



Community and Public Health Advisory Committee Meeting

Wednesday 20 October 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.	

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.

ATTENDANCE AND APOLOGIES

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.legislation.govt.nz) and “Managing Conflicts of Interest – Guidance for Public Entities” (www.oag.govt.nz).

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	Consultant	Hourly consulting rate	Member of Treaty Negotiation Team in respect of Claim 388 register with Waitangi Tribunal Wholesale supplier of water and waste water services to the Auckland region Has a joint multi-million Healthy Housing programme with Health Board Investigating a comprehensive cross agency intervention related to the Tamaki area including ADHB Oversees implementation of quality programmes in DHB nationwide Crown Negotiator Ngati Kahu Treaty of Waitangi Claim Crown Negotiator Muriwhenua Treaty of Waitangi Claim	3 September 2008
	2. Watercare Services Limited	Director	Fee		
	3. Housing New Zealand	Chair	Fee		
	4. Tamaki Establishment Board	Chair	Fee via HNZC		
	5. Quality Improvement Committee	Chair	Fee		
	6. Chief Crown Negotiator Ngati Kahu Claim	Consultant	Fee		
	7. Chief Crown Negotiator Muriwhenua Forum	Consultant	Fee		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Harry BURKHARDT (Deputy Chair)	1. Replas Ltd	Managing Director and shareholder	Salary	Plastics Manufacturing Company	6 April 2010
	2. Matta Products Ltd	Director and shareholder.		Plastics Manufacturing Company	
	3. Remat Ltd	Director and shareholder		Plastics Manufacturing Holding Company	
	4. Matt I Ltd	Shareholder/Director		Plastics Manufacturing Holding Company	
	5. Matta LLC	Trustee		Plastics Distribution Company USA	
	6. New Zealand Maori Arts and Craft Institute	Chairman	Honorarium	Government owned Maori Tourist operation	
	7. Auckland District Health Board	Deputy Chair, Chair Finance Committee			
	8. ADHB Charitable Trust	Trustee			
	9. Ngati Kuri Trust Board	Deputy Chairman and Treaty Negotiator			
	10. Packaging Council of New Zealand	Executive Member			
	11. Ngati Whatua o Orakei Health Clinic Ltd	Chairman			
Jo AGNEW	1. Senior Lecturer Nursing Auckland University		Salary		21 April 2010
	2. Casual Staff Nurse ADHB		Salary		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	<ol style="list-style-type: none"> 1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board 	<p>Self-employed</p> <p>Professional Conduct Committee member</p> <p>Professional Conduct Committee member</p>	<p>Fees</p> <p>Hourly fee</p> <p>Hourly fee</p>	<p>Writer, editor and public relations services</p> <p>Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes</p> <p>Lay member of PCC to assess complaints and determine outcomes</p>	7 August 2009
Dr Chris CHAMBERS	<ol style="list-style-type: none"> 1. Employee, Auckland District Health Board 2. Wife employed by Safekids 3. Associate, Epsom Anaesthetic Group 4. Member, ASMS 5. Shareholder, Ormiston Surgical 6. Surveyor Quality Healthcare NZ 				7 July 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	21 April 2010
	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	
	6. National Health Board	Member	Fee		
	7. Chair Whanau Ora Governance Group				
Dr Brian FERGUS	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				29 June 2010
	2. Northern (AK) Regional Ethics Committee	Chair	Fee		
Dr Ian SCOTT	1. Shareholder Chair Auckland PHO	Chair	Meeting fee		1 September 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Bob TIZARD	1. Nil				27 February 2008
Seiuli Dr Juliet WALKER	1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure	Self employed contractor	Contract hourly rate	General practitioner services	16 August 2010
	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	
	5. Panel Member, Medical Appeal Board, Work and Income		Fee		
	6. Bader Drive Healthcare	Programme Facilitator	Fee	Clinical Training Support	
Ian WARD	1. Chair, Advisory Board, Healthvision Limited		Fee		3 February 2010
	2. Principal/Director C -4 Consulting Limited			Tender to National Shared Services	

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

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lynda WILLIAMS	1. Maternity Services Consumer Council 2. Auckland Women's Health Council 3. Member National Antenatal HIV Screening Implementation Advisory Group 4. Chair Postnatal Distress Support Network Trust Board 5. ADHB Primary Maternity Services Steering Committee	Employee Employee	Salary Salary		4 August 2008
Iain MARTIN	1. University of Auckland 2. Chair Peri-Operative Mortality Review Committee	Employee	Salary		5 May 2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Anne KOLBE	1. Private Paediatric Surgical Practice 2. Employee Communitio NZ 3. Siggins Miller, Australia 4. Head, Auckland Clinical School, School of Medicine, University of Auckland 5. Husband: Employee University of Auckland 6. Risk and Audit Committee Whanganui District Health Board 7. Pharmac Board 8. South Island Neurosurgical Services Expert Panel	Director Senior Consultant Senior Consultant Employee Member Member Chair	Joint Owner Contractor Contractor Salary Fee Fee Fee		4 August 2010

CONFIRMATION OF MINUTES
- WEDNESDAY 15 SEPTEMBER 2010

Community and Public Health Advisory Committee Minutes

MEETING DETAILS											
Time and Date	2:00pm, Wednesday, 15 September 2010										
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom										
2	ATTENDANCE AND APOLOGIES										
	<p>The Chair declared the meeting open at 2.05 pm.</p> <p>Committee Members</p> <table> <tr> <td>Dr Brian Fergus (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Harry Burkhardt</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Ian Ward</td> </tr> <tr> <td>Farida Sultana</td> <td>Lynda Williams</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Taima Campbell – Executive Director Nursing Hilda Fa’asalele – General Manager Pacific Health Kerry Hiini – Planning and Funding Manager Dr Andrew Old – Public Health Physician Ian Bell – Board Administrator</p> <p>In Attendance</p> <p>Ron Hooton - Procure Peter Tranter – Procure Barbara Stevens – Auckland PHO</p> <p>Apologies</p> <p>Apologies had been received from Susan Buckland, Alfred Ngaro, Pat Snedden and Juliet Walker. An apology for lateness was recorded for Rob Cooper.</p> <p><u>Moved Ian Ward; seconded Ian Scott</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Dr Brian Fergus (Chair)	Jo Agnew	Harry Burkhardt	Dr Chris Chambers	Rob Cooper	Dr Ian Scott	Rt Hon Bob Tizard	Ian Ward	Farida Sultana	Lynda Williams
Dr Brian Fergus (Chair)	Jo Agnew										
Harry Burkhardt	Dr Chris Chambers										
Rob Cooper	Dr Ian Scott										
Rt Hon Bob Tizard	Ian Ward										
Farida Sultana	Lynda Williams										
3	CONFLICTS OF INTEREST										
	There were no declarations of conflicts of interest with any item on the agenda.										
4	CONFIRMATION OF MINUTES 21 JULY 2010										
	<p><u>Moved Brian Fergus; seconded Lynda Williams</u></p> <p><i>That the minutes of the Community and Public Health Advisory Committee meeting held on 21 July 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

5	ACTION POINTS 21 JULY 2010
	<p>Strategies for Children</p> <p>This would now be presented early next year as Richard Aickin was presently on sabbatical.</p> <p>Sexual Health</p> <p>The termination rates for Maori and Pacific were approximately three times those of European. Dr Gemmel had presented to both the Maori Health Advisory Committee and the Pacific Health Advisory Committee.</p> <p>Mental Health</p> <p>A presentation on Mental Health by Clive Bensemann and Robert Ford would be coming to the Committee either October or November.</p> <p>Asian and Migrant Health Needs</p> <p>Farida Sultana and Brian Fergus would provide a paper through Denis Jury on the health needs of Asian and migrant groups.</p> <p>Rob Cooper joined the meeting at 2:12pm.</p>
6.1	Planning and Funding Summary Report
	<p>Work was being undertaken with PHOs on the B4 School Checks programme looking at an alliance contracting model within a clear framework. Previously this was done in-house.</p> <p>There was a requirement for a Regional Service Plan with a rough draft due by 30 September which was part of the change in the national planning structure. While it would be difficult within the timeline to get Board signoff it was based on previous work and there was nothing significantly new. The Plan would evolve over time but that being submitted was based on the previous Plan. Primary Care did not have time to be consulted with and near completion a copy would be circulated for comment on the broad concepts but not the fine detail. A meeting with the National Capital Committee had been held that morning.</p> <p>The Sylvia Park Oral Health facility had opened the previous Friday which was the first clinic opened since the 1960s. Point England would open in a month's time. These were major improvements with them being hubs for treatment with assessments being done in mobile dental vans. Transport to the hubs would be provided by mini bus or parents.</p> <p>Mental Health were planning for more secure accommodation and a model for older people's rehabilitation and longer term stay in Mental Health Services was being developed.</p> <p>Health services for prisoners were delivered by Corrections at a higher cost than PBF so if it was transferred to Health it was essential to ensure that the financial risk is not transferred.</p> <p>There was research being undertaken on patient journeys, both acute and elective, and this should include the impact of cancellation on patients and families.</p>
6.2	Planning and Funding Indicators Exception Report
	<p>The data on immunisation was being reviewed as it was not well understood. The reduction of Ambulatory Sensitive Hospitalisations Aged < 5 was an improvement. The number of Other (non TB) Disease Cases notified was showing an increase due to swine flu and meningococcal notifications. Get Checked for diabetes and diabetes management were close to target and there was a general improvement in Children Caries Free at 5 years. Cardiovascular risk screening showed Maori trending lower but there were also questions on data collection. All KPIs were being reviewed to improve reporting.</p>

7	Improvement Activities
	<p>Increased access to diagnostic radiology was causing some anxiety with radiologists but the volumes are at the margin.</p> <p>The shift in minor surgery activity was small volumes and there could be a financial risk that people previously paying would now be funded. There were issues of clinical governance, training and management.</p> <p>The tele-health project had received an award and technologies were being looked at to manage long term conditions.</p>
9.1	A Locality Approach for Auckland
	<p>To support the Primary Care Plan the locality approach was progressing the previous neighbourhood approach. Feedback was being sought which had also been requested from the Maori Health Advisory Committee and Pacific Health Advisory Committee. The aim was to have better planning and delivery of services at a locality with the proposal being connection with the local boards of the new Auckland Council to link into their communities and their planning so that their plans included health. There would be stronger references to manawhenua. While the framework may appear a bit ridged the intent was to get closer to the community and also provide flexibility.</p> <p>Procure had welcomed the opportunity to review and participate and over the last few years had seen an improved relationship in primary care i.e., HVAZ with PHOs working together. The locality approach would be looked to address high needs populations. It was important that community workers individual knowledge was captured in reaching communities. While for Auckland PHO they had numbers that were enrolled that lived elsewhere the locality approach would assist and would be an opportunity for PHOs to work together on a common goal.</p> <p>ADHB had done well on the Treaty issues, Maori governance and Maori management. While people moved and do not stay in one locality the locality approach was taken as the primary direction. As the approach developed there could be changes. The Marae project with health as an adjunct to the marae community could be extended to the ward boards noting that they covered the environmental issues that impact on health.</p> <p>The approach would be started within the Tamaki Transformation Project area as it was developing an infrastructure. The Board will be kept informed.</p> <p><u>Moved Ian Scott; seconded Jo Agnew</u></p> <p><i>That the Community and Public Health Advisory Committee approves the locality health service delivery approach as described; and approves the staging of localities for planning as outlined.</i></p> <p><u>Carried</u></p> <p>Barbara Steven and Ron Hooton left the meeting at 3:23pm.</p>
8	FEEDBACK FROM THE COMMITTEES
	<p>Maori Health Advisory Committee</p> <p>The Committee had received a presentation on termination rates and there was a question of more research. Maori Coalition PHO, which had preceded the Whanau Ora policy, had presented on their development progress.</p> <p>Pacific Health Advisory Committee</p> <p>The Committee had had the presentation on terminations the previous month and staff were now working with the University on interest in research and how to bring the topic, that was very sensitive, to the community. There had been a presentation on the Pacific Quit Smoking Service who went into the work environment and an example was given of their approach to a kava group consisting of Tongan men who had high rates of smoking. The Health Housing initiative does have referrals related to Pacific houses and the Committee had generally supported the locality</p>

	<p>approach and with community engagement it was important to ensure that this is with the right people.</p>
13.1	Update on Contract Reviews
	<p>This is the second cohort of contracts to be reviewed. There is no immediate recommendations to exit contracts. There was acknowledgement of the good process.</p> <p><u>Moved Chris Chambers; seconded Jo Agnew</u></p> <p><i>That the Community and Public Health Advisory Committee notes and approves the various contracts reviewed.</i></p> <p><u>Carried</u></p> <p>The question of building infrastructure and stabilising providers was raised together with the need to develop relationships with NGO through a vigorous process of determining with whom ADHB wished to work with and although funding was for ADHB based on an annual appropriation it was important to develop the longer relationships.</p>
9.2	Alliance Contracting Presentation
	<p>Denis Jury presented to the Committee on alliance contracting outlining how virtual alliances, separate from the principals, are developed performing to define KPIs with risk and benefit sharing within the alliance. Some of the benefits were the commitment, improved project performance, productivity and innovation, early involvement of all parties in preliminary design and set up and improved risk management with safety as a given.</p> <p>For a successful alliance, partner selection was important and examples where it could apply would be elective surgery and Whanau Ora. The nature of agreements was no excuse/no blame, open book with very overt risk management and reward arrangements through an integrated project team. This was set within a "target outrun cost" for that project and there were contributions to personal development and team development with output in key result areas.</p> <p>Denis Jury would bring back examples of application for health systems.</p>
	NEXT MEETING
	<p>The meeting closed at 4.28 pm</p> <p>The next scheduled meeting is for 2:00pm, Wednesday, 20 October 2010 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Epsom</p>
CONFIRMED	
CHAIR:	DATE:

ACTION POINTS

- **WEDNESDAY 15 SEPTEMBER 2010**

**Community and Public Health Advisory Committee
Action Points from the meeting on Wednesday 15 September 2010**

Item	Detail	Designated	Action
Carried forward	A paper on strategies for children to be provided	Denis Jury	Early 2011
6.1	Regional Service Plan to be circulated for comment on the broad concepts, not detail, before the submission on 30 September 2010.	Denis Jury	
9.2	Examples of alliance contracting in health to be advised.	Denis Jury	

PLANNING AND FUNDING PERFORMANCE

- 6.1 Planning and Funding Summary Report**
- 6.2 Planning and Funding Indicators List and Exception Report**

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Planning and Funding Functional Group

Summary Report

1. Lifting the Health of people in Auckland City

Planning

The Annual Plan has now been signed by the Minister of Health. The NDSA submitted the Regional Service Plan as a draft to the NHB on 30 September. The final plan will be submitted in February next year.

Mental Health - Secure Rehabilitation

A feasibility study to evaluate the potential for development and to provide an outline business case has been completed. The report indicates that a full business case is warranted so that a more detailed financial analysis can be undertaken. Opportunities for cost savings elsewhere to fund the new service can then be explored. We have now appointed a project consultant to begin work on the full business case. We anticipate that this will be completed in March 2011.

2. Performance Improvement

B4SC Programme

The response from the Ministry to ADHB's application for discretion to be applied with regard to the failure to reach target claw back was positive with a reduction in penalty from 20% to 8%. This will enable additional resource to be applied to supporting the transition of the programme to primary care. Discussions with PHOs regarding the transition continue and it is likely that an 'Alliance' contracting model will be utilised.

Primary Care Overview

Comprehensive oversight is required to ensure implementation of key actions for ADHB to achieve timely deliverables for primary care.

This includes implementation of Government's BSMC Primary Care Strategy in the form of the three business cases that apply to the Metro Auckland region; developing regional ways of working at governance, strategic, and operational levels; business-as-usual across the primary care portfolio; and ensuring congruence with ADHB's realignment into Health Service Groups (HSG's).

Two Associate Planning and Funding Managers for Primary Care commenced on 27 September 2010 and are already heavily involved in work streams that have emerged from the activity across regional and ADHB specific response to Governments BSMC Primary Care rollout and the ADHB primary care business-as-usual work plan.

Oral Health

Six level one diagnostic units and one level two treatment unit have been ordered and funded from the Child and Adolescent Oral Health Business Case (OHBC).

Two level one diagnostic mobile dental units have been commissioned and are currently being utilised for service provision by ARDS. The third level one vehicle was delivered on 30 August, and will be in commission once the dental stool has arrived from the supplier.

The Project Team has determined to further defer the level two treatment unit (currently due for delivery May 2011). As previously reported, there are difficulties securing an appropriate site for this large vehicle – which was to service the Orakei area. An option is to build an additional fixed clinic and cancel the ordered vehicle. Assessment of fixed building sites is underway, a number of issues need to be worked through – as such the best decision now is to defer the Orakei area until later in the programme.

Residential Care

New models of care are now being extended from community to residential care with discussions occurring in respect of quality improvement, benchmarking and the adoption of the Eden Alternative care philosophy

Palliative Care

The ADHB steering group has been successful in being shortlisted for a large scale research grant on behalf of the region focussing on the testing of several of the models proposed in the ADHB needs assessment. This is a significant piece of work which will frame the implementation phase of the project in a more robust way.

Despite the research taking the focus of activity, progress with Palliative care in primary care and the LCP projects continues

Eating Disorders

This supra-regional project and service development is gathering momentum. The residential treatment service which includes the day programme was scheduled to be fully open (although with four of the nine beds available) by 30th September, but the residential unit is not open due to recruiting difficulties with senior clinicians, whilst the day programme was announced as opening at short notice.

Discussions are being held with the NGO provider to support the earliest possible availability of the residential service.

3. Live Within Our Means

A verbal review of the funding position will be provided.

IMPROVEMENT ACTIVITIES

7.1 CPHAC DAP Projects Report



Auckland District Health Board

District Annual Plan *2010 - 2011*

22 June 2010

Priority and Developmental Work for 2010-11

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

High level strategy	Objective	Strategies to achieve objectives
1.1 Reduce inequities in health status	1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	1.1.1.1 Work with the successful primary care business cases and Maori providers within these arrangements to: <ul style="list-style-type: none"> – develop Integrated Family Health Centres/Whanau Ora Centres – develop specific activities that achieve Whanau Ora – develop indicator measures for Whanau Ora – develop a Whanau Ora approach for all services devolved
		1.1.1.2 Implement the year one activities part of the cross DHB:MAPO Whanau Ora framework for 2010 - 2015
		1.1.1.3 Provide leadership in the development of Maori health workforce development
	1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	1.1.2.1 Integrate the Healthy Village Action Zone actions within the appropriate primary care business cases
		1.1.2.2 Participate in determining indicator measures for Pacific health gain in the three regional primary care business cases
		1.1.2.3 Host two Auckland DHB Pacific community leadership meetings to communicate the Auckland DHB Pacific Summit recommendations and the proposed plan
		1.1.2.4 Implement the Pacific best practice guidelines and training at Auckland City Hospital in at least 4 identified clinical areas (orthopaedic outpatient, child diabetes, renal and cardiology services) where there is high Pacific use and high DNA rates
		1.1.2.5 Complete the Healthy Village Action Zone evaluation
	1.1.3 Increase access to services for culturally and linguistically diverse populations	1.1.3.1 Cultural competency training focussed on culturally and linguistically diverse populations for all staff working in primary and secondary health services, with 50% of clinical staff completing at least two of the four on-line modules
		1.1.3.2 Increase the uptake of the Primary Health Interpreting Pilot so that 100% of the non-English speaking population using general practices in Auckland city has access to an interpreter when using General Practice services
	1.1.4 Support disabled people and improve their access to health care and support services	1.1.4.1 20% more clients over 65 are accepted into the Interim Funding Pool
		1.1.4.2 Audit report completed on accessibility: specifically physical access, culture, employment and advocacy
		1.1.4.3 KPIs developed for reporting disability issues and incidents to DSAC along with follow-up actions; for both provider audit and for Ministry of Health spot audit system

High level strategy	Objective	Strategies to achieve objectives
1.2 Improve outcomes in priority areas		
1.2a Children and young people	1.2a.1 Achieve immunisation targets	1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including: 1.2a.1.2 Work with EOI (primary care) respondents on actions to improve immunisation rates to the 91% for Auckland DHB by ensuring that Immunisation Co-ordinator roles are maintained and their effectiveness maximised 1.2a.1.3 Work with other regional DHBs and our primary care partners to achieve a regional immunisation target of 90% of all 2 year olds fully immunised
	1.2a.2 Improve the oral health of children	1.2a.2.1 Increase school dental clinics to six by June 2011 1.2a.2.2 Four new mobile clinics in total established by June 2011 1.2a.2.3 Reduce inequalities in the use of school dental services: <ul style="list-style-type: none"> - improving access by taking services to pre-schools - enhancing oral health education - increasing early enrolment with a focus on Maori and Pacific populations
1.2b Older people	1.2b.1 Home-based support services and restorative homecare initiatives	1.2b.1.1 Introduce the funding methodology for home-based services by July 2010 1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services
	1.2b.2 Quality improvement in residential care	1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations 1.2b.2.2 25% reduction in overall number of complaints from residential care
1.2c Mental health and addictions	1.2c.1 Increase effectiveness across primary, secondary, tertiary services	1.2c.1.1 Continued development of the secondary to primary care shift to achieve target of 90% of mental health clients (achieved through extension of ProGRESS+) 1.2c.1.2 Expand primary mental health; implementation of online therapies, appointment of primary care employment support worker, appointment of CSW in primary care to provide psycho-education and psycho-social interventions; and service navigators/coordinators to manage movement through the system 1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures 1.2c.1.4 Complete the reconfiguration of levels 3 and 4 residential rehabilitation; i.e. to contract for support hours that provide flexibility for consumers to get the level of service required, including residential support where needed 1.2c.1.5 Review and reconfigure the continuum of mental health services to focus on recovery and social inclusion using best practice and evidence based approaches
1.2d Long term conditions	1.2d.1 Strengthen community participation and action	1.2d.1.1 Ensure community participation at a locality level to input into the changes occurring in primary health care as part of the metro Auckland approach to long term conditions

High level strategy	Objective	Strategies to achieve objectives
	1.2d.2 Integration of services across primary and secondary care	1.2d.2.1 Work with our primary care partners to develop care pathways across primary-secondary care for at least two common long term conditions (including diabetes) 1.2d.2.2 Increase the number of GPs using electronic referral systems to at least 10%
	1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	1.2d.3.1 Meet existing target re number of the eligible adult population having their CVD risk assessed 1.2d.3.2 At least 2 cardiac rehabilitation courses are run in the community 1.2d.3.3 At least 10% of retinal screening to be undertaken in the community
	1.2d.4 Support whanau and self resilience	1.2d.4.1 Pilot coaching services to support people with long term conditions in line with evidence base 1.2d.4.2 Work with our primary care partners to improve outcomes for Maori, Pacific people and other high need groups through a range of strategies that involve families and communities
1.2e Palliative care	1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	1.2e.1.1 Service redesign for palliative care agreed, and which aligns the specialist and generalist workforce 1.2e.1.2 Liverpool Care Pathway trial is evaluated with phase 2 undertaken according to the outcome 1.2e.1.3 Review of equipment services so that equipment provision becomes aligned and streamlined by June 2011 1.2e.1.4 ProCare palliative care pilot rolled out and evaluated with 2 other PHOs beginning the programme

More detail on some of these performance measures is included on page 36

Goal 2: Performance improvement: sooner, better, more convenient

High level strategy	Objective	Strategies to achieve objectives
2.1 Efficient and effective health care system		
2.1a Primary health care	2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	2.1a.1.1 Develop a comprehensive metro Auckland primary care plan in collaboration with DHBs and primary care
2.1b Improve primary–secondary system efficiency	2.1b.1 Improve access and efficiency of service delivery	2.1b.1.1 Implement regional e-referrals, health event summaries and electronic outpatient letters
		2.1b.1.2 Increase access to diagnostic radiology for primary care by providing community assessment for up to 4,500 procedures and improving access for 16,000 patients
		2.1b.1.3 Shift minor surgery activity into the community, increasing more convenient primary care based treatments for skin cancer across the metro region from 513 to 1200 per year
		2.1b.1.4 Implement a formalised network across Auckland, proving local access to urgent care that will be integrated with general practice services
		2.1b.1.5 Improve access to primary care for palliative care clients by 15%
		2.1b.1.6 Implement a clinically led “proof of concept” process to more effectively manage the community pharmaceutical budget by facilitating appropriate prescribing and safe use of medicines. Target savings of \$1.5m
	2.1b.2 Reduce acute demand	2.1b.2.1 Increase by 50% across the metro Auckland region the number of Primary Options for Acute Care (POAC) referrals (target of 12,500 patients managed in a community setting)
2.1c Improve quality of hospital care while improving productivity	2.1c.1 Improve service throughput and productivity	2.1c.1.1 Improve cardiac surgery throughput from an average of 17 to 20 bypass procedures per week. Complete implementation of the 10 project work streams (including formalising the private / public relationship and incentive schemes)
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.1.2 Eliminate unnecessary follow ups to reduce follow up rate by 10%
		2.1c.1.3 Improve performance against the Emergency Department six-hour measure from 76% to 95% by implementing project solutions in the adult and children’s acute flow projects
		2.1c.1.4 Improve adult operating room productivity by 6% by implementing the productive operating theatre programme/lean improvement programmes (UK NHS Productive Operating Theatre Programme)*
		2.1c.1.5 Improve ward productivity by 3% by increasing the number of wards in Adults and Mental Health services using Releasing Time to Care from 6 to 24

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery 2.1c.1.7 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding 2 operating rooms providing capacity for increasing volumes; construction planned to commence early 2011 2.1c.1.8 Improve the patient experience while improving productivity by implementing service improvement projects in: <ul style="list-style-type: none"> - General medicine - Orthopaedics - Radiology - Paediatrics general surgery - General surgery - Ophthalmology
	2.1c.2 Improve mainstream effectiveness	2.1c.2.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches 2.1c.2.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori 2.1c.2.3 Over the long term reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rate from 9.6% to 9% in 2010-11) 2.1c.2.4 60% of discharge letters to Pacific people include another primary health care provider
	2.1c.3 Improve relapse prevention planning in mental health	2.1c.3.1 Greater than 95 percent of long term mental health clients have up-to-date relapse plans by July 2011
	2.1c.4 Hospitalised smokers given assistance to stop smoking	2.1c.4.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2011 2.1c.4.2 450 pregnant women enrolled into smoking cessation programme per annum
	2.1c.5 Reduce waiting times for oncology	2.1c.5.1 Radiation therapy will commence within four weeks from FSA, by December 2010 2.1c.5.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology 2.1c.5.3 Implement lung and bowel tumour stream models by June 2011
	2.1c.6 Increase elective surgical discharges to 10,227	2.1c.6.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway <ul style="list-style-type: none"> - Implement new model of care and workforce roles in the Greenlane Surgical Centre - Maintain past elective surgery improvement by including primary care in the

High level strategy	Objective	Strategies to achieve objectives
		referral pathways and patient management – Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
2.2 Improve leadership capability	2.2.1 Strengthen Clinical Leadership model	2.2.1.1 Refine, implement and monitor integrated governance model 2.2.1.2 Monitor and report against “In Good Hands” implementation
	2.2.2 Improve Senior Leadership Team Performance	2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement 2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care
2.3 Improve Clinical Quality and Professional Governance	2.3.1 Implement regional clinical networks	2.3.1.1 Provide leadership in cancer and cardiac clinical networks 2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care
	2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management 2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas 2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process 2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s 2.3.2.5 Implement Senior Leadership Team ‘Walk-around’ safety programme i.e. growth and training in clinical leadership 2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement 2.3.2.7 Evaluation against Health Excellence Framework 2.3.2.8 Continue roll out of Cornerstone accreditation across primary care 2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System
	2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity

High level strategy	Objective	Strategies to achieve objectives
2.4 Strengthen the health workforce	2.4.1 Ensure workforce capability is matched to service delivery current and future	2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces 2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme 2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015) 2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme 2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%
2.5 Information management	2.5.1 Improve the resilience and availability of core IT systems	2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time 2.5.1.2 KPI reporting for end-to-end application performance in place 2.5.1.3 IMTS user satisfaction increases by >10% against previous year 2.5.1.4 Number of unplanned system outages reduced from >20 to <5 per month 2.5.1.5 Tier 1 system availability increases to >99.95%
	2.5.2 Improve corporate records and knowledge management	2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance 2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)
	2.5.3 Improve data quality	2.5.3.1 Ministry of Health data quality targets met
2.6 Planning 2.6 Planning (cont)	2.6.1 Long term planning and change management	2.6.1.1 Undertake any Strategic Planning work as advised to meet Ministry of Health requirements and deadlines 2.6.1.2 Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030: <ul style="list-style-type: none"> – description of future models of care across the continuum of care – plan the shape, size, setting, and location for future services and inter district flow patients – provide the strategic context for major future developments and business cases – develop workforce response to current and long term service plans via regional and the national workforce planning – increase the focus on regional planning and collaboration with the regional primary care business cases 2.6.1.3 Any potential service, funding or planning changes arising from the implementation of the National Health Board and the NZHD Amendment Bill are identified and responded to

* Refer to appendix 8

Goal 3: Live within our means

High level strategy	Objective	Strategies to achieve objectives
3.1 Break-even position maintained		
3.1a Manage revenue	3.1a.1 Ensure revenue received for services provided	3.1a.1.1 Reconfigure renal services in response to Waitemata DHB repatriation and manage any associated risks 3.1a.1.2 Manage funding and other changes arising from the National Health Board and other Ministerial Review Group recommendations 3.1a.1.3 Participate in the national pricing process, particularly risk arising for 2011–12 paediatrics tertiary adjuster 3.1a.1.4 The impacts of any service reconfigurations are managed within Vote Health parameters
3.1b Cost management	3.1b.1 Improve processes	3.1b.1.3 Align systems (national and regional) where shared services across the region or the country results in greater administration efficiency
	3.1b.2 Manage labour resources	3.1b.2.1 Manage the FTE cap for management and administration staff 3.1b.2.2 Improve HR payroll processing and leave management 3.1b.2.3 Manage industrial relations (MECA) and assess draft proposals against outcomes and against financial and sustainability risks
	3.1b.3 Enhance asset and supply chain management	3.1b.3.1 Asset Management Plan alignment with the Long Term Services Plan 3.1b.3.2 Leverage national /regional procurement initiatives 3.1b.3.3 Progress procurement strategy (national and regional) and supply chain processes
3.2 Sustainable balance sheet		
3.2a Manage cash	3.2a.1 Sustainable cash management	3.2a.1.2 Cash/Financing Plan aligns with Asset Management and Long Term Services Plans

Group Pack Report

Group/Committee: Community and Public Health Advisory Committees



Goal Level Summary

DAP Projects - total projects: 26

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan			Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	19	19	7	2	2	5	2	0	15	3	0	18	0	0	18	0	0	1	0	1	0
2 Performance improvement	7	6	0	1	1	4	0	0	5	2	0	7	0	0	3	4	0	0	0	0	0
3 Live within our means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	26	25	7	3	3	9	2	0	20	5	0	25	0	0	21	4	0	1	0	1	0
Total %	100%	96%	27%	12%	12%	35%	8%	0%	77%	19%	0%	96%	0%	0%	81%	15%	0%	4%	0%	4%	0%

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

High Level Summary - total projects: 19

	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan		Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red	
			Define	Measure																	Analys
High Level Strategy																					
1.1 Reduce inequalities in health status	7	7	6	0	0	1	0	0	7	0	0	7	0	0	7	0	0	0	0	0	0
1.2a Improve outcomes for children and young people	2	2	0	1	0	0	1	0	1	1	0	2	0	0	2	0	0	0	0	0	0
1.2b Improve outcomes for older people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2c Improve outcomes for mental health and addictions	3	3	0	0	0	2	0	0	2	0	0	2	0	0	2	0	0	1	0	1	0
1.2d Improve outcomes for long term conditions	5	5	1	1	1	2	0	0	3	2	0	5	0	0	5	0	0	0	0	0	0
1.2e Improve outcomes for Palliative care	2	2	0	0	1	0	1	0	2	0	0	2	0	0	2	0	0	0	0	0	0
Total #	19	19	7	2	2	5	2	0	15	3	0	18	0	0	18	0	0	1	0	1	0
Total %	100%	100%	37%	11%	11%	26%	11%	0%	79%	16%	0%	95%	0%	0%	95%	0%	0%	5%	0%	5%	0%

Objectives







Objective	Objective Owner	Comment
1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	Aroha Haggie (ADHB)	projects under this objective are progressing as expected.
1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	Hilda Faasalele (ADHB)	All work is progressing on track. Some concerns to note regarding the pending shift of HVAZ Pacific PHO's contracts to Alliance Health+, then be managed by CMDHB. This will have a major impact on further delivery of services within HVAZ, and all the work that has been progressed up until now.
1.1.3 Increase access to services for culturally and linguistically diverse populations	Denis Jury (ADHB)	Small increases in the uptake of the interpreter service in primary care continued, but now with a project manager focussed specifically in this area we should see increased utilisation. There has been good uptake of the online refugee / new migrant cultural training packages by both ADHB primary and secondary care.
1.1.4 Support disabled people and improve their access to health care and support services	Denis Jury (ADHB)	Overall good progress with all projects. Initial Disability Responsive report received strong support from DiSAC and final report on time for delivery by the end of Oct. MoH has advised that the Interim Funding Pool will not be devolved this calendar year but discussions continuing with the national Funding GMs regarding the issues raised by the Northern Region about the disproportionate impact of the risk across the country.
1.2a.1 Achieve immunisation targets	Denis Jury (ADHB)	Immunisation rate currently 87% for ADHB population; close attention to improving the current Maori rates -a working group lead by HKO has been established to address this. A data quality initiative will be implemented during Oct and should result in an increase in reported intervention rates.
1.2a.2 Improve the oral health of children	Denis Jury (ADHB)	Progressing according to plan. Fixed site clinics are currently costing ahead of budget due to price increases from the time of the

		original plan two years ago and some unforeseen site difficulties. This is understood by the MoH, and susqent clinics will be reconfigured so as to meet the original buget.
1.2b.1 Home-based support services and restorative homecare initiatives	Denis Jury (ADHB)	Casemix / packages of care pilot on track to be implemented early Nov.
1.2b.2 Quality improvement in residential care	Denis Jury (ADHB)	Satisfactory progress; early stages of EDEN approach in residential care to be developed during Oct.
1.2c.1 Increase effectiveness across primary, secondary, tertiary services for mental health and addictions	Denis Jury (ADHB)	All projects progressing satisfactorially.
1.2d.1 Strengthen community participation and action for long term conditions	Denis Jury (ADHB)	Work has continued on the devlopment of ADHB's locality approach for the delivery of primary care following approval of the proposed process at the Sept CPHAC.
1.2d.2 Integration of services across primary and secondary care for long term conditions	Andrew Coe (ADHB)	Progressing according to plan. Pleasing to note that the ADHB TeleHealth project was the winner of the Telecommunications Industry Innovation Awards for 2010.
1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	Andrew Coe (ADHB)	Overall good progress; draft process for community retinal screening programme completed and diabetes and ophthalmology services
1.2d.4 Support whanau and self resilience for long term conditions	Aroha Haggie (ADHB)	Development of self management as expected; development of the tool kit has continued while responses from potential providers are expected in mid-Oct.
1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	Andrew Coe (ADHB)	Progressing to plan with current work underway to extend the Liverpool Care Pathway programme to additional private hospitals.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Develop Care Pathways for people with Long Term Conditions	National	Define				Good to hear about other discussions on alternate mechanisms for improving information sharing and role integration . Well done to team on their award for innovation in health.
Increase access and capacity to community diabetic eye screening	National	Analyse				A detailed implementatio plan will give us more surety of progress.
Health Targets	Regional	Measure				Original group to reform.

Legend: Red - , Orange - , Green -

Skin Lesions	Regional	Improve				Project has had a major set back, with the EOI process run to identify suitable Primary Care providers having to be withdrawn due to a process issue. Project is now behind schedule. GAIHN ALT has suggested that ADHB divert away from the regional project and look to fund Primary Care direct for this via the ProXtra tool. A recent Clinica Advisor Group has considered this request and recomendadted that ADHB stick with the regional project as originally described.
Pharmaceuticals	Regional	Measure				Project is now underway although behind schedule, unlikey to meet original targets.

Legend: Red - , Orange - , Green - 

**FEEDBACK FROM
MAORI HEALTH
ADVISORY COMMITTEE
AND
PACIFIC HEALTH
ADVISORY COMMITTEE**

PAPERS

- 9.1 Healthy Eating Healthy Action Plan**
- 9.2 Birthcare Contract – Extended Length of Stay Funding**
- 9.3 GAIHN Implementation Plan**
- 9.4 Pathways to Health Careers Update**

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Community and Public Health Advisory Committee Paper

Date	Wednesday 20 October 2010																											
To	Community and Public Health Advisory																											
From	Denis Jury Chief Planning and Funding Officer Email: denisj@adhb.govt.nz																											
Author	Kate Sladden Healthy Eating Healthy Action Manager Planning and Funding																											
Functional Group	Planning and Funding																											
Subject	Healthy Eating Healthy Action Plan																											
1	<p>Purpose This paper is to gain CPHAC endorsement for the strategies and actions in the Healthy Eating Healthy Action (HEHA) Plan for 2010-2011 that will be implemented to increase breastfeeding rates, improve nutrition and increase physical activity levels in the ADHB population.</p> <p>ADHB receives \$925,000 annually through a CFA to implement a HEHA Plan. Funding is allocated, via the CFA, to the following areas: Maori community action projects (\$157,000); Pacific community action projects (\$366,000); breastfeeding (\$180,825); provision of information (\$79,092); and coordination (\$142,460). This CFA expires on the 30 June 2012.</p>																											
2	<p>Recommendations</p> <table border="1"> <thead> <tr> <th></th> <th>DAP</th> <th>DSP</th> <th>Budget</th> </tr> </thead> <tbody> <tr> <td>Breastfeeding action</td> <td>✓</td> <td></td> <td></td> </tr> <tr> <td>Maori community action</td> <td>✓</td> <td></td> <td></td> </tr> <tr> <td>Pacific community action</td> <td>✓</td> <td></td> <td></td> </tr> <tr> <td>Provision of information</td> <td>✓</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>					DAP	DSP	Budget	Breastfeeding action	✓			Maori community action	✓			Pacific community action	✓			Provision of information	✓						
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Breastfeeding action	✓																											
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Provision of information	✓																											
3	<p>Description of Solution (Option) Underpinning the approach to implementing HEHA programmes within ADHB is a focus on building capacity and capability within key settings in localities in order to generate local action and provide channels of influence as well as support local skill development. A key strategy is providing appropriate and accessible training and mentoring of community representatives and health personnel, and ensuring availability of practical tools and resources.</p>																											
4	<p>Background In New Zealand, two out of every five deaths (40% of all deaths or 37% of years of life lost) are attributed to the joint effects of nutrition related risk factors and sub-optimal physical activity levels. Excess body weight is an important risk factor for a number of serious conditions including type 2 diabetes, cardiovascular disease and certain cancers. The prevalence of overweight and obesity in the ADHB population is 34.9% and 21.3% respectively.</p> <p>The ADHB population is also the least active population in New Zealand. The 2006/07 Health Survey revealed that less than half (40.3%) of the ADHB population is getting sufficient physical activity (30 minutes a day on five or more days a week), which is significantly below the national average of 50.5%. Furthermore, the ADHB population has a significantly higher prevalence of sedentary behaviour (less than 30 minutes of physical activity per week) than the national</p>																											

average with 18.6% classified as sedentary compared to 14% nationally.

Maori, Pacific and South Asian populations living in the ADHB bear a disproportionate burden of the health impacts from poor nutrition and sedentary lifestyles. This is highlighted in obesity prevalence data which show that 23.2% of Maori and 46.5% of Pacific people are obese compared to 16.9% of Europeans. The prevalence of obesity in the South Asian population nationally is 55%.

Breastfeeding

Breastfeeding contributes significantly to infant, maternal and whanau health in both the short and long term. In the short term, breastfeeding reduces the risk of infectious diseases such as gastroenteritis and respiratory infections, reduces the risk of SIDS, and lowers the risk of hospitalisation in the first year of life. The long term benefits include reduction in the risk of chronic disease such as obesity, type 2 diabetes and cardiovascular disease. Breastfeeding benefits for the mother include a reduction in the risk of post partum haemorrhage, and breast and ovarian cancers.

Maori, Pacific and Asian women in ADHB have low breastfeeding rates that are appreciably below the health targets set by the Ministry of Health. Full/exclusive breastfeeding rates at six weeks are 62% for Maori, 52% for Pacific and 58% for Asian women compared to 75% for 'others'; the health target is 74% or greater.

5

Strategies

Outlined below are the strategies and key activities for the HEHA implementation areas.

Breastfeeding

The breastfeeding actions focus on increasing access to breastfeeding expertise in communities, building capacity of providers to deliver consistent breastfeeding messages and ensuring health practitioners are aware of available breastfeeding support services in their localities. Major areas of work for 2010/11 are as follows:

- delivering the Community Breastfeeding Service (CBS), which employs Maori, Pacific and Asian breastfeeding support workers who provide breastfeeding advice and follow up to mothers and their families; 800 mothers registered with the service in 2009/10
- developing a model and supporting a cluster of providers in a locality to work towards Baby Friendly Community Initiative (BFCI) accreditation
- training and mentoring breastfeeding peer counsellors and supporting locality based breastfeeding peer support groups
- evaluating and updating the Breastfeeding Service Directory for the ADHB catchment area.

Maori Community Action

A HEHA Kaimahi Forum has been established and will continue to oversee a project grant process for distributing the funding (this is a requirement of the CFA). This process supports Maori communities to identify their priorities and the solutions for supporting breastfeeding, improving nutrition and increasing physical activity. There is a focus on locality and setting based projects and enhancing community and health initiatives. Ten projects were funded in 2009/10 in settings including Marae, Kohanga Reo and sports clubs; a similar process will be used in 2010/11.

Pacific Community Action

The HVAZ framework will continue to provide the structure and entry point for HEHA activity in Pacific communities. During 2009/10 a range of training initiatives were funded for church representatives including nutrition, Community Coach, First Aid and 'Zumba' instructor courses. This year the church Community Coaches will receive ongoing support to deliver weekly activity sessions through a newly established mentoring programme as well as additional training for new activity programmes. The church 'Nutrition Champions' will receive mentoring from the HVAZ Nutritionist with a focus on supporting churches to implement nutrition guidelines and thus influence food provision at church events. Youth HEHA programmes will be implemented in three localities utilising the successful model used for Zumba sessions in Otahuhu during 2009/10.

	<p>Provision of information</p> <p>A key area of work will be supporting implementation of the Clinical Guidelines for Weight Management through identifying opportunities and undertaking actions to enable primary care to better support overweight and obese patients. Resources to support this work include 'Food Habits' (electronically tailored nutrition messages) for use in general practice and development of a Practice Nurse Nutrition Guide for obesity and long term conditions. These enhancements will also be linked into the Green Prescription Programme.</p>
6	<p>Issues and Risks for Chosen Option</p> <p>There are minimal risks with implementing this HEHA Plan. However an issue is the difficulty in determining efficacy of the programmes being implemented. To this end there will be carefully monitoring of programme outputs that can be plausibly linked to desired outcomes. It is important to acknowledge that some of the outcomes can only be measured in 10 or 20 years from now. However, it is as important to have interim indicators that show the strategies are enabling gains to influence the longer term goal, such as breastfeeding and reduced obesity.</p>
7	<p>Budget Implications</p> <p>Implementation of this HEHA Plan uses CFA funding. An additional \$120,000 of DHB funding is allocated to the Community Breastfeeding Service. This amount was approved after a robust prioritisation process in 2008.</p>
8	<p>Regional / National Implications</p> <p>This HEHA Plan is aligned with national and regional strategies.</p>
9	<p>Appendices available on request</p>

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Community and Public Health Advisory Committee Paper

Date	Wednesday 20 October 2010																												
To	Community and Public Health Advisory Committee																												
From	Denis Jury Chief Planning Officer Email: denisj@adhb.govt.nz																												
Author	Ajit Arulambalam, Planning and Funding Manager																												
Functional Group	Planning and Funding																												
Subject	Birthcare Contract – Extended Length of Stay funding																												
1	<p>Purpose</p> <p>This paper is for information and endorsement of the continued implementation of the extended length of post natal stay for mothers in line with Ministerial expectations.</p> <p>In May 2009, when this initiative was announced by the Minister of Health, it was funded for implementation by DHBs over three and a half years, beginning January 2010 and ending June 2013.</p> <p>Note:</p> <p>ADHB implemented this initiative from 1 July 2009 being six months ahead of funding (due to agreement of the providers to absorb any additional cost).</p> <p>That total funding of \$1,029,000 will be allocated to the extended length of stay for post natal mothers for each of the next three years.</p> <p>The above funding will be split proportionately between Birthcare Auckland Limited (BAL) and National Women's Health (NWH) on a 74:26 ratio as agreed by the two providers and subject to annual review.</p> <p>That this funding will be fixed, and the providers bulk-funded with agreement to manage both volume and fiscal risk.</p> <p>The funding of this additional post natal length of stay initiative will end on 30 June 2013</p> <p>That BAL has already being bulk-funded \$197,428.85 for the first quarter (July to September 2010).</p> <p>Endorse:</p> <p>A formal contract for service to be entered into with BAL.</p> <p>Approval being sought from ADHB Board Finance Committee</p>																												
2	<p>Recommendations</p> <table border="1"> <thead> <tr> <th></th> <th>DAP</th> <th>DSP</th> <th>Budget</th> <th>Regional DAP</th> </tr> </thead> <tbody> <tr> <td>Implement full funding of Government's Extended Post Natal LOS</td> <td>√</td> <td></td> <td>√</td> <td>√</td> </tr> <tr> <td>Total annual value of funding for this Government initiative: 2010/11: \$1,029,952; 2011/12: \$1,029,952; & 2012/13: \$1,029,952.</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Enter into formal contract with Birthcare Auckland Limited</td> <td>√</td> <td></td> <td>√</td> <td>√</td> </tr> <tr> <td>Total annual value of contract with BAL: 2010/11: \$564,743.07; 2011/12: \$762,171.84; & 2012/13: \$762,171.84.</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>					DAP	DSP	Budget	Regional DAP	Implement full funding of Government's Extended Post Natal LOS	√		√	√	Total annual value of funding for this Government initiative: 2010/11: \$1,029,952; 2011/12: \$1,029,952; & 2012/13: \$1,029,952.					Enter into formal contract with Birthcare Auckland Limited	√		√	√	Total annual value of contract with BAL: 2010/11: \$564,743.07; 2011/12: \$762,171.84; & 2012/13: \$762,171.84.				
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3

Overview

For the first year of this initiative, ADHB like other DHBs received six months funding (i.e. \$ 515k for 09/10); the expectation being that the initiative will be implemented only in the second half of the year.

For the second year (2010/11), ADHB's Funding Envelope contained the first year's half year funding as part of the base funding. The MOH view was that the additional funding for this initiative was to come from within the broader year-on-year increase in funding that DHBs received.

The Minister of Health has communicated directly with stakeholders that Government's expectation is that DHBs will 'fully fund' this initiative in each of the remaining three years from with their Funding Envelope budgets.

Background

In May 2009, Government announced a set of initiatives that it expected all DHBs to implement.

Within this, four years of additional funding was indicated for extending postnatal length of stays in primary maternity facilities for mothers who their Lead Maternity Carer determines as meeting certain non/clinical criteria, such as lack of confidence with breast feeding. In that announcement, the Minister of Health outlined that:

For 09/10, half a year's funding was allocated, which for ADHB amounted to \$515,718.

For 10/11, 11/12, & 12/13, new monies to be provided for a full year's funding in each of the next three years (i.e. for ADHB approximately \$1,029,952 pa).

Given the above expectation and feedback from a number of maternity clinicians and local service managers on the build up of patient demand (& need from a Lead Maternity Carer's perspective), Planning & Funding decided to work to implement the above extra post-natal care initiative as soon as possible in 09/10. Thus, working in collaboration with both National Women's Hospital & Birthcare Auckland Limited (the two maternity providers in the district), we secured formal agreement to provide additional post-natal care for women who have been identified by their Lead Maternity Carer as meeting the criteria— on the understanding that in future years, full year's funding will be passed onto the providers.

The key deliverable that was agreed with both National Women's Hospital and Birthcare Auckland Limited was to monitor an increased length of stay for these women. After the first three months (July to September 09), a review of both providers was undertaken. This showed that Lead Maternity Carers at Birthcare Auckland Limited were identifying approximately 27% of birthing mothers as requiring extended post natal length of stay (this compares to 15% expected from a national survey).

The results also showed that National Women's Hospital was incorporating a high proportion of caesarean section mothers as requiring extended lengths of stay; however these women would already have been getting extra lengths of stay for post-operative recovery. To some extent, this is because National Women's Hospital operates a secondary & tertiary maternity service. As a result, agreement was reached with both Birthcare Auckland and National Women's that:

The remaining residual funding (i.e. after paying on invoice for the first two months) would be bulk funded to both providers on an agreed proportionate basis (rather than the earlier method of submitting an invoice and volume report)

Both providers would continue to provide additional post natal stays as needed and identified by their patients' respective Lead Maternity Carers - and each provider will internally manage any fiscal risk of high(er) volumes

The remaining residual budget will be shared on a 76:24 proportionate basis (BAL:NWH) – this proportion was based on an analysis of the rate of increase in LOS over the period of the initiative, when compared to previous years (without the initiative).

A letter of agreement (LOA) will formalise the above arrangement.

The overall situation in relation to funding is as follows:

	09/10	10/11
Identified New funding, in FE additional to PBF	\$515K	\$0
Funding assumed in PBF	\$0	\$515k
Minister's expectation of FE increase available (i.e. top up funding) Budget 09	\$0	\$514k
Total Funding	\$515k	\$1,029k

This was the same message recently conveyed by the Minister to the Maternity Services Consumer Council in a letter dated 21 June 2010; that sufficient funding to meet the above expectation has been incorporated into DHB funding for the second year.

For 2010/11

From a funding perspective, the prevailing arrangements for the provision of the extended post natal stay service need to be continued because this will meet Government policy expectations as well as a health need in the community.

In doing so, it is proposed that the proportionate 'share' of the funding between the two providers remains as previously agreed; i.e. NWH: BAL – 24:76 (until such a time as more detailed volume data from both providers indicate that a shift is necessary). At the same time, funding is constrained, and therefore the providers will need to agree that the additional post natal stay will be provided to all eligible women and the fiscal risk will be managed internally.

A more formal contractual approach is proposed; in that, it will formalise the service requirements as well as ensure that for the next three years, funding is allocated subject to ADHB/P&F prioritisation processes. Accordingly, it is considered appropriate that a contract be entered into with BAL for a period of 3 years.

This contract will have a total value of \$2,089,086.75 over the next three years.

4

Options Considered

1. Do Nothing Additional

There is the option of not doing anything additional to the exiting service arrangement. In this scenario, ADHB is already funding the post natal LOS initiative to \$515k per annum. The risk is two-fold: (1) that providers such as BAL continue to have the expectation of the full implementation of the initiative; & (2) ADHB will not be consistent in applying national health care initiatives and as a consequence not meet population health need.

2. Support The Extended Post Natal Los Initiative

Fully implementing the above initiative calls for additional funding amounting to \$515k per year for each of the next three years. The annual total spend will therefore amount to \$1,029k per year for the next 3 years.

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Community and Public Health Advisory Committee

Paper

Date	Wednesday 20 October 2010
To	Community and Public Health Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre, 214 Greenlane West, Epsom Phone: 09 630 9943 Email: denisj@adhb.govt.nz
Author	Denis Jury, Chief Planning and Funding Officer
Functional Group	Planning and Funding Functional Group
Subject	GAIHN Implementation Plan
1	<p>Recommendations</p> <p>That CPHAC recommends to the Board;</p> <p>i/ That GAIHN's Implementation Plan should be endorsed and;</p> <p>ii/ Approve payment of establishment funding to GAIHN of 61c per enrolled ADHB patient for the 2010 / 11 financial year.</p>
2	<p>Executive Summary</p> <p>ADHB is a partner in the Greater Auckland Integrated Health Network (GAIHN). GAIHN's Implementation Plan for 2010/11 has been completed and GAIHN is asking all its partner organisations to endorse the document prior to its being submitted to the Ministry of Health (MoH). Acceptance of the Implementation Plan by the MOH is important because it allows GAIHN to access the benefits of being a Better, Sooner, More Convenient (BSMC) business case.</p> <p>The Implementation Plan contains three major areas of commitment. The first is the 2010/11 District Annual Plan (DAP) Projects that have previously been supported by the Board. There are no significant changes. The second commitment is to undertake planning in the areas of long term conditions, acute demand management, reducing inequalities, and community nursing integration with a view to providing advice to the 2011/12 DAPs. These are areas of significant importance to ADHB. The third deals with the establishment of the important governance and operation groups of GAIHN.</p> <p>ADHB's financial commitment to this Implementation Plan is for the 2010/11 DAP projects and for the funding of the GAIHN infrastructure. They are in line with previous indications.</p> <p>We ask CPHAC to recommend to the Board that GAIHN's Implementation Plan should be endorsed.</p>
3	<p>Introduction/Background</p> <p>The Greater Auckland Integrated Health Network (GAIHN) is a collective of the three Auckland DHBs and ten PHOs which provide services to 1.25 million enrolled patients. ADHB has previously been involved in the development of its business case and endorsed that document's submission to the Ministry of Health (with some caveats). ADHB supports GAIHN as an important regional vehicle for realising both ADHB's and the region's primary care aspirations.</p> <p>An Implementation Plan for GAIHN is required by the MOH prior to the GAIHN business</p>

	<p>case being given the 'green light'. Once this occurs GAIHN will be able to apply for MoH Better, Sooner, More Convenient (BSMC) funding and projects. The Implementation Plan has been delayed in its development because of the need to resolve internal issues within GAIHN. GAIHN has now requested all its partner organisations to endorse the attached Implementation Plan for 2010/11. ADHB has been involved throughout its development. Significant parts of the Implementation Plan have previously been agreed by ADHB and are currently being implemented.</p>
4	<p>Risks/Issues</p> <p>ADHB's commitment to GAIHN does entail it delegating budget and decision making to GAIHN's Alliance Leadership Team (ALT). However this delegation is always within a limited scope and this Implementation Plan scope is in line with previous agreements and what ADHB wishes to see achieved through GAIHN.</p> <p>A further risk of the Implementation Plan is that we are committing to achieving many of our important primary care objectives through GAIHN and therefore may, to some degree, limit our ability to achieving them in a more timely fashion through district action. However, in the longer term we believe regional action will be more effective.</p>
5	<p>Approach/Methodology/Analysis/Justification</p> <p>5.1 Implementation Plan</p> <p>The full Implementation Plan can be provided if required, but in summary the document includes;</p> <ul style="list-style-type: none"> • An executive summary • Part 1 is covers the GAIHN clinical initiatives for 2010/11 that are already reflected in our District Annual Plan (DAP). More detail is contained in the document's Appendix Part 1 • Part 2 covers GAIHN scope, establishment, structure, planning and resources. More detailed information is contained in the document's Appendix Part 2. <p>This paper draws CPHAC's attention to particular issues of importance.</p> <p>5.2 Scope of GAIHN in 2010/11</p> <p>The scope of GAIHN is important because under the Alliance partner organisations delegate their authority to GAIHN's Alliance Leadership Team (ALT) to make decisions on their behalf within that scope. The scope the Alliance is defined by Schedule 1 of the Alliance Agreement which is in the Appendix. The rest of the Implementation Plan provides more detail on what is in the scope. There are some areas in the Implementation Plan that are not included in scope. These are discussed in 5.6 of this paper.</p> <p>The scope of GAIHN is in three parts that are discussed below</p> <ul style="list-style-type: none"> • The 2010/11 DAP projects which have already been agreed • Development of strategic initiatives in key areas, initially for the 2011/12 DAP • Establishing GAIHN's infrastructure <p>None of these involve significant delegation of authority or budget that is unexpected.</p> <p>5.3 District Strategic Plan 2010/11</p> <p>The Implementation Plan confirms GAIHN's commitment to the regionally agreed primary care part of the DAP. The clinical projects remain unchanged although in some cases more detail has been added. The budgets and outputs are what have previously being agreed.</p> <p>5.4 Development for action in 2011/12 and Strategic Initiatives</p>

GAIHN is committing to planning strategic initiatives in four areas:

- Long term conditions
- Acute demand management
- Reducing inequalities
- Community nurse integration

ADHB management supports these being priority areas and their being addressed through GAIHN. The commitment given is to participate in the planning of initiatives. Once plans are developed they will be brought back to ALT and partner organisations for endorsement and consideration of funding. The plans will be developed by Clinical Alliance Teams which will be clinically led and supported by GAIHN. The intention is that plans will be developed in a timeframe that aligns with DHB 2011/12 DAP planning.

The scope also includes a commitment to undertake a stocktake of DHB provided primary care, community and public health services and develop a plan for devolution for agreed services to PHOs. It is unclear from the Implementation Plan how this will be undertaken.

5.5 GAIHN Infrastructure

The Implementation Plan outlines establishment of a number of important structures:

- Alliance Leadership Team (ALT) – this is the governance group of GAIHN and consists of a single representative from each DHB and PHO, two iwi partners, six clinicians from the Active Clinical Network, and an independent chair (being recruited presently). Denis Jury is ADHB’s current ALT member.
- Active Clinical Network (ACN) – this is a group of 20 clinicians drawn from primary and secondary care, and including doctors, nurses and allied health. It provides overall clinical leadership to GAIHN in a number of areas including oversight of the CATs. It was established in August. Detailed information on the ACN is included in the appendix of the Implementation Plan.
- Clinical Active Teams (CATs) – these teams will be established to lead development of the strategic initiatives. They will be clinically lead but will also include managers and other expertise. They will be resourced to have some dedicated personnel. Detailed information on CATs is included in the appendix of the Implementation Plan.
- GAIHN operations – an office will be established with a director, a part time clinical lead, and supporting staff.

GAIHN will become an Alliance. The Implementation Plan outlines some key documents related to establishing this alliance. These include the Alliance Charter which ALT members will sign and the Alliance Agreement. These documents have been developed by the MOH with some local adaption. The scope of the GAIHN will be set out in Schedule 1 of the Alliance Agreement.

5.5 Other areas covered in the Implementation Plan

There are several other topics that are in the Implementation Plan that are not included in the scope of GAIHN. In some cases they are only contained in the appendix.

- Developing GAIHN performance measures- the aim is to develop an outcomes framework that allows all stakeholders to assess whether GAIHN is making a difference to service users. This will be implemented by May 2011.
- Integrated planning – this acknowledges the importance of aligning with the DHB DAP and regional planning processes and also the other two Auckland primary care business cases. Detailed timelines are provided.
- Communications, IT, and training – the importance of these areas are discussed but there is no commitment to more than existing capability and apart from the need for GAIHN to have communications capability and a plan.

	<p>6.1 Strategic Context</p> <p>GAIHN's Implementation Plan aligns with the 2010/11 DAP as discussed. The Strategic Initiative work should also inform the 2011/12 DAP and regional service plan development.</p> <p>GAIHN will be the main mechanism for implementing the Better, Sooner, More Convenient policy and for implementing ADHB's Primary Care Plan within a locality context as previously approved by the Board.</p> <p>Of ADHB's four PHOs two will be partners in GAIHN, and one in each of Alliance Health+ and The National Maori PHO Coalition.</p> <p>6.2 Impact on reducing inequalities and Maori Health Gain.</p> <p>There is good evidence that much of the health system's impact on health inequalities is achieved through primary care. GAIHN will have the predominant influence on primary care's ability to impact on inequalities and Maori health. GAIHN has made a substantial commitment to reducing inequalities. This is yet to be realised but there is significant potential to do this through the strategic initiatives, particularly the reducing inequalities and long term conditions initiatives.</p>
7	<p>Costs/Resources/Funding</p> <p>There are two areas of cost commitment for ADHB</p> <ul style="list-style-type: none"> • The DAP projects which the board has already approved (\$745,833) for the 2010/11 year) <p>GAIHN infrastructure establishment. ADHB has already made a commitment of 25c per resident enrolled with GAIHN PHOs until December (\$117,894 plus GST). GAIHN is also requesting a further 23c per resident until the end of the financial year (\$108,462 plus</p> <ul style="list-style-type: none"> • GST). For the 2011/12 year GAIHN is estimating a total cost of 61c per resident. <p>The PHOs are matching these contributions.</p> <p>The Strategic Initiatives will develop plans which will have cost implications in the 2011/12 year for both DHBs and PHOs. However, these will be brought to the Board as part of the DAP planning process.</p>

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Community and Public Health Advisory Committee Paper

Date	Wednesday, 20 th October 2010
To	Community and Public Health Advisory Committee Maori Health Advisory Committee Pacific Health Advisory Committee
From	<p>Taima Campbell Executive Director Nursing Auckland District Health Board Ph: 09 3074922 ext 24795 Mob: 021442476 taimac@adhb.govt.nz</p> <p>Naida Glavish Chief Advisor Tikanga / General Manager Maori Health Ph: 09 6309943 ext 4963 Ph: 021722086 nglavish@adhb.govt.nz</p> <p>Hilda Fa'asalele General Manager Pacific Health Auckland District Health Board Ph: 09 630 9943 ext: 4907 Mob: 021 774252 hfaasalele@adhb.govt.nz</p>
Author	Henry Dowler Programme Director: Tāmaki Transformation: Pathways to Health Careers Programme, Ph: 027 344 6691, henry.dowler@hankstar.co.nz
Functional Group	Planning & Funding
Subject	Pathways to Health Careers Programme Progress Update
1 Purpose	The purpose of this paper is to provide Committee members with a progress update on the Tāmaki Transformation: Pathways to Health Careers Programme ('The Pathways Programme').
2 Recommendations	<p>It is recommended that CPHAC:</p> <ol style="list-style-type: none"> a. Receive the paper; b. Note that Māori and Pacific communities in Tāmaki and many partner organisations (government and non-government) continue to be actively involved and engaged in the ongoing development of the Programme and all have confirmed their support for the proposed approach; and c. Note the update information presented in this paper.

3	<p>Background</p> <p>In July 2010 the Committee noted a detailed overview of the Pathways Programme, including initial planning information relating to workstreams, risk management, financial implications and the short-term work programme. Since July, Māori and Pacific communities in Tāmaki and many partner organisations (government and non-government) have been actively involved and engaged in the ongoing development of the Programme. All have confirmed their strong support for the proposed approach.</p> <p>The Pathways Programme Strategic Plan has been substantially rewritten in light of feedback received and is almost ready for publication. Consequently, the document is more streamlined than previous versions to better inform and support community understanding of the overall direction and intentions behind the Programme. When published, the document will present clear and concise information about:</p> <ul style="list-style-type: none"> • the Programme ‘mission’ and goals and how the Programme contributes to the wider Tāmaki Transformation Programme; • what the Programme is expected to deliver and what participating in the Programme should feel like; • the investment needed to secure the benefits of the Programme; • principles developed to guide ongoing activities; and • how different people and organisations are expected to contribute to ensuring the success of the Programme. <p>Particular emphasis is given to:</p> <ul style="list-style-type: none"> • how the Programme will utilise and build on the strengths of the Tāmaki community; • the need to take a different approach if transformational change is to actually be achieved; and • the opportunity to build a health and disability workforce that understands how to provide innovative ‘<i>better, sooner and more convenient</i>’ healthcare for whānau/families in a way that aligns to the principles of Whānau Ora.
4	<p>General information</p> <p>The Pathways Programme will launch up to 900 low income Māori and Pacific along with some other qualifying residents from Tāmaki on a transformational journey towards obtaining a degree level qualification and successful health and disability career. The Programme will aim to have at least 300 participants degree qualified between 2014 and 2017 and working in a health and disability career.</p> <p>This will be an explicit opportunity to train participants in different models of care suitable to meeting future health needs of the local population. Models of care will reflect Whānau Ora service delivery systems which will lead to improvements in Whānau Ora outcomes. Core components of models of care could include Whānau Ora assessments, planning, integrated service delivery, coordination and management. Linked into this is the opportunity to engage with the development of Whānau Ora centres and integrated family health centres.</p>
5	<p>Funding proposal to Health Workforce New Zealand (HWNZ)</p> <p>To maintain the substantial momentum of the Programme and to enable full-scale implementation to commence as quickly as possible, a proposal was submitted to the September 2010 meeting of the HWNZ Board recommending that the HWNZ Board agree:</p>

- subject to a December 2010 report back on a detailed review of current estimates (including clarification of the availability of alternative Crown funding sources) and prior agreement on annual performance milestones, to provide initial funding for the Pathways Programme of up to \$7.66 million for the 2010/11, 2011/12 and 2012/13 financial years;
- subject to performance milestones being met for the previous three financial years, to provide further funding for the Pathways Programme of up to \$10.45 million for the next four financial years (2013/14 – 2016/17); and
- to review and confirm in December 2010 funding decisions in light of the outcomes of a detailed review of current estimates and clarification around the availability of alternative Crown funding sources for elements of the Pathways Programme.

It was also proposed that, concurrent with the review of current estimates, draft performance milestones for the three 'foundation years' will be developed in consultation with HWNZ officials for inclusion in the December 2010 report back for the HWNZ Board's consideration.

A formal response from the HWNZ Board remains to be received. We have, however, been advised informally that the HWNZ Board supported the proposal in principle and noted that there are other similar "pipeline" or "incubator" programmes in existence, though these lack the scope of our Programme.

Informal discussions with HWNZ representatives have also confirmed the need for the December 2010 report back to include some further information about alignment with developing innovative, new models of care, programme costs and potential economic benefits. Close work will be undertaken with HWNZ officials to ensure that the HWNZ Board receives the information it needs to confirm the funding needed for full-scale implementation of the Programme.

The HWNZ Board also noted that it is currently funding the evaluation of one of the Counties Manukau 'Health Could Be for You' (HCB4U) project and will consider the outcome of this evaluation when it becomes available. The final draft HCB4U evaluation report is available now. As the Programme design explicitly addresses all the areas for improvement identified in the draft evaluation report, there should be no reason for the HWNZ Board to withdraw its in principle support.

6 An early start

As noted above, full-scale implementation of the Programme will depend upon confirmation of a large-scale investment by the Crown. However, with financial and other support from the Ministry of Health, Auckland District Health Board and community partners, activities are continuing to enable an early start, before the end of 2010, with an initial cohort of at least 15 Tāmaki people.

Until the final, wider Crown investments have been confirmed, Auckland DHB will sustain the resources required to support this early start. The early start activities relate to matters such as:

- follow up telephone calls to around 90 potential participants who were identified in the course of the community engagement process and the development of a database to capture consistent information about potential participants;
- development, in partnership with educational institutions and social support partners, of a consistent participant and family/whānau needs assessment process;
- preparation of initial promotion and communications materials to support the initial targeted recruitment and engagement processes;
- development of templates and other resources to support the preparation of programme portfolios, plans and commitment processes; and

- considering approaches to induction and orientation activities to acknowledge and celebrate the commencement of the participants' journey.

Great care will be taken during the initial phases of the Programme to engage and involve the community in selecting participants and in providing them with purpose designed foundation training that could lead them into any part of the new health workforce along a continuum that matches their skills.

Communications will also be clear that this is not a risk free enterprise. Whilst there is low financial risk to participants, the programme will be required to meet clear milestones to maintain its funding support. A lack of educational progress and community commitment to the end goals will weaken the case for future support.

Participants will also be encouraged to give back to the Tāmaki community and will to serve as a catalyst for more expansive aspirations within the health and disability sector and the broader urban redevelopment strategy.

7 Appendices

Appendix 1 - Pathways to Health careers, frequently asked questions

10

CONFIRM

10.1 Action Points for next CPHAC Meeting

10.2 CPHAC Feedback to Board

Use Forms at beginning of Meeting Pack

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GENERAL BUSINESS

12

APPENDICES

12.1 FAQ – Pathways to Health Careers

Appendix 1 - PATHWAYS TO HEALTH CAREERS

Working together to prosper and thrive through health and disability careers

Frequently Asked Questions

1. What is *Pathways to Health Careers*?

Pathways to Health Careers is about supporting people living in Tāmaki on a pathway to a career in health. This includes support to study and achieve a health qualification so you can work in the health and disability area. The focus will mainly be on supporting Māori and Pacific and low income families/whanau.

Pathways to Health Careers is part of the *Tāmaki Transformation Programme* which is about working together to achieve great results for all people in Tāmaki.

2. What does *Pathways to Health Careers* want to achieve?

Between 2010 and 2017 *Pathways to Health Careers* will support up to 900 Tāmaki people into study and careers in the health and disability area.

Between 2014 to 2017, 300 Tāmaki people will have graduated with a health degree, for example a Bachelor in Nursing, and many more will have completed or be on a study pathway to gain other health qualifications.

3. Who will be able to join *Pathways to Health Careers*?

Pathways to Health Careers is for people who live in Tāmaki. The focus will mainly be on supporting Māori and Pacific and low income families/whanau. You could be a school leaver. You might be on a benefit. You could be unemployed. Or you may already have a job but want a new career with better prospects.

Wherever you are right now, *Pathways to Health Careers* is an opportunity for you to start a journey toward a rewarding health and disability career.

4. How will it work?

If you meet certain criteria, *Pathways to Health Careers* will support you and your whānau to achieve your study and career goals. This support means that nothing will prevent you from studying and graduating to the best of your ability and succeeding on your health and disability career pathway.

5. What kind of health and disability careers is *Pathways to Health Careers* aiming for?

Pathways to Health Careers wants to see people train in health and disability careers, in particular people that will serve the future needs of Māori and Pacific communities, especially the Tāmaki community.

You will be supported to make wise career choices for you, and to succeed in whatever health and disability career you choose.

You may choose nursing, midwifery or medicine.

You might want to be a podiatrist, a physiotherapist or a paramedic.

You might want to work in primary health, specialise for example in mental health, or want to work with people with disabilities.

6. Who in Tāmaki is being targeted by *Pathways to Health Careers*?

Pathways to Health Careers is primarily targeted at Māori or Pacific people who have lived in Tāmaki for at least 6 months and who are on a low income (eg, people who are eligible for a community services card). You must also be a New Zealand citizen or permanent resident.

7. What about people who live in Tāmaki but who are not Māori or Pacific?

The programme will be open to all qualifying Tamaki residents, but the most urgent need is for more Māori and Pacific health workers in Tāmaki and the wider Auckland region. Around 50% of Tāmaki residents are Pacific people and around 25% of its residents are Māori.

8. What kind of support will *Pathways to Health Careers* provide?

You will be supported in solving issues that may prevent you from starting or finishing your health career pathway, including university fees, money for books, childcare and whānau responsibilities and transport.

Everyone's situation is different so the support will be different for each person on *Pathways to Health Careers*. You and your whānau will receive whatever support we can reasonably provide to make sure that nothing is going to stop you completing your journey.

9. What kind of education and training programmes will be offered?

We will support you in pre-entry to university, as well as certificate and diploma courses that will lead to a degree course in any health career.

This support may include on the job training, work experience, and cadetships as you progress into your health and disability career.

10. What will happen once I say I want to join *Pathways to Health Careers*?

We will arrange for you to meet one of our team to talk more about where you are right now in relation to your whānau and your community.

Once we have worked through what health career you have in mind, and what you need to get there, we will work out a study and career plan with you and your whānau. That way we can make sure you have all the right kind of support in place from the start.

You will be supported from pre-entry level through to graduation and entry into the workforce. And, depending on your previous education and experience, you can get on the pathway at any stage.

11. What is the role of whānau in this programme?

The role of whānau is huge. Their support and understanding makes your journey easier. If necessary, we will help you get their support and let them know how important your success is for them as well.

12. Can I get onto in *Pathways to Health Careers* even though I have started out on a different course of study and am unsure of what I am doing?

Please talk to us. If your current course of study does not feel right for you then you can certainly talk to us about a career in health.

13. Can I get onto in *Pathways to Health Careers* if I started training for a health career and then gave up?

Please talk to us. If you were once on a pathway to a health career we may be able to help you work through the issues you faced and help you confidently finish your training.

14. What happens if I start out on *Pathways to Health Careers* and I find it's not for me?

If you find study is really not for you, and nothing we can do makes it any better for you, we will direct you to where you can get help with moving into something that suits you better.

15. What happens if I start out on *Pathways to Health Careers* and something happens that means I cannot continue?

If you still want to complete the study and have a health career, we can help you put your study on hold and put plans into place for when you are ready to start back on the pathway.

16. How do I enrol in *Pathways to Health Careers*?

Fill out the *Pathways to Health Careers* form to let us know you are interested. We will then let you know that we have received your form and let you know what the next step is.

Community and Public Health Advisory Committee Agenda

MEETING DETAILS	
Time and Date	2:00 p.m. – 5:00 p.m. Wednesday 20 October 2010
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre
Members	Dr Brian Fergus (Chair), Jo Agnew, Susan Buckland, Harry Burkhardt, Dr Chris Chambers, Rob Cooper, Dr Ian Scott, Pat Snedden, Rt Hon Bob Tizard, Seiuli Dr Juliet Walker, Ian Ward, Rev Alfred Ngaro, Farida Sultana, Lynda Williams
Apologies	
In Attendance	Garry Smith, Dr Denis Jury, Taima Campbell, Hilda Fa'asalele, Naida Glavish, Janice Mueller, Ian Bell

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1	Karakia	001
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3	Conflicts of Interest	007
4	Confirmation of Minutes - Wednesday 15 September 2010	019
5	Action Points - Wednesday 15 September	025
6	Planning and Funding Performance 6.1 Planning and Funding Summary Report 6.2 Planning and Funding Indicators List and Exception Report	029
7	Improvement Activities 7.1 DAP Projects Report	035
8	Feedback from Maori Health Advisory Committee and Pacific Health Advisory Committee	053
9	Papers 9.1 Healthy Eating Healthy Action Plan 9.2 Birthcare Contract – Extended Length of Stay Funding 9.3 GAIHN Implementation Plan 9.4 Pathways to Health Careers Update	055

Community and Public Health Advisory Committee Agenda

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10	Confirm 10.1 Actions Points for next CPHAC Meeting 10.2 CPHAC Feedback to Board	081
11	General Business	083
12	Appendices 12.1 FAQ – Pathways to Health Careers	085
NEXT MEETING		
	Date and Time:	2:00 p.m. – 5:00 p.m. Wednesday, 17 November 2010
	Venue:	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre