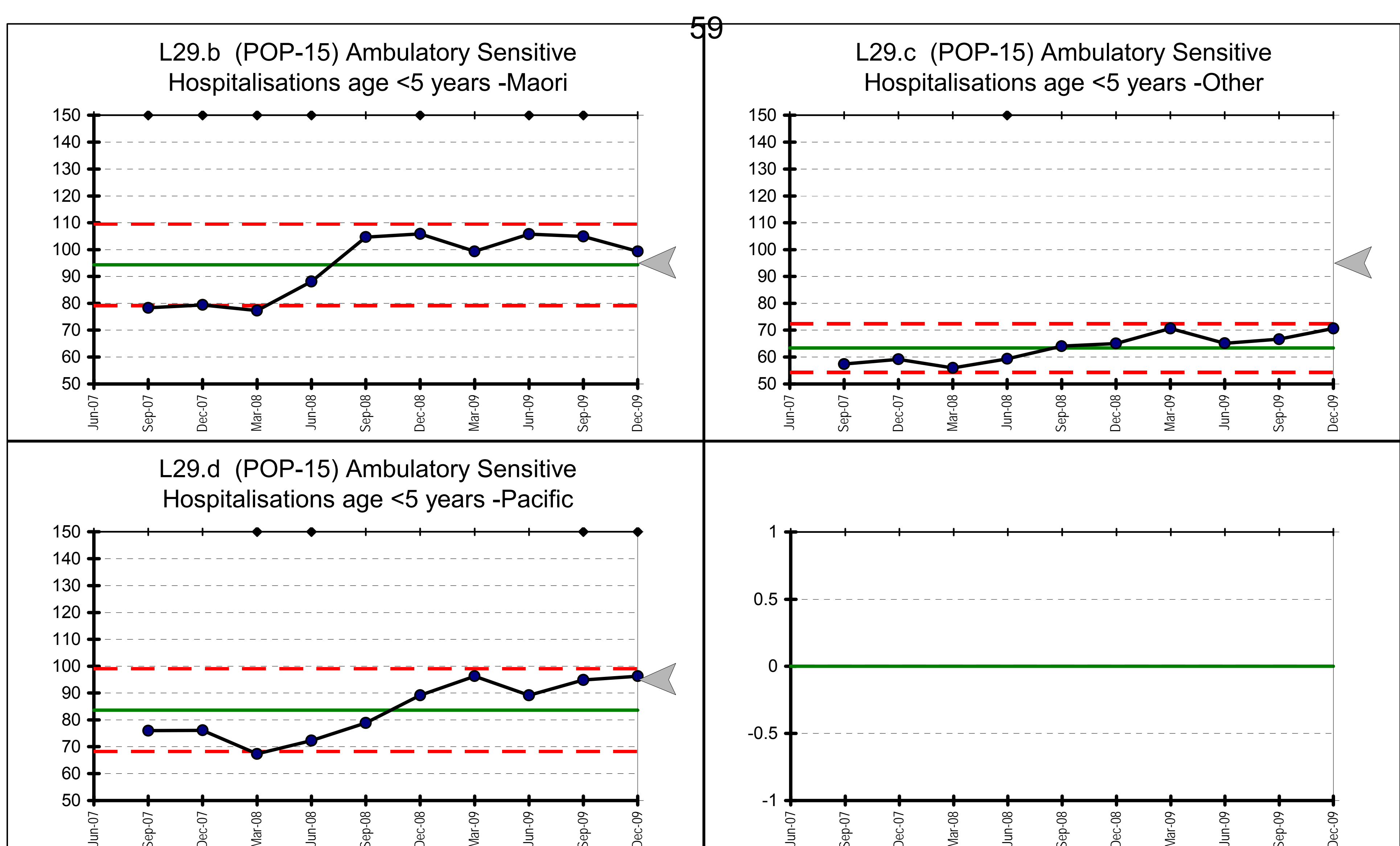
L21. Diabetic Retinal Screening for people with diabetes -Total
L21.b Diabetic Retinal Screening for people with diabetes -Maori
L21.d Diabetic Retinal Screening for people with diabetes -Pacific
L21.e Diabetic Retinal Screening for people with diabetes -Indian
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09

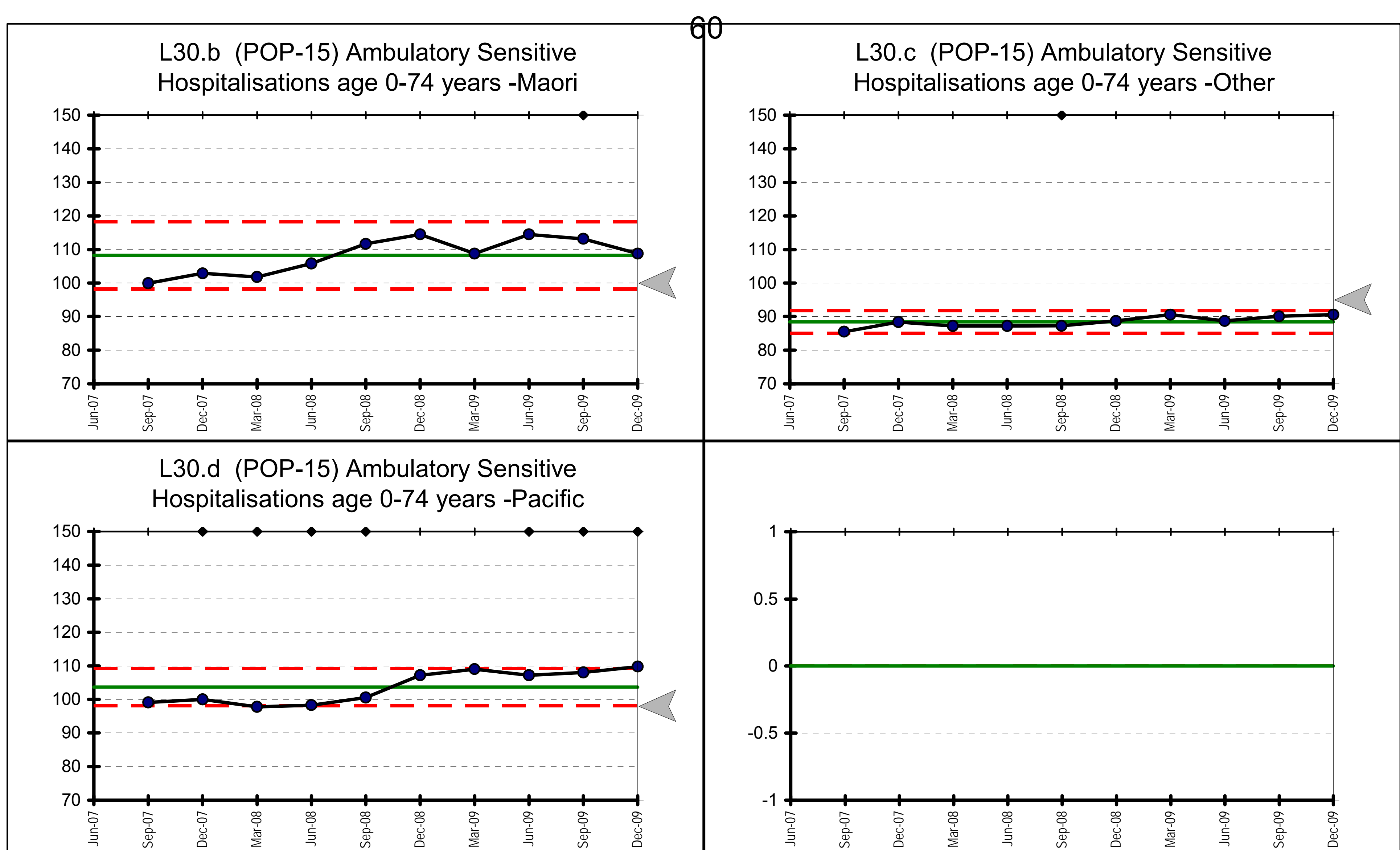


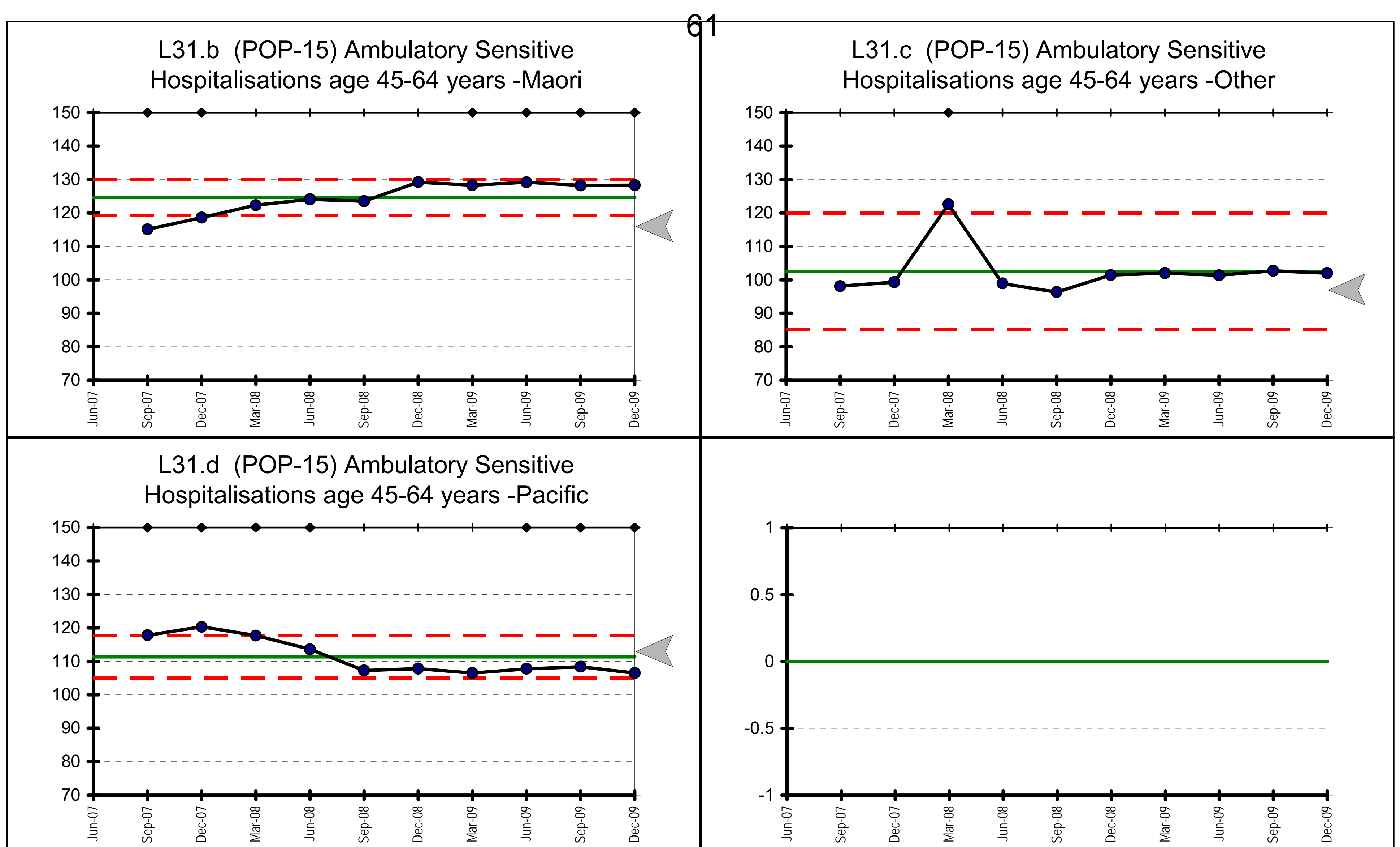
L21.c Diabetic Retinal Screening for people with diabetes -Other (excl. M, P, I)
L21.f Diabetic Retinal Screening for people with diabetes -Other (excl. M, P)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1
0.5
0
-0.5
-1
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09

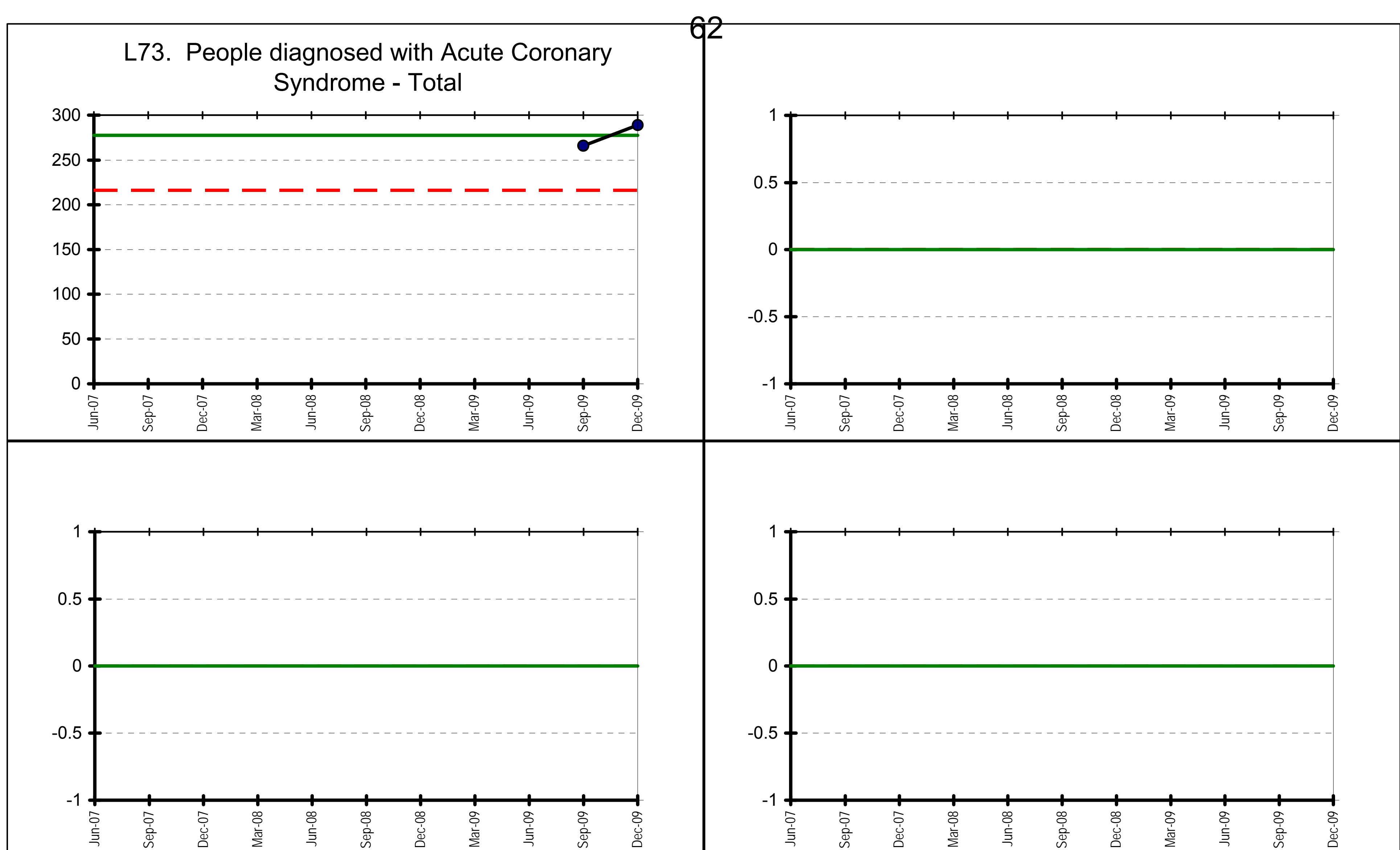

L42. Percentage of Mental Health providers audited over 3 yr cycle (starting 1 July 09)
120%
100%
80%
60%
40%
20%
0%
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09
L27. Care plus enrolled population (baseline 2008)
L28. Palliative client in receipt of PHO services
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
L34. Number of people 85+ years who are able to remain in their own homes (new referrals for the quarter)

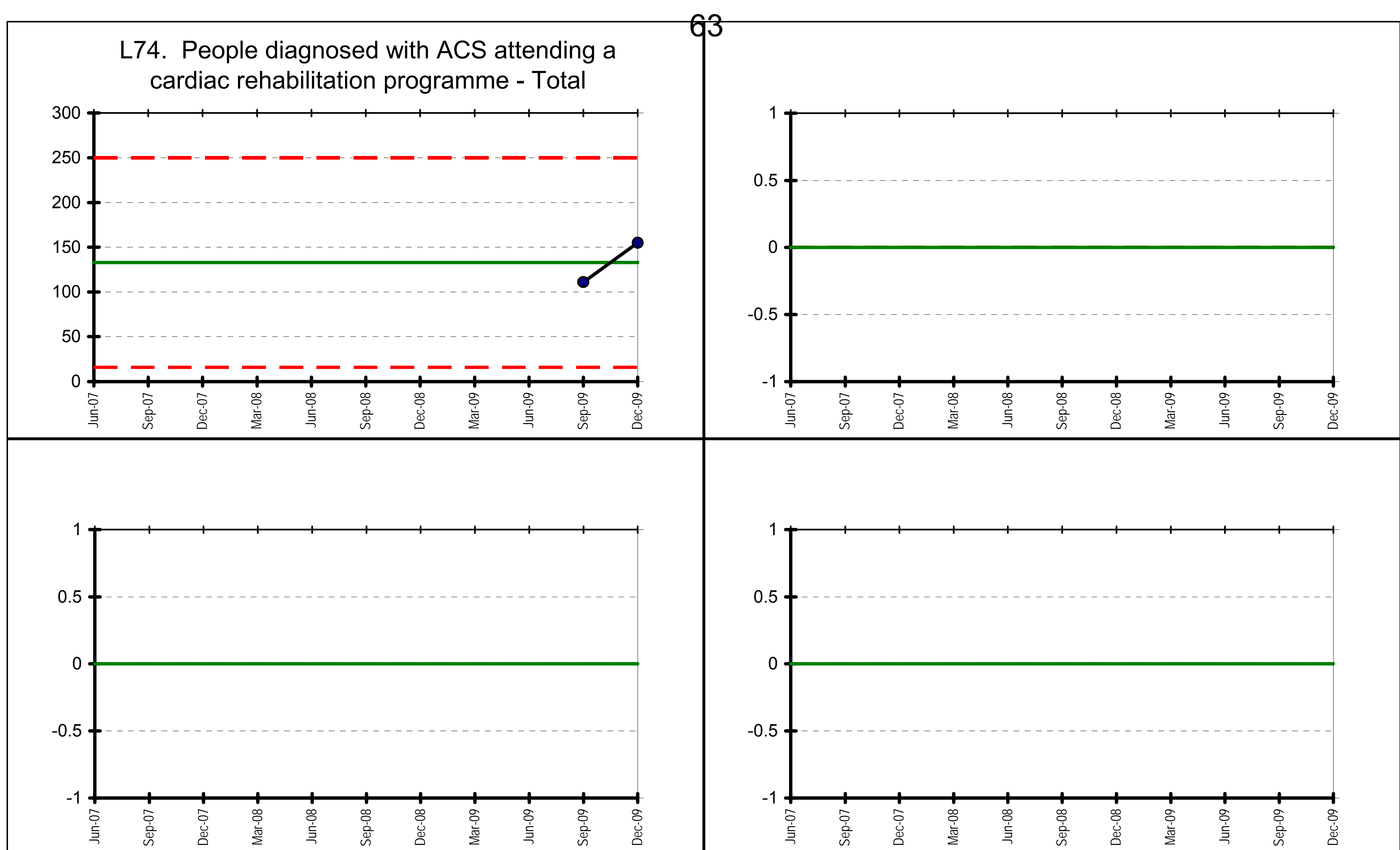

L36. Length of stay for home based support clients
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09
L38. New admissions to rest home level care (NASC referrals only)
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09
L02. Investigations to monitor/improve the quality of drinking water
60
50
40
30
20
10
0
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09
L03. Emergency investigations on hazardous substances and new organisms
20
18
16
14
12
10
8
6
4
2
0
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09

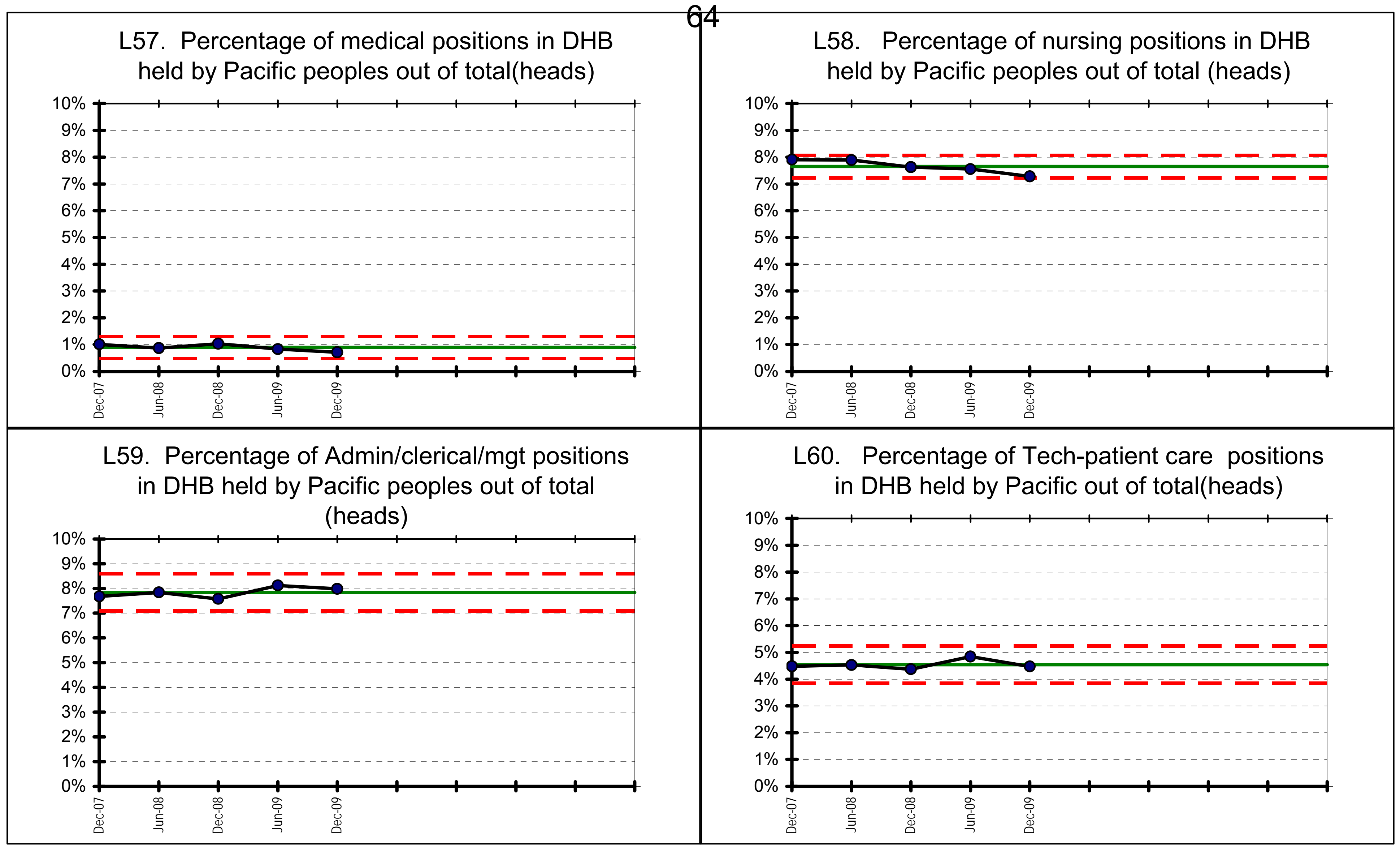

L29.b (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Maori
L29.c (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Other
L29.d (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Pacific
150
140
130
120
110
100
90
80
70
60
50
1
0.5
0
-0.5
-1
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09


L30.b (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Maori
L30.c (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Other
L30.d (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Pacific
150
140
130
120
110
100
90
80
70
1
0.5
0
-0.5
-1
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09

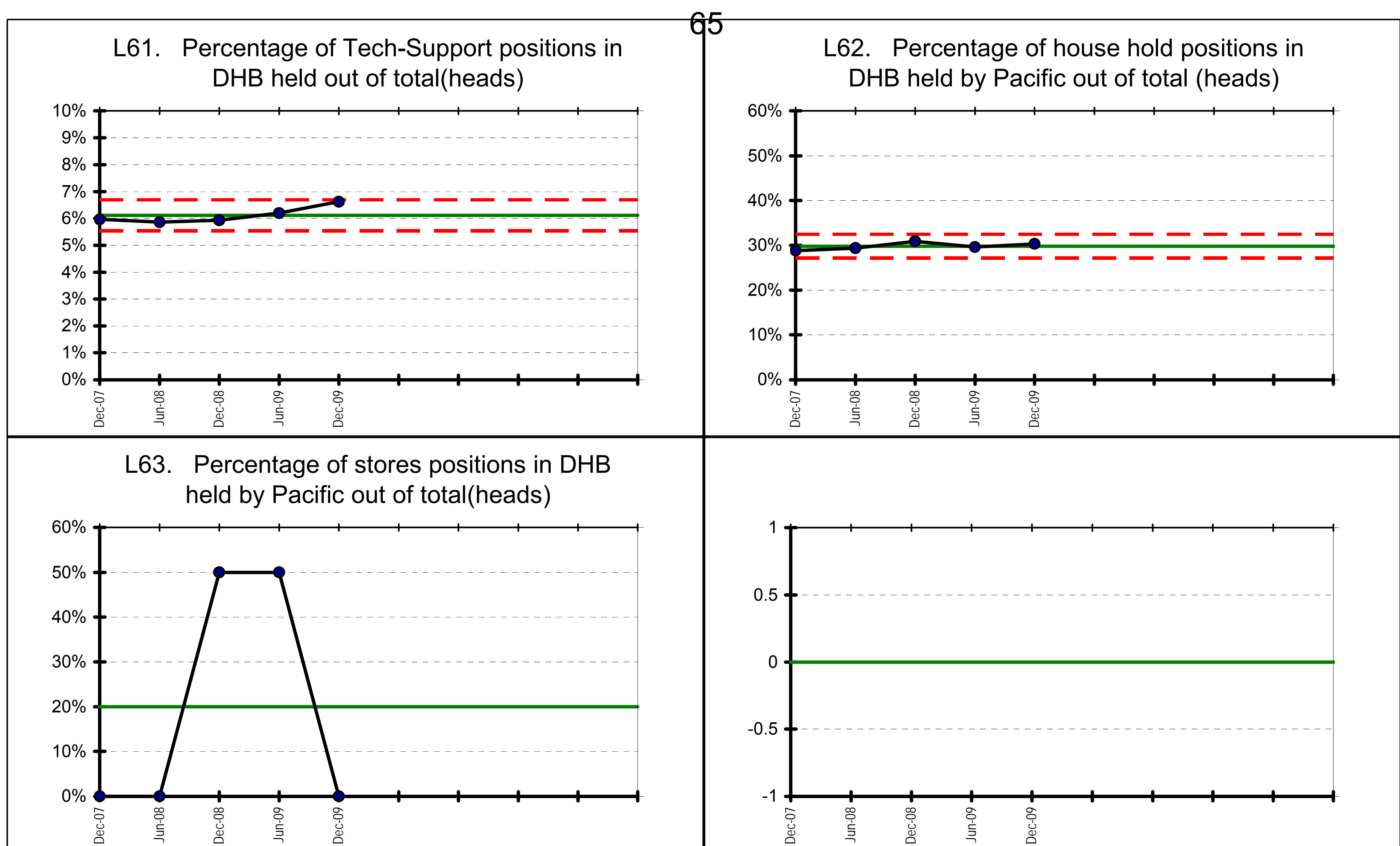

L31.b (POP-15) Ambulatory Sensitive Hospitalisations age 45-64 years -Maori
L31.c (POP-15) Ambulatory Sensitive Hospitalisations age 45-64 years -Other
L31.d (POP-15) Ambulatory Sensitive Hospitalisations age 45-64 years -Pacific
150
140
130
120
110
100
90
80
70
1
0.5
0
-0.5
-1
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09

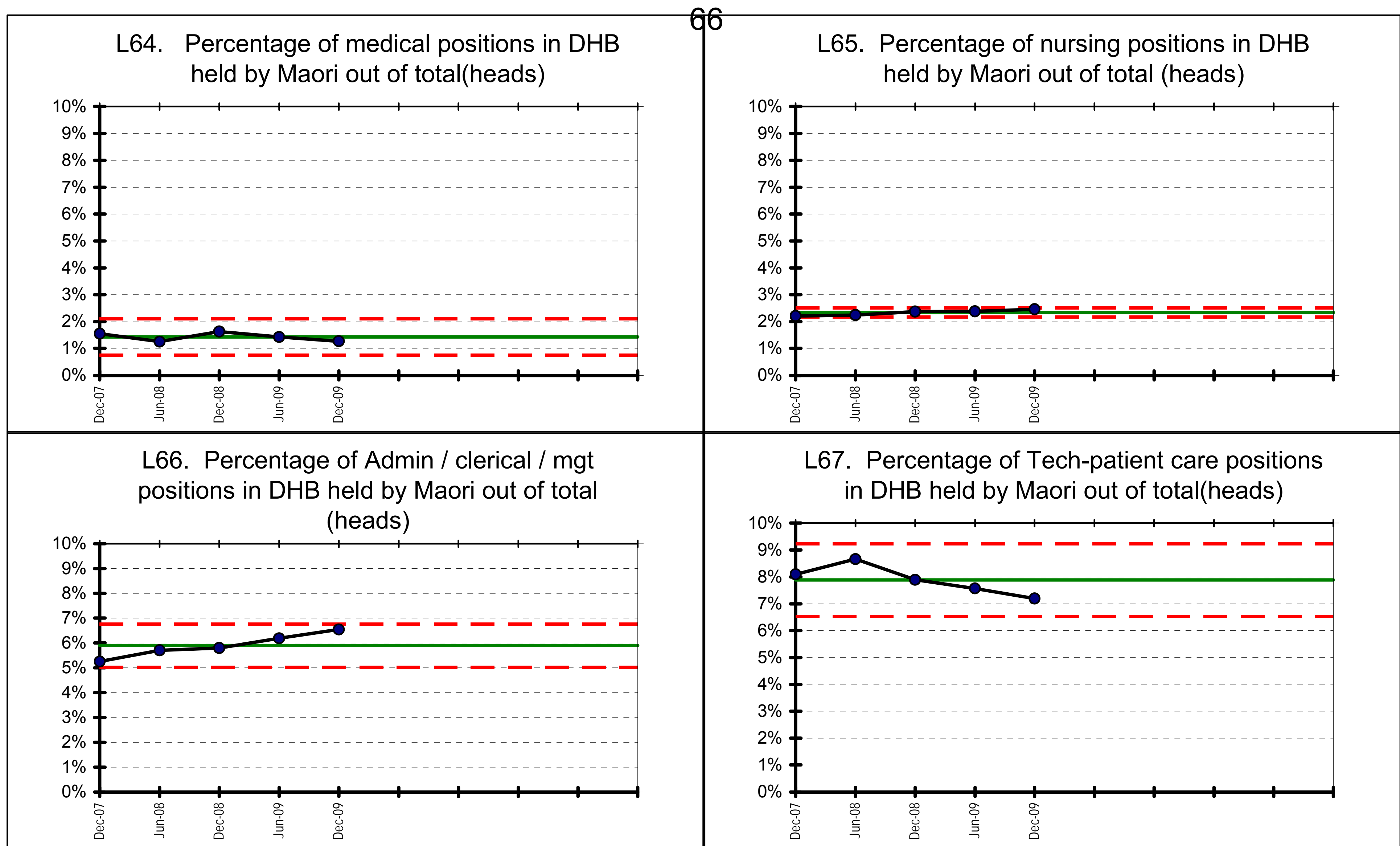

L73. People diagnosed with Acute Coronary Syndrome - Total
300
250
200
150
100
50
0
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09
1
0.5
0
-0.5
-1

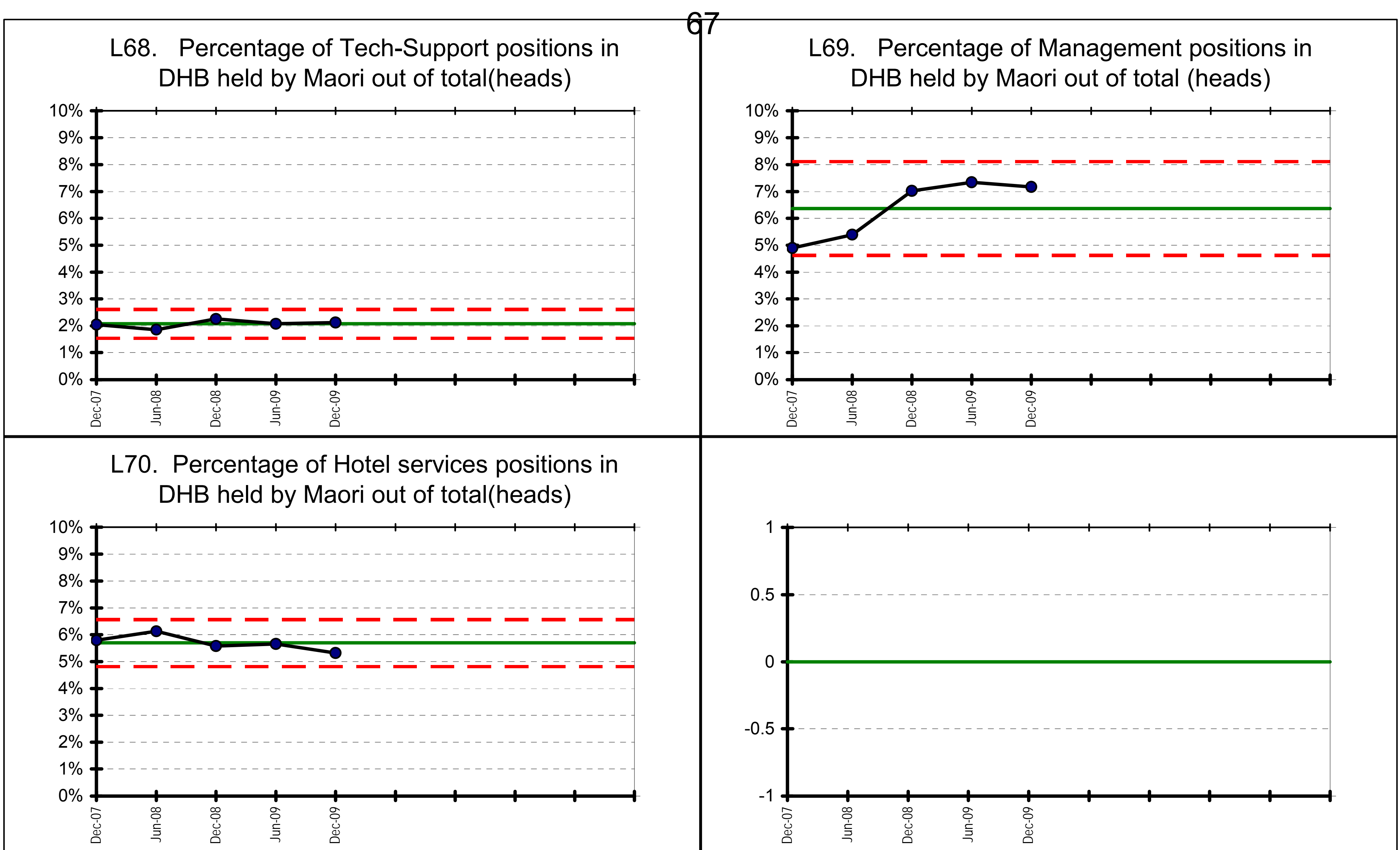

L74. People diagnosed with ACS attending a cardiac rehabilitation programme - Total
300
250
200
150
100
50
0
1
0.5
0
-0.5
-1
Jun-07
Sep-07
Dec-07
Mar-08
Jun-08
Sep-08
Dec-08
Mar-09
Jun-09
Sep-09
Dec-09

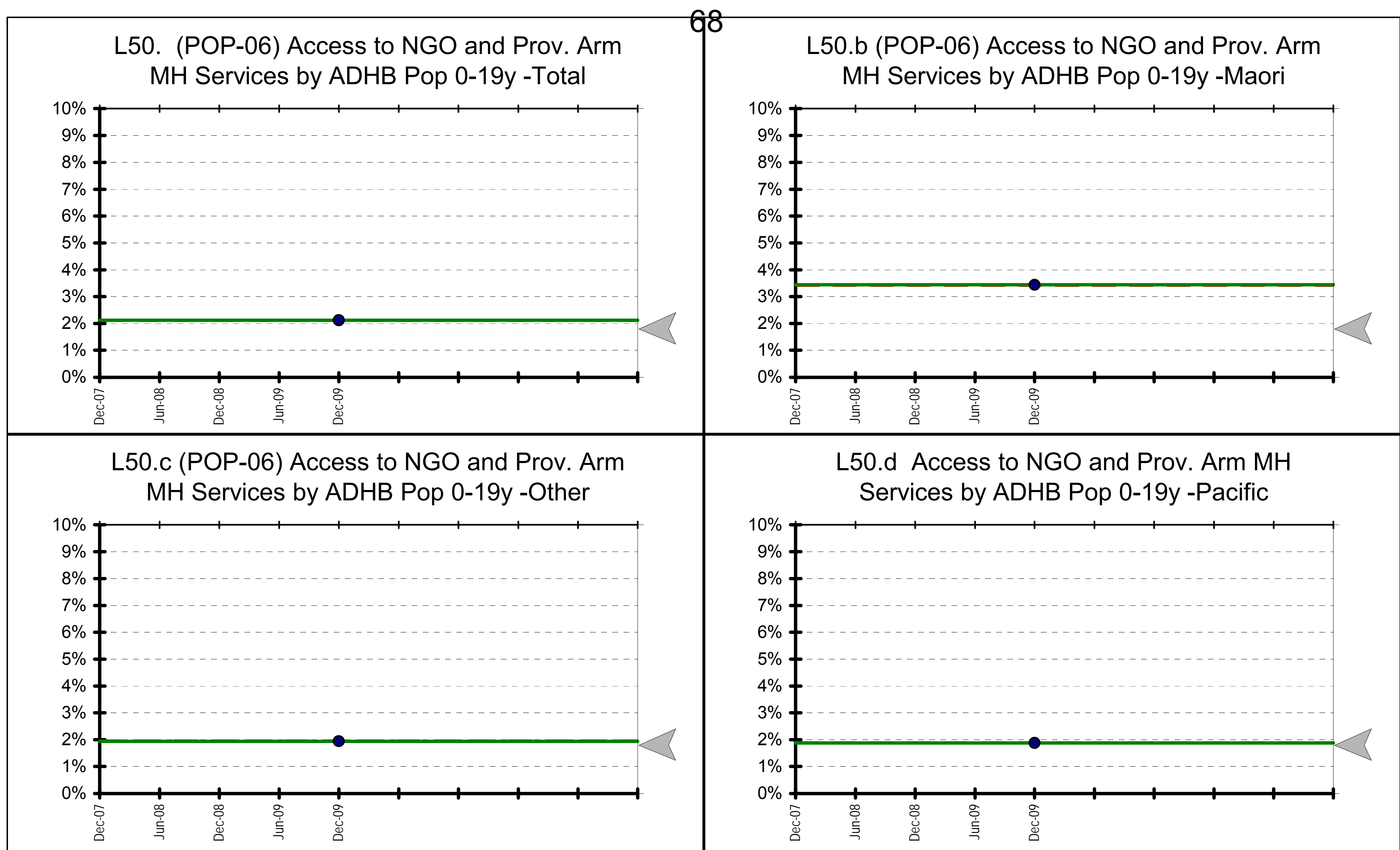


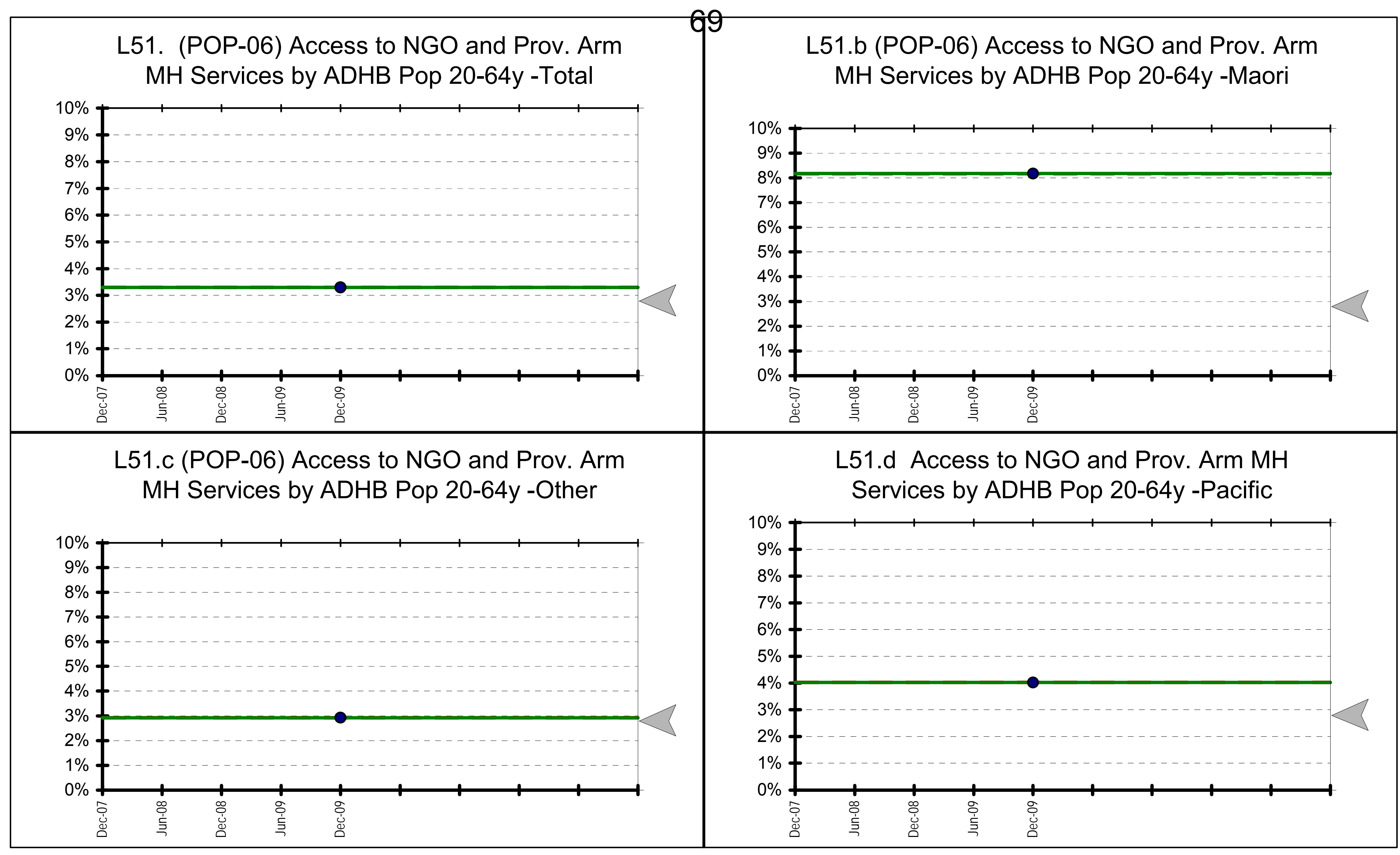
L57. Percentage of medical positions in DHB held by Pacific peoples out of total(heads)
L58. Percentage of nursing positions in DHB held by Pacific peoples out of total (heads)
L59. Percentage of Admin/clerical/mgt positions in DHB held by Pacific peoples out of total (heads)
L60. Percentage of Tech-patient care positions in DHB held by Pacific out of total(heads)
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09

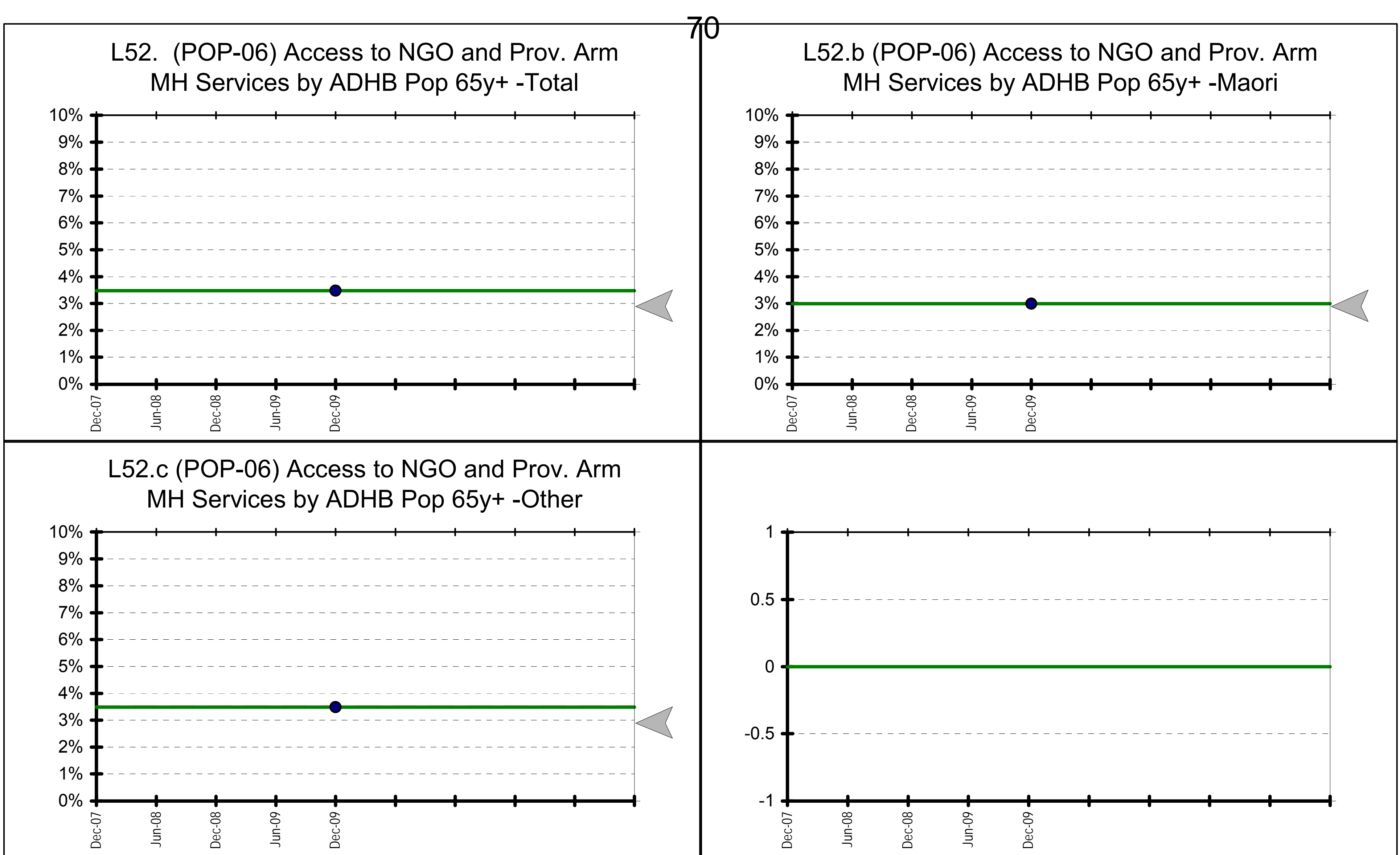

L61. Percentage of Tech-Support positions in DHB held out of total(heads)
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09
L62. Percentage of house hold positions in DHB held by Pacific out of total (heads)
60%
50%
40%
30%
20%
10%
0%
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09
L63. Percentage of stores positions in DHB held by Pacific out of total(heads)
60%
50%
40%
30%
20%
10%
0%
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09
1
0.5
0
-0.5
-1
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09

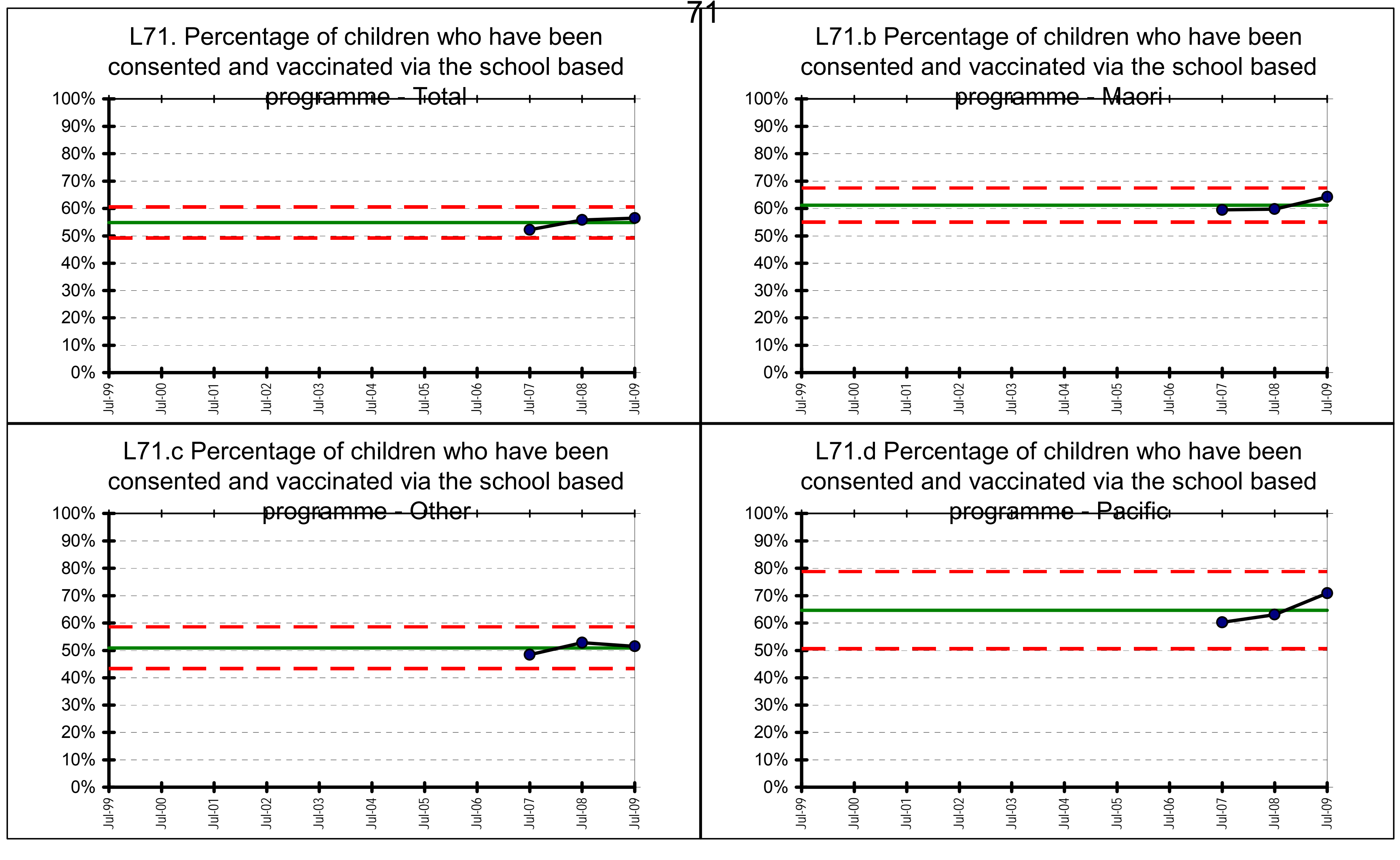

L64. Percentage of medical positions in DHB held by Maori out of total(heads)
L65. Percentage of nursing positions in DHB held by Maori out of total (heads)
L66. Percentage of Admin / clerical / mgt positions in DHB held by Maori out of total (heads)
L67. Percentage of Tech-patient care positions in DHB held by Maori out of total(heads)
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09

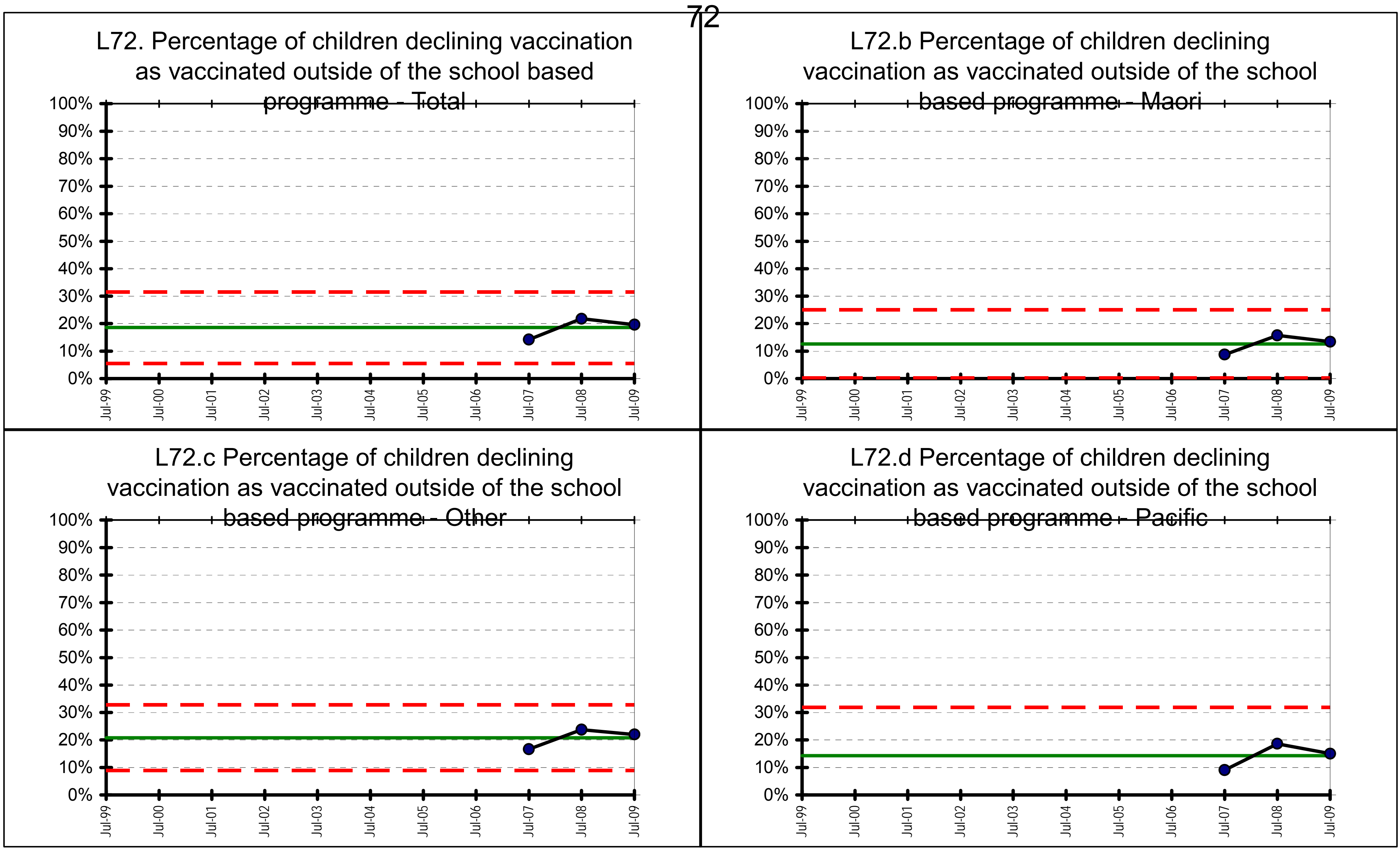

L68. Percentage of Tech-Support positions in DHB held by Maori out of total(heads)
L69. Percentage of Management positions in DHB held by Maori out of total (heads)
L70. Percentage of Hotel services positions in DHB held by Maori out of total(heads)
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
1
0.5
0
-0.5
-1
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09


L50. (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 0-19y -Total
L50.b (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 0-19y -Maori
L50.c (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 0-19y -Other
L50.d Access to NGO and Prov. Arm MH Services by ADHB Pop 0-19y -Pacific
0%
1%
2%
3%
4%
5%
6%
7%
8%
9%
10%
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09


L51. (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 20-64y -Total
L51.b (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 20-64y -Maori
L51.c (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 20-64y -Other
L51.d Access to NGO and Prov. Arm MH Services by ADHB Pop 20-64y -Pacific
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09


L52. (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 65y+ -Total
L52.b (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 65y+ -Maori
L52.c (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 65y+ -Other
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
1
0.5
0
-0.5
-1
Dec-07
Jun-08
Dec-08
Jun-09
Dec-09


L71. Percentage of children who have been consented and vaccinated via the school based programme - Total
L71.b Percentage of children who have been consented and vaccinated via the school based programme - Maori
L71.c Percentage of children who have been consented and vaccinated via the school based programme - Other
L71.d Percentage of children who have been consented and vaccinated via the school based programme - Pacific
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul-99
Jul-00
Jul-01
Jul-02
Jul-03
Jul-04
Jul-05
Jul-06
Jul-07
Jul-08
Jul-09


L72. Percentage of children declining vaccination as vaccinated outside of the school based programme - Total
L72.b Percentage of children declining vaccination as vaccinated outside of the school based programme - Maori
L72.c Percentage of children declining vaccination as vaccinated outside of the school based programme - Other
L72.d Percentage of children declining vaccination as vaccinated outside of the school based programme - Pacific
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul-99
Jul-00
Jul-01
Jul-02
Jul-03
Jul-04
Jul-05
Jul-06
Jul-07
Jul-08
Jul-09

# 7

# IMPROVEMENT ACTIVITIES

## 7.1 CPHAC DAP Projects Report

## Goal 1: Lift the health of people living in Auckland city

| High Level Strategy | Objective | Strategies to achieve objectives |
| --- | --- | --- |
| **Reduce inequities in health status** | | |
| Maori | Increase access to services | 1. Reduce Maori DNA rates.<br>2. Increase enrolment of Maori in PHOs<br>3. Rangatiratanga - Maori Health Equity Framework |
| Pacific | Build healthy communities | 1. Healthy Village Action Zone (HVAZ) evaluation<br>2. Implement and monitor revised KPIs for HVAZ Parish Community Nurses<br>3. Healthy Village Action Zone leadership and coordination |
| **Improve outcomes in priority areas** | | |
| Children & young people | Achieve agreed Ministry of Health immunisation targets (focus Maori & Pacific) | 1. Increase PHO/primary care involvement in managing immunisation<br>2. Practice level reporting<br>3. Practice nurse NIR training<br>4. Maori immunisation initiative |
| | Improve oral health outcomes for children | 1. Auckland DHB wide oral health promotion<br>2. Implement new service model |
| Older People | Streamline access to older people's services | 1. Create a single point of entry to services<br>2. Develop clinical triage according to need (direct referral to community support)<br>3. Establish new Home Based Support Services<br>4. Increase packages of care available<br>5. Restorative care process implemented |
| Mental Health | Increase effectiveness across primary, secondary & tertiary services | 1. Eating Disorder Services<br>2. Reconfigure Maori Mental Health Services<br>3. Reconfigure current level 3 & 4 residential rehab services<br>4. Implement share care project (PROGRESS+) Primary /secondary integration |
| Palliative Care | Implement revised service model to align with client need | 1. Unbundle current resources<br>2. Restructure programs to achieve effective use of general and specialist services<br>3. Increase the input of primary care teams in palliative care services |
| **Prevent & manage long term conditions** | Strengthen community participation and action | 1. Work with Healthy Village Action Zones initiative to spread lessons<br>2. Plan the approach to maximise community engagement<br>3. Achieve target for cardiovascular risk screening |
| | Support whanau and self resilience | 1. Increase efficiency, capacity and options of self-management approaches |
| | Proactive planned coordinated care | 1. Run a GP clinical network for long term conditions that develops planned care<br>2. Increase retinal screening capacity<br>3. Develop care pathways for people with long term conditions |
| | Intensive support for people with high needs | 1. Pilot case management<br>2. Increase the percentage of people utilising cardiac rehabilitation<br>3. Develop workforce for Kaupapa Maori cardiac rehabilitation |

# Goal 2: Performance Improvement (Better, Sooner, More Convenient)

| High Level Strategy | Objective | Strategies to achieve Objective |
| --- | --- | --- |
| **Improve the effectiveness & efficiency of Healthcare System** | | |
| Primary healthcare | Implementation of PHO-DHB primary healthcare plan | 1. Implement approach to providing efficient & effective coordinated care in the neighbourhood |
| | Improve access to after hours primary care | 1. Develop after-hours services including palliative and residential care |
| Improve Primary Secondary system efficiency -decrease total system cost | Improve information availability across system<br>Improve access & efficiency of service delivery | 1. e-referrals, health event summaries and electronic outpatient letters<br>2. Increase access to diagnostic tests in primary care<br>3. Transfer some services to primary/community |
| Improve hospital efficiency / throughput | Improve the performance of ED | 1. Projects to improve performance against 6 hr benchmark (OPJ)<br>2. Increase the use of and capacity of primary options |
| | Improve the acute capacity management | 1. OPJ Starship theatre project<br>2. Adult inpatient capacity step (beds and workforce) |
| | Improve Cardiac Surgery Throughput | 1. OPJ Cardiac surgery project |
| Reduce waiting times for elective services | Increase elective services to National Intervention rates | 1. Increase Greenlane capability to a full elective services centre (feasibility) |
| | Achieve Radiation Oncology intervention rates and reduce waiting times for both radiation & medical oncology | 1. Improve service scheduling process & utilisation of day stay<br>2. Tumour specific model implementation<br>3. Optimising the patient journey projects |
| | Improve Outpatient Management for Surgical Patients while improving patient satisfaction | 1. Patient centred scheduling and communication<br>2. Accurate waiting time information. Reduced Waiting time<br>3. Increased input from GP's |
| | Reduce unmet need for elective services | 1. Establish a new elective services centre |
| **Improve Leadership Capability** | Clinical leadership model: implement, monitor and evaluate<br>Improve senior leadership team performance | 1 Leadership development, mentoring and engagement process<br>2 Integrated governance reporting implemented<br>3. Define baldrige roll out plan and complete base line |
| Improve clinical quality & professional governance | Implement sector wide clinical networks | 1. Develop GP network (collaborative) with primary care |
| | Improve safety and quality of care | 1. Implement NQIP Medication Safety, Infection Prevention & Control, Mortality Review, Incident Management<br>2. Increase the number of GP practices with Cornerstone accreditation |
| **Strengthen the health workforces** | Improve clinical staff retention<br>Healthy workplace<br>Develop response to Long Term Services Plan | 1. Targeted recruitment ICU, Midwives, RMOs, OR staff<br>2. Define, train and implement new workforce roles<br>3. Review performance based incentive programs<br>4. Improve the ease of application and entry |
| **Information management** | Improve resilience and availability of core IT systems | 1. Implement the resilience improvement plan |
| | Regional Strategic Plan | 1. Regional Strategic Plan development in alignment with NZ HIS 2009 |
| **Planning** | Improve Capacity Management | 1. Implement dynamic planning process (right beds, staff, facilities) |
| | Long Term Services Planning | 1. National 2. Regional 3. Local |

## Goal 3: Live Within Our Means (Improve Value for Money)

| High Level Strategy | Objective | Strategies to achieve Objective |
| --- | --- | --- |
| Manage Revenue | Ensure revenue received for services provided | 1. IDF annual agreements ensure we are paid for what we do.<br>2. Participate in National pricing process |
| Improve Productivity | Reduce Administration Cost | 1. Improve HR payroll processing and leave management<br>2. Reduce back office cost (regional shared services)<br>3. Manage administration of M&A FTE cap |
| | Improve Clinical Effectiveness | 1. Improve clinical resource utilisation<br>2. Reduce variation in Clinical Practice |
| | Health Service Process Improvement | 1. Implement improvement programs to reduce waste, improve flow and enhance the patient experience. |
| | Achieve procurement savings | 1. Leverage national/regional procurement initiatives<br>2. Refine procurement strategy<br>3. Deliver direct treatment cost savings<br>4. Deliver indirect treatment cost savings<br>5. Monitor and collect rebates within contracts for supplies and services |
| Manage Cash | Optimise stock holding | 1. Revisit replenishment parameters<br>2. Improve supply chain systems and processes |
| | Sustainable Cash Management Plan | 1. Asset Management Plan alignment with the Long Term Services Plan<br>2. Improve prioritisation process for new capital<br>3. Long term financial modelling process is implemented |

# Goal Level Summary Report (Planning and Funding)

## DAP Projects

Total Projects: 35

| DAP GOAL | Number (#) | Started (#) | Current Phase | | | | | | On Time | | | On Budget | | | Expected Outcome | | | Finished | Post Implementation Benefits | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Plan | | | Do/Check | Act | Cancelled | Green | Orange | Red | Green | Orange | Red | Fully deliver | Partially deliver | Not deliver | | Green | Orange | Red |
| | | | Define | Measure | Analyse | Improve | Control | | | | | | | | | | | | | | |
| 1) Lifting the Health of the people in Auckland City | 25 | 25 | 8 | 2 | 4 | 7 | 2 | 0 | 23 | 2 | 0 | 25 | 0 | 0 | 25 | 0 | 0 | 2 | 2 | 0 | 0 |
| 2) Performance Improvement | 10 | 10 | 5 | 0 | 3 | 1 | 0 | 0 | 9 | 1 | 0 | 10 | 0 | 0 | 10 | 0 | 0 | 1 | 1 | 0 | 0 |
| 3) Living within our Means | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Totals #** | **35** | **35** | **13** | **2** | **7** | **8** | **2** | **0** | **32** | **3** | **0** | **35** | **0** | **0** | **35** | **0** | **0** | **3** | **3** | **0** | **0** |
| **Totals %** | **100%** | **100%** | **37%** | **6%** | **20%** | **23%** | **6%** | **0%** | **91%** | **9%** | **0%** | **100%** | **0%** | **0%** | **100%** | **0%** | **0%** | **9%** | **9%** | **0%** | **0%** |

# High Level Summary Report

## Goal 1 Lift the Health of the people in Auckland City

### DAP Projects

Total Projects: 25

| DAP HLS | Number (#) | Started (#) | Current Phase | | | | | | On Time | | | On Budget | | | Expected Outcome | | | Finished | Post Implementation Benefits | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Plan | | | Do/Check | Act | | | | | | | | | | | | | | |
| | | | Define | Measure | Analyse | Improve | Control | Cancelled | Green | Orange | Red | Green | Orange | Red | Fully deliver | Partially deliver | Not deliver | | Green | Orange | Red |
| | | | | | | | | | | | | | | | | | | | | | |
| 1.1 Reduce inequalities in health status | 5 | 5 | 1 | 0 | 1 | 3 | 0 | 0 | 4 | 1 | 0 | 5 | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1.2 Improve outcomes in priority areas | 14 | 14 | 4 | 1 | 3 | 3 | 2 | 0 | 14 | 0 | 0 | 14 | 0 | 0 | 14 | 0 | 0 | 1 | 1 | 0 | 0 |
| 1.3 Prevent and manage long term conditions | 6 | 6 | 3 | 1 | 0 | 1 | 0 | 0 | 5 | 1 | 0 | 6 | 0 | 0 | 6 | 0 | 0 | 1 | 1 | 0 | 0 |
| | | | | | | | | | | | | | | | | | | | | | |
| **Totals #** | **25** | **25** | **8** | **2** | **4** | **7** | **2** | **0** | **23** | **2** | **0** | **25** | **0** | **0** | **25** | **0** | **0** | **2** | **2** | **0** | **0** |
| **Totals %** | **100%** | **100%** | **32%** | **8%** | **16%** | **28%** | **8%** | **0%** | **92%** | **8%** | **0%** | **100%** | **0%** | **0%** | **100%** | **0%** | **0%** | **8%** | **8%** | **0%** | **0%** |

# Goal 1 Lift the Health of the people in Auckland City

Review

Overall good progress

## Objectives:

| Objective | Objective Owner | Comment |
|---|---|---|
| 1.1.1 Increase Maori access to services | Naida Glavish (ADHB) | This objective has 3 major DAP projects, DNA reduction, Increasing Maori enrollments in PHO and the Maori health outcomes Framework. All projects have siginificant challenges however all projects are currently on track with the exception of the DNA project which we are planning to undertake a review |
| 1.1.2 Build healthy Pacific Communities | Hilda Faasalele (ADHB) | COngoing engagement with Pacific communities. Pacific Summit held on Oct 1st to engage and gain input by Pacific into ADHB District Strategic Plan. Consultation on ADHB Pacific Action Plan. Analysis of feedback of feedback in progress. |
| 1.2.1 Achieve agreed Ministry of Health children and young people's immunisation targets (focus Maori and Pacific) | Denis Jury (ADHB) | Good progress continues with immunisation rates now at 82%, although there are still issues of low coverage for european women and girls remain. |
| 1.2.2 Improve oral health outcomes for children and young people | Denis Jury (ADHB) | Progress according to plan. First mobiles completed, blessed and programme launched from week of 8 Feb. |
| 1.2.3 Streamline access to older people's services | Denis Jury (ADHB) | Good progress continues with the focus now on the development of funding models for year 2. |
| 1.2.4 Increase effectiveness of mental health services across primary, secondary and tertiary services | Denis Jury (ADHB) | Good progress across all projects |
| 1.2.5 Implement revised palliative care service model to align with client need | Denis Jury (ADHB) | Good progress, but note impact of timing with regard to primary care EoI processes |
| 1.3.1 Strengthen community participation and action | Celia Palmer (ADHB) | To date one project is funded under this objective and this is progressing well. There are other projects which could be potentially linked to this objective e.g. HVAZ. Further projects should be planned to fully deliver on this objective |
| 1.3.2 Support whanau and self resilience | Naida Glavish (ADHB) | There are no DAP projects against this objective at present. |
| 1.3.3 Proactive planned coordinated care | Celia Palmer (ADHB) | There is no funding attached to the care pathways project yet this has huge potential to deliver on the objective. It may be that this can be linked to the devolution work in order to make sure the work is linked to some resource otherwise it will not be able to deliver . |
| 1.3.4 Intensive support for people with high needs | Denis Jury (ADHB) | Good progress |
| 1.1.3 Increase refugee population access to services | Denis Jury (ADHB) | Overall good progress, with increasing uptake of primary care interpreting service. |

## Exceptions:

There are no projects to display

# High Level Summary Report

## Goal 2 Performance improvement

### DAP Projects

Total Projects: 10

| DAP HLS | Number (#) | Started (#) | Current Phase | | | | | | On Time | | | On Budget | | | Expected Outcome | | | Finished | Post Implementation Benefits | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Plan | | | Do/Check | Act | | | | | | | | | | | | | | |
| | | | Define | Measure | Analyse | Improve | Control | Cancelled | Green | Orange | Red | Green | Orange | Red | Fully deliver | Partially deliver | Not deliver | | Green | Orange | Red |
| | | | | | | | | | | | | | | | | | | | | | |
| 2.1 Improve the effectiveness & efficiency of the healthcare system-primary care | 4 | 4 | 2 | 0 | 2 | 0 | 0 | 0 | 4 | 0 | 0 | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2.2 Improve the efficiency and effectiveness of the healthcare system– decrease total system cost- primary secondary interface | 4 | 4 | 2 | 0 | 1 | 1 | 0 | 0 | 3 | 1 | 0 | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2.3 Improve the efficiency and effectiveness of the healthcare system - hospital efficiency /throughput | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2.4 Improve the efficiency and effectiveness of the healthcare system – reduce waiting times for elective services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2.5 Improve leadership | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| capability | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2.6 Improve leadership performance in clinical quality& professional governance | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2.7 Strengthen the health workforce | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2.8 Information management | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 |
| 2.9 Planning | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | | | | | | | | | | | | | | |
| **Totals #** | **10** | **10** | **5** | **0** | **3** | **1** | **0** | **0** | **9** | **1** | **0** | **10** | **0** | **0** | **10** | **0** | **0** | **1** | **1** | **0** | **0** |
| **Totals %** | **100%** | **100%** | **50%** | **0%** | **30%** | **10%** | **0%** | **0%** | **90%** | **10%** | **0%** | **100%** | **0%** | **0%** | **100%** | **0%** | **0%** | **10%** | **10%** | **0%** | **0%** |

## Goal 2 Performance improvement

Review

Overall good progress, with continued activity to support the primary care business plan process to meet 1 March due date.

### Objectives:

| Objective | Objective Owner | Comment |
|---|---|---|
| 2.1.1 Implementation of PHO-DHB primary healthcare plan | Celia Palmer (ADHB) | Work is progressing on implementing the plan in line with the new government initiatives. |
| 2.1.2 Improve access to after hours primary care | Celia Palmer (ADHB) | Essential background work and linking to key stakeholders is being undertaken and on track |
| 2.2.2 Improve access and efficiency of service delivery | Celia Palmer (ADHB) | Projects progressing well. We may want to see devolution as an objective rather than a particular project where it does not seem to fit. |

### Exceptions:

| Short Name | Coverage | Phase | On Time | On Budget | Expected Outcome | Sponsor Review |
|---|---|---|---|---|---|---|
| Devolution of services | ADHB | Define | ● | ● | ● | Funding available for radiology and palliative care and these are going ahead. For other areas planning in progress. |

# 8

# PAPERS

8.1 Impace of the In-utero Environment on the Health of the Body – Professor Sir Peter Gluckman (verbal presentation)

8.2 ADHB Immunisation Strategy

8.3 Primary Care Business Case Sign Off

(i) National Maori PHO Coalition

(ii) Alliance Health+ (Pacific PHO Alliance)

(iii) Greater Auckland Integrated Health Network (GAIHN)

8.4 DAP and SOI Approval Recommendation

## 8.1 Impact of the In-utero Environment on the Health of the Body - Verbal

## 8.2 ADHB Immunisation Strategyl

# Community and Public Health Advisory Committee
# Paper

| | |
|---|---|
| Date | Wednesday, 17 February 2010 |
| To | Community and Public Health Advisory Committee |
| From | Dr Denis Jury, Chief Planning and Funding Officer<br>Level 8, Building 13, Greenlane Clinical Centre<br>Phone: ext 8071<br>Email: denisj@adhb.govt.nz |
| Author | Carol Stott, Planning and Funding Manager, Children, Youth and Women's Health. Phone: ext 4341. Email: carols@adhb.govt.nz<br>Ruth Bijl, Projects Manager, Children, Youth and Women's Health, Planning and Funding. Phone: ext 27920. Email: RBijl@adhb.govt.nz |
| Functional Group | Planning and Funding |
| Subject | ADHB Immunisation Strategy |

**1 Purpose**

Childhood immunisation is a key health target. Currently, ADHB has achieved 82% coverage. The Ministry of Health has set a target of 95% by 2012. To achieve this target it is necessary to focus on immunisation and implement a range of initiatives to ensure that every child and young person is protected from vaccine preventable disease. You are requested to:

- **Note** ADHB has developed an Immunisation Strategy
- **Note** ADHB is using this strategy to engage regional DHBs in shared immunisation goals and targets.

**2 Recommendations**

| | DAP | DSP | Budget |
|---|---|---|---|
| **Note** ADHB Immunisation Strategy in development. | | | |
| **Note** ADHB engaging regionally on immunisation. | | | |
| | | | |

**3 Description of Solution (Option)**

Children, Youth and Women's Health Planning and Funding are developing an ADHB Immunisation Strategy to focus and guide efforts aimed at achieving the 95% immunisation coverage target by 2012. Encouraging progress is being made on developing this strategy as a regional initiative. A regional strategy is ADHB's preferred option as Ministry of Health targets are being set regionally and consistent messaging to families/whanau and the sector is essential if the high target is to be achieved.

**4 Background**

Immunisation is widely acknowledged as one of the most "cost effective public health interventions in history".[1] Vaccines are available for a range of life threatening diseases such as Tetanus and Pertussis (Whooping Cough) and have been successful in eradicating some diseases. To be effective at a population level, high immunisation coverage rates (90 – 95%) need to be achieved and sustained.[2] Currently, 82% of Auckland children are fully immunised at 2 years of age[3] and this represents a significant increase over the last two years. Around 5% of families 'conscientiously object' to immunisation making a 95% coverage rate attainable. Australia achieves this immunisation coverage.

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[1]. World Health Organisation. 2005. *Global Immunization Vision and Strategy 2006 – 2015*. pp.18, 33.
2 Ministry of Health. 2007. *The National Childhood Immunisation Coverage Survey 2005*. Ministry of Health.
3 National Immunisation Register. Total immunisation coverage rate 5 January 2010.

| | |
|---|---|
| | Achieving high immunisation rates requires multifaceted approaches.[4] This is reflected in ADHB's immunisation strategy. The strategy recognises that more effort needs to go into decreasing the barriers to immunisation both for families/whanau and for health professionals and into increasing 'demand' so timely immunisation is seen as the standard of care for all children in New Zealand. The lack of demand for immunisation in New Zealand is considered in part to be a consequence of the success of immunisation and of vaccine preventable disease being less visible in the community. However, the community can not afford to be complacent about immunisation as recent outbreaks of pertussis and measles have demonstrated. Whilst most children and adults who catch these infections have mild symptoms, some will develop severe disease and require hospitalisation, develop pneumonia, deafness or permanent neurological disability. Both diseases can be fatal.<br><br>The immunisation strategy was developed with key stakeholders and applies 5 principles across 4 key result areas. The key result areas list actions associated with:<br><br>- consistency of key messages;<br>- access issues;<br>- workforce; and,<br>- systems, including funding mechanisms.<br><br>It is recognised that factors for success cross DHB boundaries. Efforts to engage with the other Auckland DHBs are being made and it is hoped that a shared strategy with DHB area specific action can be agreed.<br><br>The strategy does not anticipate new funding although an approach has been made to the Starship Foundation to support a social marketing campaign. |
| **5** | **Options Considered**<br>A social marketing campaign in isolation was considered. However, evidence shows that efforts to achieve high immunisation rates need to be multi-factorial and coordinated. Consequently, a guiding strategy was considered appropriate as a means of focusing attention and aligning effort to get immunisation rates from the 80 to the 90 percents. The previous 'silver bullet' of the national immunisation register appears to have achieved all it is able to do in isolation of other coordinated initiatives. The final percentage points are only expected to come from fully coordinated activity around messages, access, the workforce and systems.<br><br>There is no plan to formally publish the strategy. The strategy's function is to coordinate and guide activity locally and, ideally, regionally. |
| **6** | **Issues and Risks for Chosen Option**<br><br>Increasing the emphasis on immunisation may increase funding demand particularly for the general practice immunisation subsidy. Research has demonstrated that the rate paid is less than the cost associated with delivery.[5] This funding is paid from the Ministry of Health to practices. There may also be pressure to continue recently established DHB funding for immunisation coordinators in PHOs. Immunisation coordinators appear to have improved PHO engagement with immunisation. |
| **7** | **Budget Implications**<br><br>There are no current budget implications. Budget implications will be reviewed as the strategy is actioned. |
| **8** | **Regional / National Implications**<br><br>The strategy is expected to be adopted regionally. A draft has been discussed with Ministry of Health officials. The strategy is ADHB's response to priority given to immunisation by the Ministry. |
| **9** | **Appendix available**<br><br>Immunisation Strategy for Children and Young People in Auckland District Health Board. |

4. NICE. 2009. *Reducing differences in the uptake of immunisations (including targeted vaccines) among children and young people aged under 19 years*. NHS.
5. Immunisation Advisory Centre. The cost of immunising in General Practice. Accessed on 29 January 2010 on http://www.immune.org.nz/?t=972

## 8.3 Primary Care Business Case Sign Off

# Community and Public Health Advisory Committee Paper

| | |
|---|---|
| Date | Wednesday 17 February 2010 |
| To | Community and Public Health Advisory Committee |
| From | Dr Denis Jury, Chief Planning and Funding Officer<br>Level 8, Building 13, Greenlane Clinical Centre<br>Phone: 09 630 9943 ext 8071<br>Mobile: 021 306 044<br>Email: denisj@adhb.govt.nz |
| Author | Andrew Coe, Manager PHOs and Primary Care<br>Auckland District Health Board<br>Level 8, Building 13, Greenlane Clinical Centre<br>Email: acoe@adhb.govt.nz<br>Mailing: Private Bag 92-189, Auckland 1142<br><br>Phone 09 630 9943 Ext 4085<br>Mobile: 021 242 3923 |
| Functional Group | Planning and Funding Functional Group |
| Subject | Primary Care Business Case Sign Off |

## 1 Background

The Primary Care Business Cases are required to have DHB sign-off and be submitted to the MoH by 1 March 2010.

An overview of each case was presented to the 27 January CPHAC meeting and feedback from the Board has been provided to the respective groups. In particular the requirement to show that Integrated Family Health Clinic position and structure was responsive to our high needs populations was noted.

Also, the requirement of the Minister for some DHB's to show consolidation of PHO's in their area has also been conveyed to the EOI groups.

At its 3 February meeting the Board approved delegated authority to the Chair and CEO for final review and sign-off for 1 March submission of the business cases.

The business case from each EOI group will be circulated under separate cover and you are requested to review each and provide advice regarding sign-off to management, and to the Board Chair and CEO.

## 2 Recommendations

That the Community and Public Health Advisory Committee;

i) **Note** the business cases prepared by each of the three primary care EOI groups in the ADHB district.

ii) **Provide advice** regarding any requirements for sign-off to management, Board Chair and CEO

## 8.4 DAP and SOI Approval Recommendation

# COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE

# Paper

| | |
|---|---|
| Date | Wednesday 17 February 2010 |
| To | Community and Public Health Advisory Committee |
| From | Denis Jury, Chief Planning and Funding Officer<br>Level 8, Building 13, Greenlane Clinical Centre<br>Phone: 630 9943 ext 8071<br>Email: denisj@adhb.govt.nz |
| Author | Julie Helean Ext 4390 jhelean@adhb.govt.nz |
| Functional Group | Planning and Funding Functional Group |
| Subject | 2010-2011 District Annual Plan and Statement of Intent |

**1 Purpose**

To present the first draft of the District Annual Plan for 2010-11 for review and any input and to update on progress re the Statement of Intent

**2 Recommendations**

That the Committee

- **review** the attached District Annual Plan and note any changes required prior to Board approval
- **note** the progress in developing the Statement of Intent

**3 District Annual Plan 2010-11**

This document is attached for review.

**4 Statement of Intent**

The Statement of Intent is due with the Ministry of Health on 19th March. The document has not yet been developed but will contain very similar content to the District Annual Plan.

The Committee will be asked to review the draft material at their 17 March meeting. The Committee will also be asked to approve that version in its draft form.

# 9

# CONFIRM

**9.1 Action Points for next CPHAC Meeting**

**9.2 CPHAC Feedback to Board**

**Use Forms at beginning of Meeting Pack**

# 10

# GENERAL BUSINESS

# 11

# APPENDICES

**11.1 ADHB Immunisation Strategy**

**11.2 DAP 2010 - 2011 - under separate cover**

## 11.1 ADHB Immunisation Strategy

*Our Healthy Children and Young People*

# Immunisation Strategy 2010 - 2015

## For Children and Young People in Auckland City

Our Healthy Children and Young People. Our Community. Our Vision.

# Immunisation Strategy for Children and Young People in Auckland District Health Board

## Introduction

Immunisation is widely acknowledged as one of the most "cost effective public health interventions in history".[1] Vaccines are available for a range of life threatening diseases such as Tetanus and Pertussis (Whooping Cough) and have been successful in eradicating some diseases.

To be effective at a population level, high immunisation coverage rates (90 – 95%) need to be achieved and sustained.[2] These coverage levels are not achieved in Auckland City or New Zealand as a whole. At the beginning of 2010, 82% of Auckland children were fully immunised at 2 years of age.[3] Auckland District Health Board (ADHB) is aiming to achieve 95% coverage of all children aged 2 years by 2012. Achieving high immunisation rates requires multifaceted approaches[4] and this is reflected in ADHB's immunisation strategy.

The success of immunisation programmes means that vaccine preventable disease is less visible in the community. However, the community cannot afford to be complacent about immunisation as recent outbreaks of pertussis and measles have demonstrated. Whilst most children and adults who catch these infections have mild symptoms, some develop severe disease and require hospitalisation. A proportion has long term complications including deafness and permanent neurological disability. In New Zealand, nearly 150 children and young people are hospitalised every year due to a vaccine preventable disease. A small proportion die.

We know families and whanau love and nurture their children and want the best for them. It is important that timely immunisation is accepted as being a fundamental way of protecting and caring for our families. We know that some families who are under-immunised don't want to see their baby hurt but need to re-balance the immediate concern regarding an injection against the possibility of the far more serious risk of a life-threatening disease. We also know that families face a raft of competing priorities. This strategy is about making timely immunisation one of our community's highest priorities.

Thank you to Alison Leversha, Aroha Haggie, Barbara Stevens, Carol Stott, Louisa Wall, Leane Els, Lulu Padotan, Natalie Desmond, Nikki Turner, Rosemary Gordon, Ruth Bijl, Sheryl Orton, Sue Radford, Theo Brandt and Members of the ADHB Child Health Stakeholders Advisory Group for developing this strategy.

This immunisation strategy sits under the ADHB Child Health Improvement Plan 2006 – 2011 and reflects the notion of equity of access to quality healthcare for all children. The immunisation strategy is also guided by and responds to a range of over-arching strategies including The New Zealand Health Strategy; The New Zealand Disability Strategy; He Korowai Oranga (the Maori Health Strategy); The Pacific Health Action Plan; ADHB Primary Care Plan; ADHB Strategic Plan; and, the United Nations Convention on the Rights of the Child (UNCROC).

## Strategic Aim

Auckland DHB will achieve the lowest possible incidence of vaccine preventable disease and reduce inequalities by reaching the highest possible immunisation coverage across the whole population.

## Guiding Principles

- Treaty of Waitangi and whanau ora – Maori families supported to achieve their maximum health and wellbeing.
- Evidence-based – The best available evidence informs decisions and practice.
- Culturally relevant – Planning, processes and services are responsive, contribute to health gain and align with best cultural practice.
- Accountability – Roles, responsibilities and targets are clearly defined and appropriate levers are applied to achieve agreed outcomes.
- Strengths- based – Families are supported to understand that immunisation protects the health and well-being of all the whanau and prevents illness for individual whanau members.

## Key result areas

Auckland DHB has developed four key result areas.

**Key Result Area 1:** Communication

**Key Result Area 2:** Community and collaboration

**Key Result Area 3:** Competency, consistency and confidence

**Key Result Area 4:** Coordination

## Key roles in immunisation

Parents and families/whanau have an important role as decider, influencer or facilitator of immunisation. We respect the choices families make but want to ensure that immunisation decisions are based on the best possible information.

Primary care is the home of immunisation. Primary care is the major point of engagement with the health sector for families as well as the locality for vaccine administration. Health professionals from antenatal care providers through to health workers in a range of settings such as schools have a key role in providing information through to delivering support to help families make informed choices regarding immunisation, facilitating access and immunising.  Primary care providers are important facilitators of the completion of the immunisation schedule.

## Key Results Areas/Strategic Objectives

### Key Result Area 1: Communication

Effective communication and health promotion underpins evidence informed decisions. Information and communication needs to be tailored for health professionals and for health consumers. Health professionals need to be supported to communicate confidently and health consumers have a right to be fully informed about the benefits and risks associated with immunisation both at an individual and community level. Auckland DHB will:

- Ensure that all primary care health practitioners and their teams are fully informed about immunisation and an atmosphere that encourages immunisation is created so every child is offered the benefits of immunisation.
- Provide appropriate supports to health professionals to assist them to effectively communicate the benefits and risks associated with immunisation to all families and whanau.
- Engage the community in an evidence-based discussion about the benefits and risks for individuals, families and the community associated with immunisation. This discussion will positively engage Maori and normalise immunisation as a key way to protect whanau.
- Ensure that the health workforce is well informed about risks to specific groups of babies, children and young people in terms of vaccine-preventable disease and can readily access best practice information.
- Ensure information is communicated in a timely and effective way so that families can make the best decisions for their child.

**Actions:**

1. Develop an immunisation communication strategy.

2. Prepare a business case to support the development, implementation and evaluation of a social marketing campaign which positively reinvigorates the immunisation attitudes and behaviour of both health consumers and health professionals. Ensure the campaign:
   - is evidence-based
   - is strengths-based
   - delivers key messages in a range of languages and through a variety of channels
   - promulgates key messages consistently
   - is accessible to Maori.

3. Advocate to the Ministry of Health to increase the reach of immunisation information resources in a wider range of languages and deliver key messages that support whanau ora - cultural values, beliefs and practices particularly for Maori whanau.

4. Ensure that the health workforce, particularly LMCs and primary care teams, is well informed regarding indications and contraindications and can access a range of support tools to support their day to day practice.

**Key Result Area 2: Community and collaboration**

A range of factors make it difficult for some families to access health services. Issues include limited knowledge or motivation, fear, lack of transport or money. For others, immunisation is just not a priority. To increase immunisation uptake the health and wider community needs to remove these barriers and establish immunisation as the expected standard of care for all families. Auckland DHB will:

- Develop approaches and systems that are culturally responsive to support ease of access to general practice.
- Develop approaches and systems that support the earliest possible enrolment of babies with general practice.
- Bring immunisation to the families that have greatest difficulty accessing immunisation.
- Provide multiple entry points and opportunities for families to access immunisations.
- Engage with a range of community organisations that can support access to immunisation.
- Encourage families to immunise on-time every time.

**Actions:**

1. Review all possible enrolment points for newborns in health and other sectors including through new initiatives such as whanau ora workers and prepare a plan to support the earliest possible enrolment of newborns with general practice.

2. Work with primary care to develop and implement a variety of entry points to immunisation and increase clinic hours.

3. Develop approaches to positively reinforce on-time immunisation and adherence to the national immunisation schedule, targeting hardest to reach families in particular.

4. Work with a range of key governmental and non-governmental agencies beyond health to develop and implement whole child approaches that include immunisation information and access opportunities.

5. Review international evidence on methods associated with incentivising immunisation.

6. Review how best to reach out into the community to improve access for the hardest to reach families.

7. Work with other Northern region DHBs on regional strategies to increase consistency and maximise immunisation opportunities.

**Key Result Area 3: Competence, consistency and confidence**

Many people and organisations are totally committed to immunisation and work really hard to reach out to families. We need to support this workforce better and ensure that we have a well trained, motivated and confident immunisation workforce right across the health system to deliver immunisation on-time, every time, to everyone. Auckland DHB will:

- Build on the strengths of the Quality Managers and Immunisation Coordinators within PHOs as champions of immunisation.
- Engage mid-wives and antenatal education providers in disseminating evidence based immunisation information.
- Embed core immunisation skills within all health professionals' training.
- Improve access to immunisation training, cultural responsiveness training and the immunisation skill set for the primary care workforce.
- Ensure that the health workforce is supported to offer and deliver targeted vaccines.

**Actions:**

1. Review the role of immunisation coordinators in primary care with a view to strengthening their role across primary care.

2. Support quality managers and immunisation coordinators to develop and implement practice nurse competency and audit tools.

3. Explore options to increase the range of health care professionals delivering immunisation.

4. Work with training agencies and professional colleges to ensure that immunisation is enhanced as a core subject and there is a clear and consistent understanding about the benefits and risks of immunisation.

5. Ensure that health professionals have access to a range of effective immunisation decision support tools.

**Key Result Area 4: Coordination**

Systems issues can increase the time and effort required to deliver a full immunisation programme and de-motivate staff. Wherever possible systems should be user-friendly and eliminate duplication of effort. Systems need to interface effectively to eliminate error or loss of information. Users need to be able to access ongoing education on system functionality so that quality is maintained over time. Systems need to support the identification and management of children and young people at special risk of infectious diseases due to medical conditions such as chronic diseases and compromised immunity. Auckland DHB will:

- Enhance the interface between practice management systems and the national immunisation register (NIR) and ensure that the skills required to manage these systems are built and maintained.
- Continue to support the management and administration of the NIR.
- Review funding structures and approaches to increase immunisation uptake in hard to reach populations.
- Develop mechanisms that support primary care's achievement of immunisation targets for their enrolled populations.
- Ensure systems to indentify children with special risks are robust, understood and applied systematically.

**Actions:**

1. Support immunisation coordinators and NIR administrators to remove obstacles to the efficient and accurate management of immunisation information.

2. Ensure that general practices have quality practice level information regarding their immunisation coverage performance.

3. Review funding and incentivisation mechanisms and implement appropriate and effective recommendations within the available funding.

4. Develop feedback and monitoring systems to allow individual practices and PHOs to review progress and targets.

5. Work with primary care to develop more effective precall, recall and flagging systems.

6. Develop more effective systems to increase opportunistic immunisation.

7. Review systems, processes and effectiveness of identifying, offering and delivering vaccines to children with special risks.

8. Explore options for monitoring and evaluating the effectiveness of targeted immunisations.

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**Notes**

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## 11.2 DAP 2010 - 2011 - Under Separate Cover