



Community and Public Health Advisory Committee Meeting

Wednesday 27 January 2010

2:00pm

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

*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.	

1

KARAKIA

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.

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

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. Credentialing Committee for private hospitals 				4 March 2009

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	1 September 2009
	2. New Zealand Research Centre for Growth and Development	Board Member	Fee (to Ngati Hine Health Trust)	Governs a leading health sciences research centre	
	3. James Henare Research Centre, University of Auckland	Advisory Board Member	Fee (to Ngati Hine Health Trust)	Advises U o A on Maori research in Northland	
	4. Manaia PHO, Whangarei	Shareholder	Fee (to Ngati Hine Health Trust)	Governs a Whangarei based PHO	
	5. Whanau Ora Task Force	Member	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
Dr Brian FERGUS	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				15 July 2009
Dr Ian SCOTT	1. Shareholder Deputy Chair and Clinical Advisor Auckland PHO	Deputy Chair	Meeting fee		7 August 2009
	2. Locum GP		Contract rate		
	3. Waiheke "Integrated Family Health Centre" Steering Group	Member			
Bob TIZARD	1. Nil				27 February 2008

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Seiuli Dr Juliet WALKER	1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure 2. Member, National Breast Screening Advisory Committee 3. Facilitator, RNZCGP General Practice Education Programme Stage II 4. ADHB Employee: contracted roster Doctor for Pohutukawa	Self employed contractor Member Contractor Contractor	Contract hourly rate Fee Contracted monthly fee Hourly rate	General practitioner services Consultant Pacific Advisor Educational Support and Training Forensic sexual assault examinations	1 November 2009
Ian WARD	1. Chair, Advisory Board, Vision Health Limited		Fee		15 July 2009

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	11 May 2009
	2. Pacific Advisory Committee, PHAC	Chair	Fee		
	3. National Task Force for Family Violence MSD	Member	Fee		
	4. Family and Community Services national advisory group	Task Force member	Fee		
		Advisory Member			
		Executive member	Voluntary		
	5. Auckland Safer Communities		Voluntary		
	6. Tamaki Achievement Pathways Schooling improvement	Chair			
		Fee	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		
7. Tamaki College Board of Trustees	Elected Trustee	Voluntary			
	8. Tamaki Community Development Trust	Member			
Farida SULTANA	1. Nil				6 August 2008

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lynda WILLIAMS	<ol style="list-style-type: none"> 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 	<p>Employee</p> <p>Employee</p>	<p>Salary</p> <p>Salary</p>		4 August 2008
Iain MARTIN	<ol style="list-style-type: none"> 1. University of Auckland 	Employee	Salary		26 June 2008
Anne KOLBE	<ol style="list-style-type: none"> 1. Private Paediatric Surgical Practice 2. Employee Communitio NZ 3. Head, Auckland Clinical School, School of Medicine, University of Auckland 4. Husband: Employee University of Auckland 5. Member Risk and Audit Committee Whanganui District Health Board 				12 December 2008

CONFIRMATION OF MINUTES

- 18 NOVEMBER 2009

Community and Public Health Advisory Committee Minutes

MEETING DETAILS											
Time and Date	2:00pm, Wednesday, 18 November 2009										
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom										
2	ATTENDANCE AND APOLOGIES										
	<p>Committee Members</p> <table> <tr> <td>Dr Brian Fergus (Chair)</td> <td>Susan Buckland</td> </tr> <tr> <td>Harry Burkhardt</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Pat Snedden</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Seiuli Dr Juliet Walker</td> </tr> <tr> <td>Rev Alfred Ngaro</td> <td>Lynda Williams</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Hilda Fa’asalele – General Manager Pacific Health Aroha Haggie – Maori Health Gain Manager Celia Palmer – Clinical Leader, Planning & Funding Ian Bell – Board Administrator</p> <p>Apologies</p> <p>The Chair declared the meeting open at 2:04pm. Apologies had been received from Jo Agnew, Rob Cooper, Ian Ward, Farida Sultana and Taima Campbell. An apology for lateness was recorded for Pat Snedden</p>	Dr Brian Fergus (Chair)	Susan Buckland	Harry Burkhardt	Dr Chris Chambers	Dr Ian Scott	Pat Snedden	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Rev Alfred Ngaro	Lynda Williams
Dr Brian Fergus (Chair)	Susan Buckland										
Harry Burkhardt	Dr Chris Chambers										
Dr Ian Scott	Pat Snedden										
Rt Hon Bob Tizard	Seiuli Dr Juliet Walker										
Rev Alfred Ngaro	Lynda Williams										
3	CONFLICTS OF INTEREST										
	There was no notification of conflicts of interest for any item on the agenda.										
4	CONFIRMATION OF MINUTES 20 OCTOBER 2009										
	<p>It was noted from the minutes that H1N1 was a notifiable disease but there were elements of non reporting. There were increased incidents in the US and there was preparation for a second wave and it was expected to be in the guidelines for vaccination next year.</p> <p>The Public Health Services funding had been discussed at the regional CEO meeting and a letter had been sent to the Ministry of Health as there is no resolution at this point. If funding was not available there would be cuts to services.</p> <p>Population Based Funding (PBF) did not take into account burdens of diseases in different parts of the country i.e. HIV, TB or move of older people into the Auckland area. This was not just a New Zealand issue but was also experienced in Florida and Mediterranean countries. There is no easy solution but with the formation of the National Health Board funding of national services may be held there. PBF is, however, probably the fairest way of funding but may need some small adjustments.</p> <p>With the universal newborn hearing screening programme there was appropriate treatment. While it has been difficult in getting funding for the programme because it was technologically expensive, \$200k had been found to fund appropriately.</p> <p>While ED had to take everyone, homeless were being invited to the clinics that had been set up in</p>										

	<p>the city.</p> <p><u>Moved Ian Scott; seconded Lynda Williams</u></p> <p><i>That the minutes of the Community and Public Health Advisory Committee meeting held on 20 October 2009 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
5	ACTION POINTS 21 OCTOBER 2009
	The clarification concerning Community Laboratory Services had been discussed at the previous Board meeting.
6.1	Planning and Funding Summary Report
	<p>There had been three successful EOI in the region. The governance of the Health+ Alliance PHO was spread and there could be challenges with the governance structure. The GAIHN recognised the amount of work to be done to do things differently at a time when there is preparation of the District Annual Plans (DAPs). Tamaki PHO is in the national Maori PHO Collective and GAIHN. There is collaboration with the three DHBs. Integrating and coordination of services as well as integrated family health centres would need to involve clinical leaders, planning and funding and contract some support. Funding had been suggested at \$1 per enrolled patient and there is an issue of how ADHB could provide support either in cash or kind. All business cases required DHB signoff by 14 February 2010 so it would be signed off at the February Board meeting or a special meeting.</p> <p>Pat Snedden joined the meeting at 2:30pm.</p> <p>It was noted that there could be an issue with communication with GPs in the short timeframe. The aim was to reduce duplication and streamline services and to avoid IDFs there may be a need to capitate across the region. There was a need to get responsiveness of funding and planning closer to delivery, get the governance structures right and be prepared to give up some DHB autonomy. One of the biggest challenges would be unpicking funding so that it is fair on DHBs and new providers. Originally \$600k had been provided to ADHB for planning for devolvement of services but when the EOI started this was taken back by the MoH. Devolution is to be clinical led as, to devolve or not rather than it being a financial decision should be a clinical decision although there could be a number of mechanisms i.e. risk sharing. With regards to Pacific there was concern around the process and more exposure to providers with Pacific providers particularly vulnerable with an unrealistic timeframe adopted.</p> <p>Funding for Eating Disorder Services had finally been resolved with a funding line for 4 years of between \$4.6m - \$4.8m per annum for the region although there was a risk at the end of the period. There was a process for inpatient services through an NGO provider with Starship catering for under 15s with increased clinical support. Having the funding coming to ADHB dilutes regional support so a regional governance group had been established to manage led by Ian McKenzie managing implementation with the ADHB funding shifted to NDSA so ADHB is not seen to be at an advantage. This was a move away from the concept of lead DHBs for regional services. The Committee asked for an updated paper and that the consumer group are communicated with.</p> <p>There was considerable interest in the heart failures telehealth pilot with \$15k being used to pilot with 14 people. Work was continuing regionally on Auckland Regional Public Health services to have a new structure from 1 July 2010 with now focus on regulation rather than health promotion which was a rational response to funding constraints. There was still concerns and disappointment with HCNZ regarding Home Based Support Services.</p>
6.2	Planning and Funding Indicators Exception Report
	The rise in the number of non TAB disease investigations was partly due to changes in health regulations and notification requirements for swine flu, measles and whooping cough. While diabetes annual checks were ok for Maori, Pacific and Indian, the European population was not doing as well.

6.3	Planning and Funding Indicators
	The improved immunisation rates for 2 year olds was partly due to improvement of data with the national register now operating properly so the rates previously may have been better than thought. Pacific were the best in the country.
7.1	DAP Projects Report
	<p>The one orange indicator was retinal screening. This had been updated to the Maori Health Advisory Committee in that a preferred provider with a network of optometrists and a mobile service to meet the gaps feeding into one database was the preferred solution.</p> <p>The Maori DNA project group had presented to the Clinical Board putting in texting, reply texting, transport and other strategies before patients came in. They would be reporting back to the Maori Health Advisory Committee in the new year and it was asked that there be comparisons with Counties Manukau and nationally.</p>
8	FEEDBACK FROM MAORI HEALTH ADVISORY COMMITTEE AND PACIFIC HEALTH ADVISORY COMMITTEE
	<p>Maori</p> <p>The Committee had discussed the issue of Maori provider sustainability with a need for a Maori providers sustainability framework. The review of contracts needed to ensure Maori health gains are not compromised and with the Maori Health Equity Framework there needed to be a strategic vision and measures to see what is being achieved.</p> <p>Pacific</p> <p>Faith Mahoney, who is leading the evaluation team of HVAZ, had presented to the Committee on the six month report which included social network analysis with leadership and resourcing support key to networking. The Pacific communities measure of success were sought to ensure that measuring is in the right areas and collection of data is being promoted for self collection within groups. The network was growing with Heart Beat churches joining.</p>
9.1	Review of Funding Contracts – Results Framework
	<p>All funding contracts were being reviewed due to the financial situation to ensure that there is not duplication of effort, maximising effectiveness and obtaining value for money using the prioritisation tools. A whole picture view was being taken rather than cuts at the margin and included ensuring equity. The Committee asked that the prioritisation tool be distributed with the minutes. It was noted that constraints can affect employment within organisations. In mitigating risks there are external participants from the School of Population Health and Funding and Planning people.</p> <p><u>Moved Pat Snedden; seconded Ian Scott</u></p> <p><i>That the Community and Public Health Advisory Committee approves the suggested process for review of funding contracts so that the work can commence.</i></p> <p><u>Carried</u></p>
9.2	Acute Bed Blockages – Under 65 Population
	<p>Lisa Gestro was in attendance and reminded the Committee of the boundary issues between over/under 65 with under 65 being funded through MoH. The ongoing issue was to move under 65s from the hospital however there was several layers of bureaucracy in funding and placement. There had been recent publicity concerning placements of under 65 into aged care. There needed to be clear definitions with the Ministry and not have shifts of those definitions. There was a suggestion that there be a step down facility while there are discussions on funding and placement. The MoH had agreed to work on this in principle. It was suggested that this may just move the problem rather than getting assessments right. At present there is a funding pool which sits between the MoH/ADHB with access to the funds managed through Taikura. This applies to</p>

	<p>20-25 people per year. There were links to the ED project in terms of data with questions of getting the right model of care i.e. facilities or wraparound care.</p> <p><u>Moved Linda Williams; seconded Ian Scott</u></p> <p><i>That the Community and Public Health Committee:</i></p> <ul style="list-style-type: none"> • <i>Notes the current issues being experienced, and the budget implications that these are having on ADHB; and</i> • <i>Supports the proposal to develop a series of immediate steps to resolve the current situation, which would involve the Ministry of Health agreeing to some performance KPIs and agreeing on some operational policies such as funding definitions which are currently contributing to discharge delays; and</i> • <i>Agrees that in the event that step two above is unsuccessful then a more sustainable remedy will be sought, which may include the establishment of a step down facility, the ADHB over 65 NASC being able to assume the Need Assessment function when Taikura Trust are not able to comply with preset KPIs, or the remodelling of assessment services within ADHB to align to that of other DHBs, which is to have one NASC for all ages.</i> <p><u>Carried</u></p>
9.3	<p>2010-2011 Planning Process and Update of Review of 2006/2010 District Strategic Plan</p>
	<p>Tony O'Connor and Julie Helean were in attendance.</p> <p>The District Annual Plan and SOI for 2010/2011 overlaps with the Strategic Plan Review and would be a workload for the Committee in February with the first draft District Annual Plan being due on 5 March 2010. Parameters were tighter funding, need to break even and meet national health targets so there would be an emphasis on financial management. The period was one of considerable change and there was a need to get regional agreement to wording on primary care and regional services. The intention was to produce one draft and not have an iterative process. Efficiency and additional savings would need to be written in. There were organisational processes and ongoing projects to imbed change. With the District Strategic Plan the MoH wanted a draft that had been out for public consultation by September 2010. It was cautioned that primary care was becoming overloaded with change and processes at the moment.</p> <p>There were a number of items coming up being EOI draft business cases and DAP with a suggestion that there be a meeting about 10 February 2010 to meet the timeline of 14 February 2010 with some submissions to the 2 and 3 February Financing Committee and Board. Management was asked to produce a timetable.</p> <p><u>Moved Pat Snedden; seconded Ian Scott</u></p> <p><i>That the Community and Public Health Advisory Committee:</i></p> <ul style="list-style-type: none"> • <i>Notes the new requirements contained in the planning package</i> • <i>Allocates time in February 2010 meeting to discuss the draft DAP and SOI, and to provide feedback</i> • <i>Notes that both the DAP and SOI be approved at the March 2010 meeting of the Board as a prerequisite to submitting to the Ministry</i> • <i>Approves that all financial and non-financial information submitted in March 2010 to meet the Ministry of Health deadline; and</i> • <i>Notes the Ministry of Health requirement for DHBs to produce a draft Strategic Plan by September 2010.</i> <p><u>Carried</u></p>

	NEXT MEETING
	<p>The meeting closed at 4:10pm</p> <p>The next meeting is scheduled for 2:00pm, Wednesday, 20 January 2010 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Epsom</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	

5

ACTION POINTS

- 18 NOVEMBER 2009

**Community and Public Health Advisory Committee
Action Points from the meeting on Wednesday 18 November 2009**

Item	Detail	Designated	Action
Carried forward	Treatment of Dementia to be discussion CPHAC March 2010	Denis Jury	March 17 Agenda
6.1	The Committee asked for an updated paper on Eating Disorder Services and that the consumer group are communicated with.	Denis Jury	Agenda Item 5.1
6.3	The Committee asked for DNA rates being reported back to the Maori Health Advisory Committee be compared with Counties Manukau rates and national rates	Denis Jury Naida Glavish	Note report to MHAC
9.1	The Committee asked that the prioritisation tool be distributed with the minutes.	Denis Jury Ian Bell	Completed
9.3	Management was asked to produce a timetable for January, February and March for reviewing, debating and approving the DAP and SOI.	Denis Jury Julie Helean	Agenda Item 5.2



Community and Public Health Advisory Committee Paper

Date	Wednesday 27 January 2010
To	Community and Public Health Advisory Committee
From	Ian McKenzie Regional Director, Mental Health and Addiction Services NDSA
Author	Sue Keppel, Project Manager, Eating Disorders Implementation Project
Functional Group	NDSA
Subject	Update on Eating Disorders Implementation Project
1	<p>Purpose The purpose of this paper is to provide ADHB CPHAC with an update on the Eating Disorders Services Implementation Project.</p>
2	<p>Recommendations It is recommended that CPHAC notes the contents of this report.</p>
3	<p>Background Implementation: CPHAC has requested an update on this project.</p> <p>Implementation is progressing as described within the Northern Region Eating Disorders Implementation Plan 2008- 2013 with a number of agreed changes. These include:</p> <ul style="list-style-type: none"> • The NDSA has assumed the leadership role on an ongoing basis, in accordance with the Regional CEO decision • The Regional Eating Disorders Service will provide the clinical component of the residential treatment facility, in accordance with the Implementation Governance Group decision • A number of timeframes will be amended in the Implementation Plan, as outlined in the Issues and Risks section below. <p>Services: This plan describes implementation in two bands – services for people aged 15 years and under, and services for people over 15 years. Services for 15 years and under are provided by Starship, involving the establishment of 5 specialist beds. Much of this work is completed and specialist services are being provided. A Service Level Agreement between Starship and the Regional Eating Disorders Service is ready to be signed and is contingent on the signing of the Crown Funding Agreement (CFA) with ADHB., It is expected that the CFA will be signed at the end of January.</p> <p>Services for people over 15 include the establishment of a nine bed residential treatment facility for provision of inpatient treatment when required, and Day Programmes. There will also be capacity to provide Packages of Care under some circumstances. A Request For Proposal (RFP) for the facility and some non-clinical support services will be released in February 2010. The EDS Regional Governance Group has decided that clinical services will be provided by the existing Regional Eating Disorders Service, which will be expanded and reconfigured to allow this. This decision was reached in order to ensure safe and flexible clinical governance arrangements and to maintain the ability of the specialised service to respond across the continuum of care.</p> <p>Increased Local Capacity: Within DHBs local capacity will be increased to support a range of eating disorders services, including early identification and initial screening, early intervention, care planning, health monitoring, service referrals and continuity of care. The staff to fulfil these functions are directly employed by local DHBs, and will work</p>

	<p>closely with the Regional service.</p> <p>Community Engagement: The Project Manager has met with consumer groups including EDANZ and EDEN to update them on the project. Family participation was included in a regional workshop to develop the Patient Pathway and Model of Care at the primary/secondary point of the continuum. An invitation has been accepted to speak with the Eating Difficulties Community Coalition in February and close contact with interested groups is maintained.</p>
4	<p>Options Considered N/A</p>
5	<p>Issues and Risks for Chosen Option</p> <ol style="list-style-type: none"> 1. Timeframes for the residential facility to be operational. The date in the Implementation Plan for commencement of residential treatment services is 30 April 2010, with much of the required work to have been completed between July and November 2009. A number of factors impacted negatively on this target, including delays in the agreement of the CFA. It is now estimated that the residential service may commence in the first quarter of 2010/11. Issues which impact on a precise estimate for the start date include risk resulting from both the success and/or readiness of a provider in response to the RFP, and the process of obtaining consents. Contingency plans are in place in the event that no successful responder to the RFP is identified. 2. Workforce. Planning arrangements are underway to provide an enhanced workforce both within DHBs and the new residential unit. Training of increased staff numbers will be required. Whilst confident that the goal will be achieved, the introduction of an enhanced service requires competent staff to ensure clinical safety. Phasing of the commencement of aspects of the new services may therefore be required.
6	<p>Budget Implications Additional revenue is available for these new and enhanced services. This funding is in addition to existing regional eating disorders service funding.</p>
7	<p>Regional / National Implications This implementation is consistent with the <i>Future Directions for Eating Disorders Services in New Zealand</i>, Ministry of Health 2008. The implementation includes both Northern and Midland regions.</p>
8	<p>Appendices available on request None attached.</p>

Board and Committee Sign-Off Processes Jan – Feb 2010

	CPHAC 27/01	Finance Committee 02/02		Board 03/02	CPHAC 17/02		Finance Committee 02/03	Board 03/03	
Primary care Eol Business cases	Paper / presentation on each business case -Scope -Key Features -Finances -Implementation Feedback on any ADHB requirements	Note / discuss if any financial / funding / risk implications	Submission to Health Select Committee	-Update as required -Board approval for Chair to sign for ADHB support, following CPHAC (17/02) review, for 01/03 submission of business cases to MoH	-Review / approval of near final draft for Chair sign-off -feedback any requirements	1 March: Eol Business Case to MoH (Chair sign-off)	Finance committee to note Chair sign-off of business cases and any financial implications of that.	Board to formally note Chair sign-off of the Eol Business Cases	12 March: ADHB DAP and Sol to MoH
ADHB DAP	Update: -Driver diagrams -Funding allocations -Key issues -MoH / Minister's targets	-Funding envelope analysis -Approve preliminary budget approach			-Review final document -Approve and recommendation to the Board 03/03		Approve DAP financials and budget and recommendation the Board 03/03	Formally approve DAP for submission to the MoH on 05/03 The intent is for this to be a final document with only editorial change from this point	
ADHB Sol	As for DAP, plus draft Statement of Service performance				As for DAP, plus draft Statement of Service performance		Approve relevant Statement of Service Performance KPIs	Formally approve Sol for submission to the MoH on 05/03	
Health Select Committee Response	Review and approve for submission on 29 January 2010			Formally note CPHAC approval of the Health Select Committee response and its submission on 29 January 2010					

PLANNING AND FUNDING PERFORMANCE

- 6.1 Planning and Funding Summary Report**
- 6.2 Planning and Funding Indicators List and Exception Report**
- 6.3 Planning and Funding Indicators (Full set)**

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Planning and Funding Functional Group

Summary Report

1. Lifting the Health of people in Auckland City

PHO's and Primary Care - Expression of Interest (EOI)

Activity during November will focus on governance issues and business case framework for the successful Primary Care EOI's;

- Greater Auckland Integrated Health Network
- Health+ Alliance PHO
- National Maori PHO Coalition

Eating Disorders Services (EDS)

The work continues with a regional focus. The SLA with Starship is about to be signed off along with other structural agreements for delivery. We have now received the CFA from MoH and that has assisted with other contractual discussions.

Heart Failures Telehealth Pilot

Pilot progressing well with positive media coverage during the month.

2. Performance Improvement

Planning

CPHAC have approved the proposed approach to developing the DAP and SOI for 2010-11. Work is underway with considerable focus on finding the savings we anticipate will be required to reach a breakeven position in 2010-11.

Health of Older People

All systems go in respect of the HBSS implementation. Systems improvements continue to result in added benefits. Communication and interfaces have also improved. Initiatives in residential care are now being explored with a view to creating efficiencies

Shaken Baby Prevention programme

ADHB has agreed terms with CYF for a 2 year contract for the provision of a Shaken Baby Prevention programme to be carried out in National Women's Health Services. Women transferring to Birthcare for their post natal care will be excluded from the programme in the initial phase as well as women who are discharged home direct from Delivery Unit. Recruitment of Co-ordinators has commenced. The ADHB programme message is consistent with the CYF 'Never Shake a Baby' campaign just begun.

3. Live Within Our Means

Auckland Regional Public Health Service

Debate continues between the Auckland Metro DHB's regarding transfer of funding. No agreement has been reached and this is being progressed to the Ministry of Health for clarification and resolution

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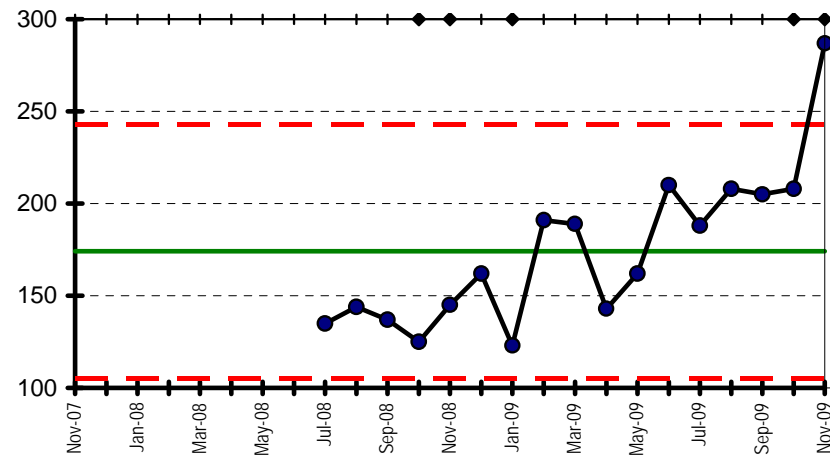
Planning and Funding Indicators Exception Report

Nov 2009

Exceptions this month

The number is increasing due to an increase in Pertussis (whooping cough) and Legionella infection.

L45. Number of other (non-TB) disease investigations - Total



Comments on Financial Performance and HR

No comments

KPI's for Review this month

No KPIs for review this month

* " D`Ubb]b[`UbX': i bX]b[`=bX]WUc'fg'ft i ``GYtL

Symbols

† = MOH Top Six indicator

‡ = IDP

Ω = SOI

Indicators	Frequency	Source	Tab	Updated this month
L01. Health assessments done of Early Childhood Education Centres	M	Ω	PFFG M4	Yes
L02. Investigations to monitor/improve the quality of drinking water	Q	Ω	PFFG Q11	No
L03. Emergency investigations on hazardous substances and new organisms	Q	Ω	PFFG Q11	No
L04. Prevalence of exposure of non-smokers to second hand smoke inside the home - Total	5Y	Ω	PFFG 5Y1	No
L04.a Prevalence of exposure of non-smokers to second hand smoke inside the home - Asian	5Y	Ω	PFFG 5Y2	No
L04.b Prevalence of exposure of non-smokers to second hand smoke inside the home - Maori	5Y	Ω	PFFG 5Y2	No
L04.c Prevalence of exposure of non-smokers to second hand smoke inside the home - Other	5Y	Ω	PFFG 5Y2	No
L04.d Prevalence of exposure of non-smokers to second hand smoke inside the home - Pacific	5Y	Ω	PFFG 5Y2	No
L05. Percentage of "never smokers" among Year 10 students -Total	A	Ω	PFFG A6	No
L07. Number enrolled on Pacific smoking cessation programs in Auckland DHB	M	Ω	PFFG M4	Yes
L10. (POP-18) Infants exclusively and fully breastfed - 6 weeks -Total	A	Ω,‡	PFFG A1	No
L10.a Infants exclusively and fully breastfed - 6 weeks -Asian	A	Ω	PFFG A1	No
L10.b (POP-18) Infants exclusively and fully breastfed - 6 weeks -Maori	A	Ω,‡	PFFG A1	No
L10.d (POP-18) Infants exclusively and fully breastfed - 6 weeks -Pacific	A	Ω,‡	PFFG A1	No
L11. (POP-18) Infants exclusively and fully breastfed - 3 months -Total	A	Ω,‡	PFFG A2	No
L11.a Infants exclusively and fully breastfed - 3 months -Asian	A	Ω	PFFG A2	No
L11.b (POP-18) Infants exclusively and fully breastfed - 3 months -Maori	A	Ω	PFFG A2	No
L11.d (POP-18) Infants exclusively and fully breastfed - 3 months -Pacific	A	Ω	PFFG A2	No
L12. (POP-18) Infants exclusively and fully breastfed - 6 months -Total	A	Ω,‡	PFFG A3	No
L12.a Infants exclusively and fully breastfed - 6 months -Asian	A	Ω	PFFG A3	No
L12.b (POP-18) Infants exclusively and fully breastfed - 6 months -Maori	A	Ω	PFFG A3	No
L12.d (POP-18) Infants exclusively and fully breastfed - 6 months -Pacific	A	Ω	PFFG A3	No
L13. Referrals to Immunisation outreach services -Total	M	Ω	PFFG M1	Retired
L13.a Referrals to Immunisation outreach services -Asian	M	Ω	PFFG M2	Retired
L13.b Referrals to Immunisation outreach services- Maori	M	Ω	PFFG M2	Retired
L13.c Referrals to Immunisation outreach services- Other	M	Ω	PFFG M2	Retired
L13.d Referrals to Immunisation outreach services-Pacific	M	Ω	PFFG M2	Retired
L14. (MOH-04) Percentage of two year olds immunised - Total	Q	†,Ω	PFFG Q1	No
L14. a Percentage of two year olds immunised -Asian	Q	†,Ω	PFFG Q1	No
L14. b (MOH-04) Percentage of two year olds immunised -Maori	Q	†,Ω	PFFG Q1	No
L14. c Percentage of two year olds immunised -Other	Q	†,Ω	PFFG Q2	No
L14. d (MOH-04) Percentage of two year olds immunised -Pacific	Q	†,Ω	PFFG Q1	No
L14. g Percentage of two year olds immunised -NZ European	Q	†,Ω	PFFG Q2	No
L18. B4 School Checks completed	M	Ω	PFFG M3	No
L19. Diabetes Annual Check -Total	Q	Ω,†	PFFG Q3	No
L19.b (MOH-06) Diabetes Annual Check -Maori	Q	Ω,†	PFFG Q3	No
L19.c Diabetes Annual Check -Other (excludes Indian data as per DHB reporting)	Q	Ω,†	PFFG Q4	No

Indicators	Frequency	Source	Tab	Updated this month
L19.d (MOH-06) Diabetes Annual Check -Pacific	Q	Ω,†	PFFG Q3	No
L19.e Diabetes Annual Check -Indian	Q	Ω	PFFG Q3	No
L19.f (MOH-06) Diabetes Annual Check -Other + (includes Indian data as per DHB reporting)	Q	Ω,†	PFFG Q4	No
L20. Get Checked Patients with an HbA1c<8 -Total	Q	Ω,†	PFFG Q5	No
L20.b (MOH-06) Get Checked Patients with an HbA1c<8 -Maori	Q	Ω,†	PFFG Q5	No
L20.c Get Checked Patients with an HbA1c<8 -Other (excludes Indian data as per DHB reporting)	Q	Ω,†	PFFG Q6	No
L20.d (MOH-06) Get Checked Patients with an HbA1c<8 -Pacific	Q	Ω,†	PFFG Q5	No
L20.e Get Checked Patients with an HbA1c<8 -Indian	Q	Ω,†	PFFG Q5	No
L20.f (MOH-06) Get Checked Patients with an HbA1c<8 -Other + (includes Indian data as per DHB reporting)	Q	Ω,†	PFFG Q6	No
L21. Diabetic Retinal Screening for people with diabetes -Total	Q	Ω	PFFG Q7	No
L21.b Diabetic Retinal Screening for people with diabetes -Maori	Q	Ω	PFFG Q7	No
L21.c Diabetic Retinal Screening for people with diabetes -Other (excludes Indian data as per DHB reporting)	Q	Ω	PFFG Q8	No
L21.d Diabetic Retinal Screening for people with diabetes -Pacific	Q	Ω	PFFG Q7	No
L21.e Diabetic Retinal Screening for people with diabetes -Indian	Q	Ω	PFFG Q7	No
L21.f Diabetic Retinal Screening for people with diabetes -Other (includes Indian data as per DHB reporting)	Q	Ω	PFFG Q8	No
L22. Cardiovascular risk screening -Total	Q	Ω,†	PFFG Q9	No
L22.b (MOH-06) Cardiovascular risk screening -Maori	Q	Ω,†	PFFG Q9	No
L22.c (MOH-06) Cardiovascular risk screening -Other	Q	Ω,†	PFFG Q9	No
L22.d (MOH-06) Cardiovascular risk screening -Pacific	Q	Ω,†	PFFG Q9	No
L29.b (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Maori	Q	Ω,‡	PFFG Q12	No
L29.c (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Other	Q	Ω,‡	PFFG Q12	No
L29.d (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Pacific	Q	Ω,‡	PFFG Q12	No
L30.b (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Maori	Q	Ω,‡	PFFG Q13	No
L30.c (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Other	Q	Ω,‡	PFFG Q13	No
L30.d (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Pacific	Q	Ω,‡	PFFG Q13	No
L31.b (POP-15) Ambulatory Sensitive Hospitalisations age 45-64 years -Maori	Q	Ω,‡	PFFG Q14	No
L31.c (POP-15) Ambulatory Sensitive Hospitalisations age 45-64 years -Other	Q	Ω,‡	PFFG Q14	No
L31.d (POP-15) Ambulatory Sensitive Hospitalisations age 45-64 years -Pacific	Q	Ω,‡	PFFG Q14	No
L32. Percentage of children caries free at 5 years -Total	A	Ω,‡	PFFG A4	No
L32.b (POP-05) Percentage of children caries free at 5 years -Maori	A	Ω,‡	PFFG A4	No
L32.c (POP-05) Percentage of children caries free at 5 years -Other	A	Ω,‡	PFFG A4	No
L32.d (POP-05) Percentage of children caries free at 5 years -Pacific	A	Ω,‡	PFFG A4	No
L33. Number of teeth decayed, missing or filled (DMFT) yr 8 students -Total	A	Ω,‡	PFFG A5	No
L33.b (POP-04) Number of teeth decayed, missing or filled (DMFT) yr 8 students -Maori	A	Ω,‡	PFFG A5	No
L33.c (POP-04) Number of teeth decayed, missing or filled (DMFT) yr 8 students -Other	A	Ω,‡	PFFG A5	No
L33.d (POP-04) Number of teeth decayed, missing or filled (DMFT) yr 8 students -Pacific	A	Ω,‡	PFFG A5	No
L34. Number of people 85+ years who are able to remain in their own homes	Q	Ω	PFFG Q10	No
L35. # low level home-based support clients self managing on support packages with input from key workers	M	Ω	PFFG M3	No
L36. Length of stay for home based support clients	Q	Ω	PFFG Q11	No
L37. Number of reassessments for clients receiving home based support services	M	Ω	PFFG M3	No
L38. New admissions to rest home level care (NASC referrals only)	Q	Ω	PFFG Q19	No
L39. Number of complaints from residential care	Q	Ω	PFFG A6	No

Indicators	Frequency	Source	Tab	Updated this month
L41. Education sessions delivered by specialist providers to aged care facilities	M	Ω	PFFG M3	No
L42. Percentage of Mental Health providers audited over 3 yr cycle	Q		PFFG Q10	No
L44. Number of TB investigations - Total	M	Ω	PFFG M6	Yes
L44.b Number of TB investigations - Maori	M	Ω	PFFG M6	Yes
L44.c Number of TB investigations - Other	M	Ω	PFFG M6	Yes
L44.d Number of TB investigations - Pacific	M	Ω	PFFG M6	Yes
L45. Number of other (non-TB) disease investigations - Total	M	Ω	PFFG M7	Yes
L47. Number of Healthy Housing Project - Assessments	M	Ω	PFFG M4	Yes
L48. Number of Healthy Housing Project - Health and social referrals	M	Ω	PFFG M4	No
L49. (POP-14) Percentage of adolescent Oral Health utilisation	A		PFFG A6	No
L50. (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 0-19y -Total	6M	‡	PFFG 6M5	No
L50.b (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 0-19y -Maori	6M	‡	PFFG 6M5	No
L50.c (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 0-19y -Other	6M	‡	PFFG 6M5	No
L50.d Access to NGO and Prov. Arm MH Services by ADHB Pop 0-19y -Pacific	6M	‡	PFFG 6M5	No
L51. (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 20-64y -Total	6M	‡	PFFG 6M6	No
L51.b (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 20-64y -Maori	6M	‡	PFFG 6M6	No
L51.c (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 20-64y -Other	6M	‡	PFFG 6M6	No
L51.d Access to NGO and Prov. Arm MH Services by ADHB Pop 20-64y -Pacific	6M	‡	PFFG 6M6	No
L52. (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 65y+ -Total	6M	‡	PFFG 6M7	No
L52.b (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 65y+ -Maori	6M	‡	PFFG 6M7	No
L52.c (POP-06) Access to NGO and Prov. Arm MH Services by ADHB Pop 65y+ -Other	6M	‡	PFFG 6M7	No
L71. Percentage of children who have been consented and vaccinated via the school based programme - Total	A	Ω	PFFG A7	No
L71.b Percentage of children who have been consented and vaccinated via the school based programme - Maori	A	Ω	PFFG A7	No
L71.c Percentage of children who have been consented and vaccinated via the school based programme - Other	A	Ω	PFFG A7	No
L71.d Percentage of children who have been consented and vaccinated via the school based programme - Pacific	A	Ω	PFFG A7	No
L72. Percentage of children declining vaccination as vaccinated outside of the school based programme - Total	A	Ω	PFFG A8	No
L72.b Percentage of children declining vaccination as vaccinated outside of the school based programme - Maori	A	Ω	PFFG A8	No
L72.c Percentage of children declining vaccination as vaccinated outside of the school based programme - Other	A	Ω	PFFG A8	No
L72.d Percentage of children declining vaccination as vaccinated outside of the school based programme - Pacific	A	Ω	PFFG A8	No
L73. People diagnosed with Acute Coronary Syndrome - Total	Q	Ω	PFFG Q15	No
L73.b People diagnosed with Acute Coronary Syndrome - Maori	Q	Ω	PFFG Q16	No
L73.c People diagnosed with Acute Coronary Syndrome - Other	Q	Ω	PFFG Q16	No
L73.d People diagnosed with Acute Coronary Syndrome - Pacific	Q	Ω	PFFG Q16	No
L73.e People diagnosed with Acute Coronary Syndrome - Indian	Q	Ω	PFFG Q16	No
L74. People diagnosed with ACS attending a cardiac rehabilitation programme - Total	Q	Ω	PFFG Q17	No
L74.b People diagnosed with ACS attending a cardiac rehabilitation programme - Maori	Q	Ω	PFFG Q18	No

Indicators	Frequency	Source	Tab	Updated this month
L74.c People diagnosed with ACS attending a cardiac rehabilitation programme - Other	Q	Ω	PFFG Q18	No
L74.d People diagnosed with ACS attending a cardiac rehabilitation programme - Pacific	Q	Ω	PFFG Q18	No
L74.e People diagnosed with ACS attending a cardiac rehabilitation programme - Indian	Q	Ω	PFFG Q18	No

Planning & Funding Functional Group Process Indicators	Frequency	Source	Tab	
H1. Payments Made Against Unsigned Contracts	M		PFFG M4	Yes
H2. Number of Contracts Expiring within next 6 months (including unresolved from previous months)	M		PFFG M4	Yes
H3. Outstanding Moderate Risk Audit Issues	M		PFFG M4	Yes
H4. Outstanding High Risk Audit Issues	M		PFFG M4	Yes

Primary care	Frequency	Source	Tab	
L27. Care plus enrolled population (baseline 2008)	Q	‡	PFFG Q10	No
L28. Palliative client in receipt of PHO services	Q	Ω	PFFG Q10	No
L53 b. Percentage of ADHB Maori enrolled within a PHO	Q	Ω	PFFG Q19	No
L53 d. Percentage of ADHB Pacific People enrolled within a PHO	Q	Ω	PFFG Q19	No
L53. Percentage of ADHB population enrolled within a PHO	Q	Ω	PFFG Q19	No
L54 b. Percentage of enrolled ADHB Maori enrolled in non-ADHB PHOs	Q	Ω	PFFG Q20	No
L54 d. Percentage of enrolled Pacific People enrolled in non-ADHB PHOs	Q	Ω	PFFG Q20	No
L54. Percentage of enrolled ADHB population enrolled in Non-ADHB funded PHOs	Q	Ω	PFFG Q20	No
L55 b. Percentage of ADHB Maori Children under 5 years enrolled within a PHO	Q	Ω	PFFG Q21	No
L55 d. Percentage of ADHB Pacific Children under 5 years enrolled within a PHO	Q	Ω	PFFG Q21	No
L55. Percentage of ADHB Children under 5 years enrolled with a PHO	Q	Ω	PFFG Q21	No

Maori Health Process Indicators	Frequency	Source	Tab	
L64. Percentage of medical positions in DHB held by Maori out of total(heads)	6 mthly , 2nd & 4th Q	‡	PFFG 6M3	No
L65. Percentage of nursing positions in DHB held by Maori out of total (heads)	6 mthly , 2nd & 4th Q	‡	PFFG 6M3	No
L66. Percentage of Admin / clerical / mgt positions in DHB held by Maori out of total (heads)	6 mthly , 2nd & 4th Q	‡	PFFG 6M3	No
L67. Percentage of Tech-patient care positions in DHB held by Maori out of total(heads)	6 mthly , 2nd & 4th Q	‡	PFFG 6M3	No
L68. Percentage of Tech-Support positions in DHB held by Maori out of total(heads)	6 mthly , 2nd & 4th Q	‡	PFFG 6M4	No
L69. Percentage of Management positions in DHB held by Maori out of total (heads)	6 mthly , 2nd & 4th Q	‡	PFFG 6M4	No
L70. Percentage of Hotel services positions in DHB held by Maori out of total(heads)	6 mthly , 2nd & 4th Q	‡	PFFG 6M4	No

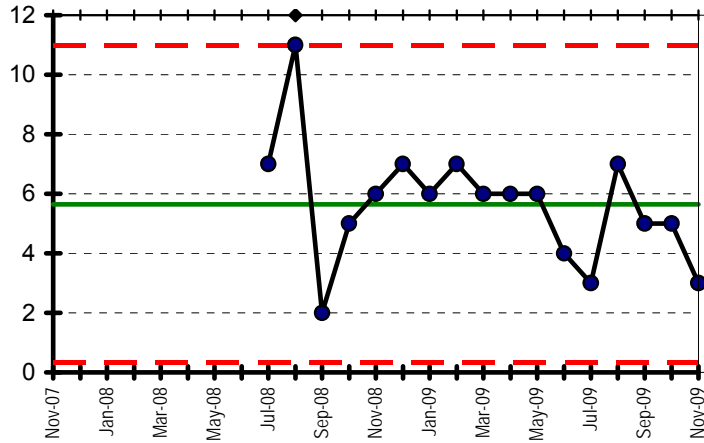
Pacific Health Process Indicators	Frequency	Source	Tab	
L57. Percentage of medical positions in DHB held by Pacific peoples out of total(heads)	6 mthly	‡	PFFG 6M1	No
L58. Percentage of nursing positions in DHB held by Pacific peoples out of total (heads)	6 mthly	‡	PFFG 6M1	No
L59. Percentage of Admin/clerical/mgt positions in DHB held by Pacific peoples out of total (heads)	6 mthly	‡	PFFG 6M1	No
L60. Percentage of Tech-patient care positions in DHB held by Pacific out of total(heads)	6 mthly	‡	PFFG 6M1	No
L61. Percentage of Tech-Support positions in DHB held out of total(heads)	6 mthly	‡	PFFG 6M2	No
L62. Percentage of house hold positions in DHB held by Pacific out of total (heads)	6 mthly	‡	PFFG 6M2	No
L63. Percentage of stores positions in DHB held by Pacific out of total(heads)	6 mthly	‡	PFFG 6M2	No

Indicators not currently reported on through PFFG or otherwise	Frequency	Source	Tab
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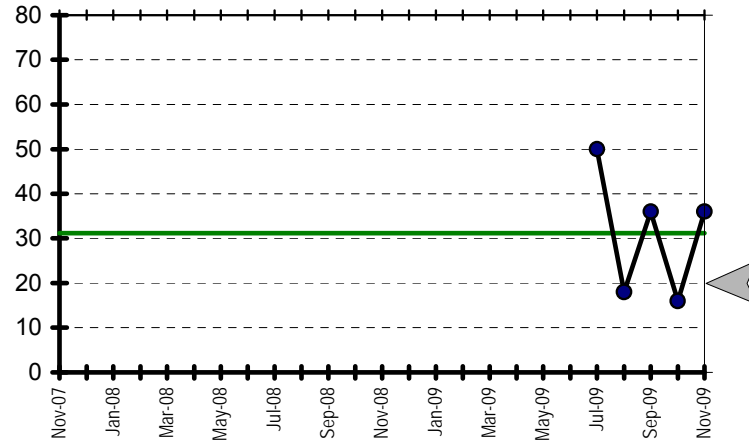
Indicators	Frequency	Source	Tab	Updated this month
MOH-05 % of smokers visiting a PHO being provided with advice and help to quit	Q	†,Ω		
L06. Percentage of homes where there is a smokefree policy when there are smokers who live or visit the home	5Y	Ω		
L06. Percentage of homes where there is a smokefree policy when there are smokers who live or visit the home	5Y	Ω		
% of children fully immunised by 6 mos of age	6 mthly , 2nd & 4th Q	‡		
% of children fully immunised by 12 mos of age	6 mthly , 2nd & 4th Q	‡		
% of children fully immunised by 18 mos of age	6 mthly , 2nd & 4th Q	‡		
L16. Breast Screening - Two year coverage rate for 50-64 yr old women		Ω		
L17. Cervical Screening - 3 yr coverage rate for 20-65 yr old women		Ω		
POP-03 Stroke # of people who have suffered a stroke event, who have been admitted to organised stroke services and remain there for their entire hospital stay	Q	‡		
K13/ L31. (POP-14) % of adolescent from Year 9 up to and including age 17 years utilising DHB funded dental services - Total	A - Q4	Ω,‡		
K13/ L31. (POP-14) % of adolescent from Year 9 up to and including age 17 years utilising DHB funded dental services - Maori	A - Q5	Ω,‡		
K13/ L31. (POP-14) % of adolescent from Year 9 up to and including age 17 years utilising DHB funded dental services - Pacific	A - Q6	Ω,‡		
K13/ L31. (POP-14) % of adolescent from Year 9 up to and including age 17 years utilising DHB funded dental services - Other	A - Q7	Ω,‡		
L32.a Percentage of children caries free at 5 years - Asian	A - part of Q3	Ω		
L32.e Percentage of children caries free at 5 years - European	A - part of Q3	Ω		
L33.a Number of teeth of 8 yr olds decayed, missing or filled (DMFT) -Asian	A - part of Q3	Ω		
L33.e Number of teeth of 8 yr olds decayed, missing or filled (DMFT) -European	A - part of Q3	Ω		
L43. Percentage of people with mental illness in paid work, education or appropriate discharges		Ω		
POP-07 Alcohol and other drug service waiting times	one mth , 2nd & 4th Q	‡		
L30/ K03 (POP -15) Ambulatory Sensitive (avoidable) Hospitalisations age 0-74 yrs	6 mthly , 2nd & 4th Q	Ω,‡		Pacific, Maori and Other reported
L29/ K04 (POP -15) Ambulatory Sensitive (avoidable) Hospitalisations age <5 yrs Total	6 mthly , 2nd & 4th Q	Ω,‡		Pacific, Maori and Other reported
L31/ K05 (POP -15) Ambulatory Sensitive (avoidable) Hospitalisations age 45-64 yrs	6 mthly , 2nd & 4th Q	Ω,‡		Pacific, Maori and Other reported
L45.b Number of other (non-TB) disease investigations - Maori	Q	Ω		DSU state that data can't be collected as not reported by ethnicity
L45.c Number of other (non-TB) disease investigations - Other	Q	Ω		DSU state that data can't be collected as not reported by ethnicity

Indicators	Frequency	Source	Tab	Updated this month
L45.d Number of other (non-TB) disease investigations - Pacific	Q	Ω		DSU state that data can't be collected as not reported by ethnicity
L46. Snug Homes - number of retrofits		Ω		
SER-07 Number of PHO practices that demonstrate that all increased subsidiaries translate into low or reduced cost access for eligible patients	Q	‡		
SER-01 General practitioner consultations for persons enrolled in PHOs, excluding casual visits		‡		
HKO-01 Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain		‡		
HKO-01.1 % of PHOs with Maori Health Plans that have been agreed to by the DHB	6 mthly , 2nd & 4th Q	‡		
HKO-01.2 % of DHB members that have undertaken Treaty of Waitangi training	6 mthly , 2nd & 4th Q	‡		
HKO - 01.3-7 are qualitative measures	6 mthly , 2nd & 4th Q	‡		
HKO-02.3 Number of other positions in DHB FTEs held by Maori out of total	6 mthly , 2nd & 4th Q	‡		
HKO - 04 DHBs will set targets to increase funding for Māori Health and disability initiatives		‡		
HKO-04.1 DHB to report actual expenditure on Maori Health Providers by GL code	A - part of Q4	‡		
HKO-04.2 DHB to report actual expenditure for Specific Maori Service provided within mainstream services targeted to improving Maori health by Purchase Unit	A - part of Q4	‡		
HKO - 4.3 DHB predicted expenditure for Maori health in the DHB 2009/10 DAP in comparison to actual expenditure, with explanation of variances	A - part of Q4	‡		
HKO-04.4 DHB to report total actual expenditure for Iwi/Maori held PHOs	Q	‡		

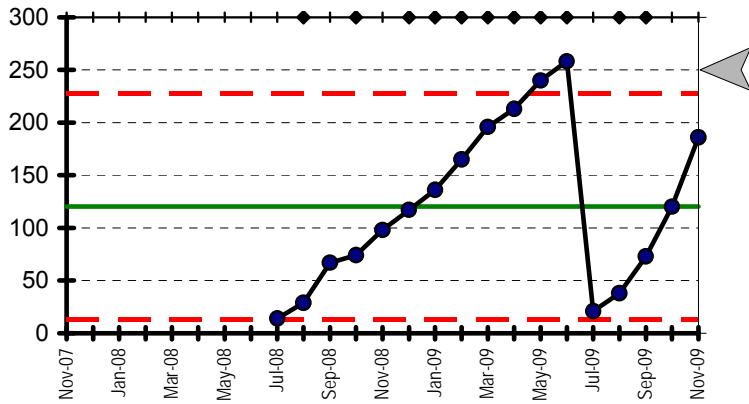
L01. Health assessments done of Early Childhood Education Centres



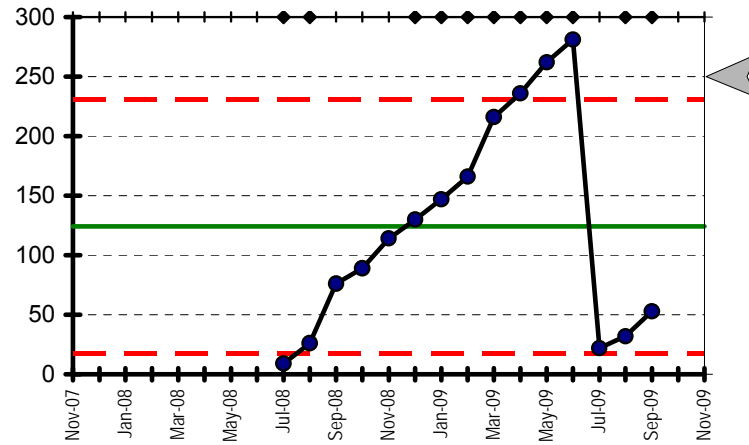
L07. Number enrolled on Pacific smoking cessation programs in Auckland DHB



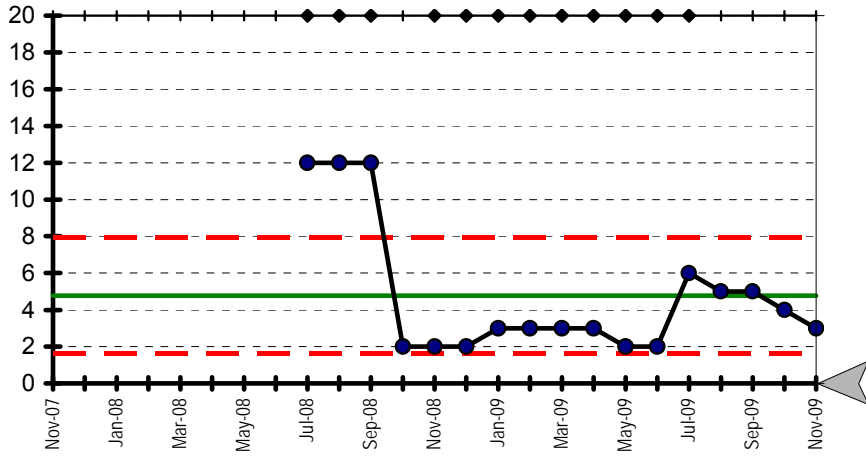
L47. Number of Healthy Housing Project - Assessments



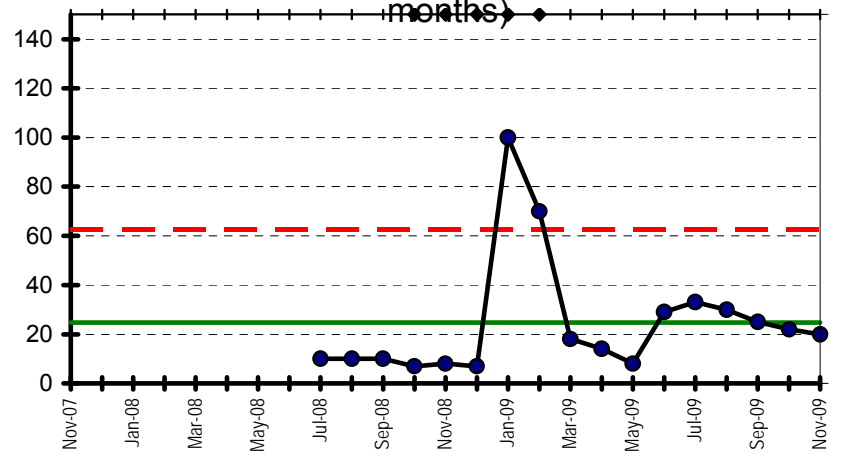
L48. Number of Healthy Housing Project - Health and social referrals



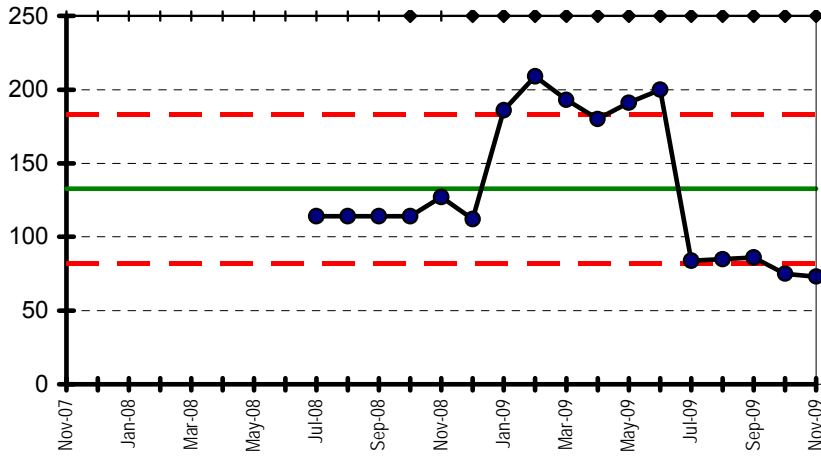
H1. Payments Made Against Unsigned Contracts



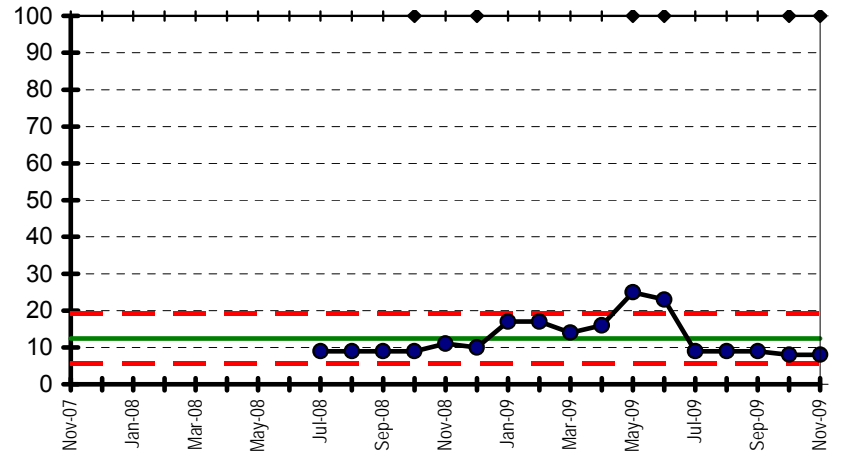
H2. Number of Contracts Expiring within next 6 months (including unresolved from previous months)



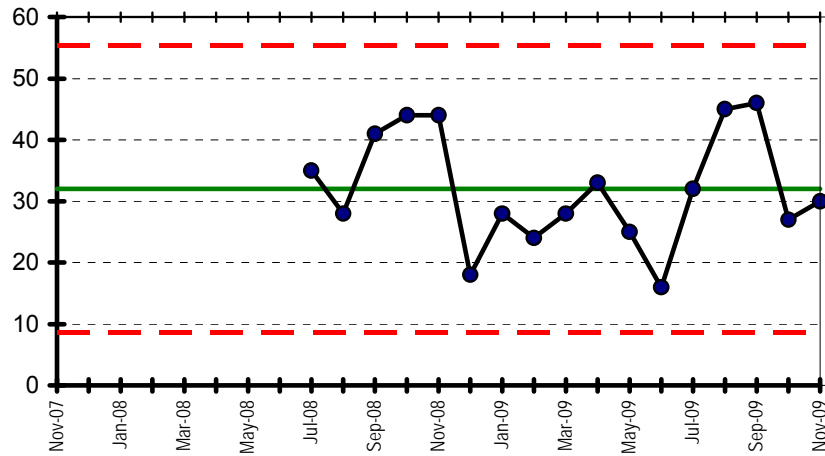
H3. Outstanding Moderate Risk Audit Issues



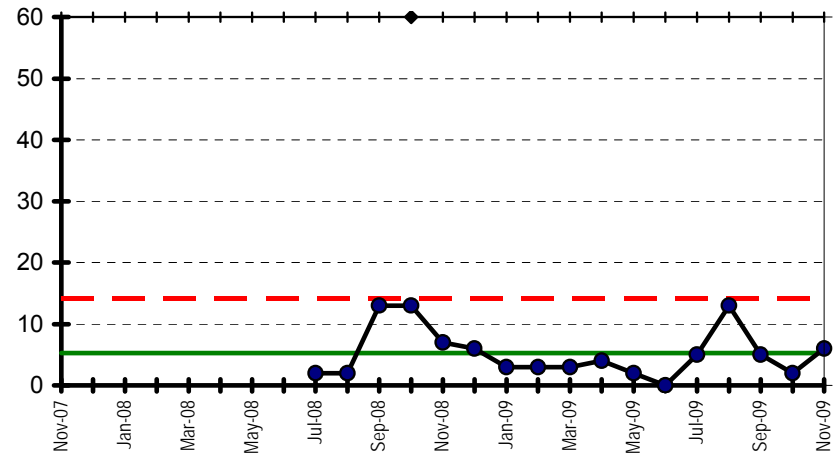
H4. Outstanding High Risk Audit Issues



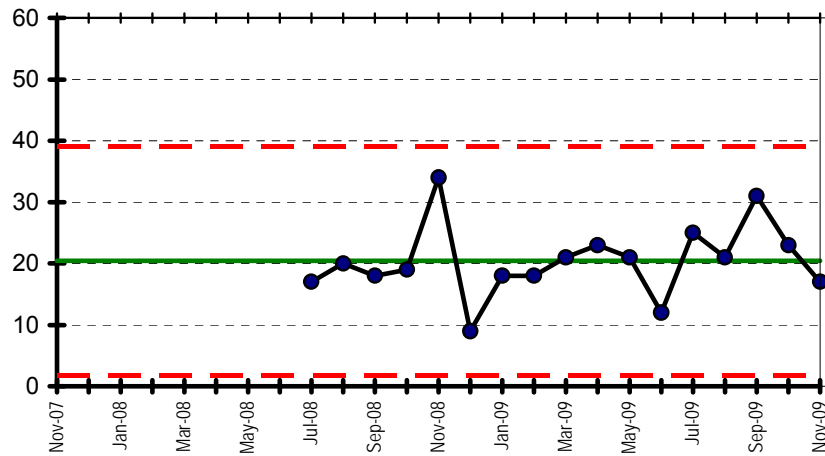
L44. Number of TB investigations - Total



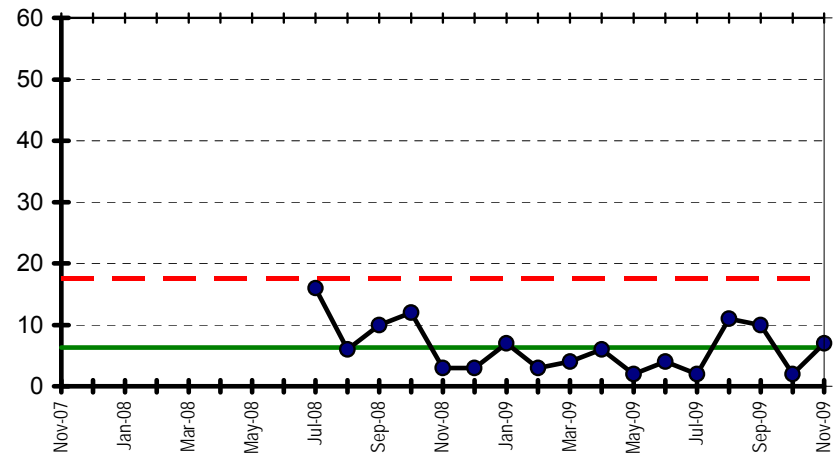
L44.b Number of TB investigations - Maori



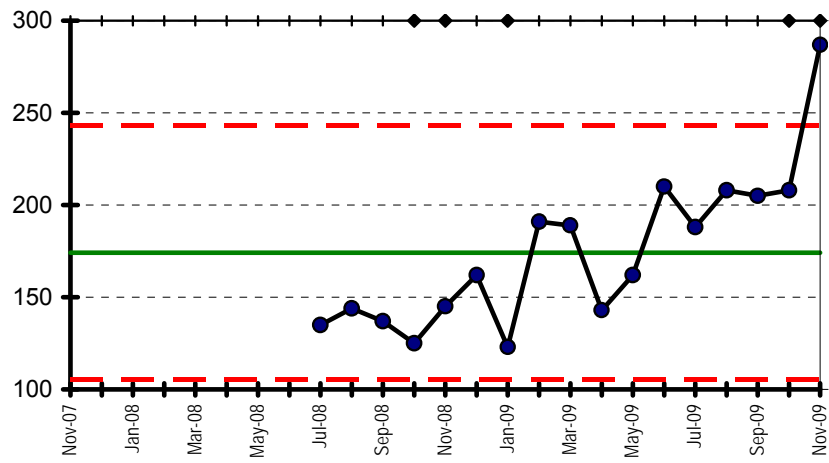
L44.c Number of TB investigations - Other



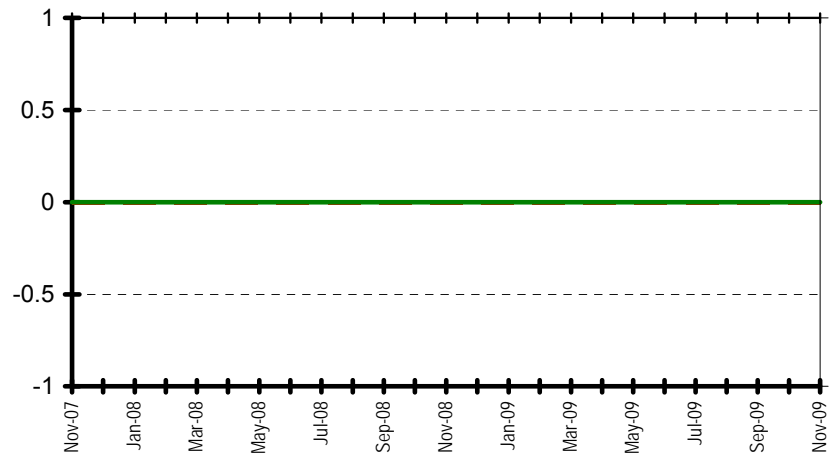
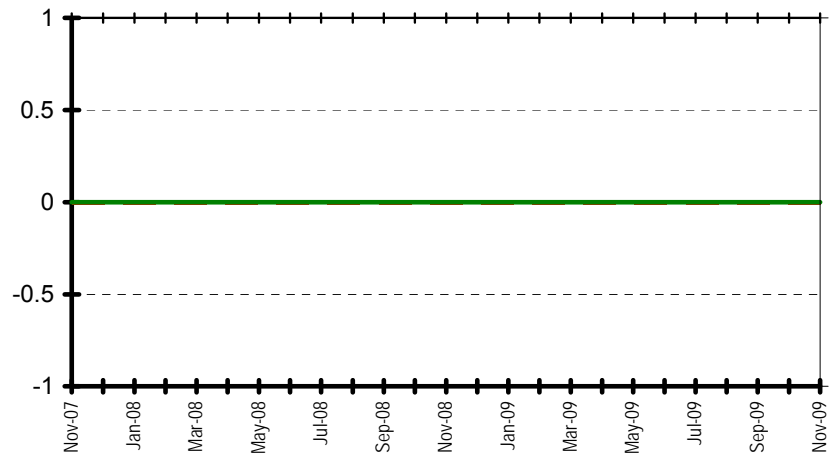
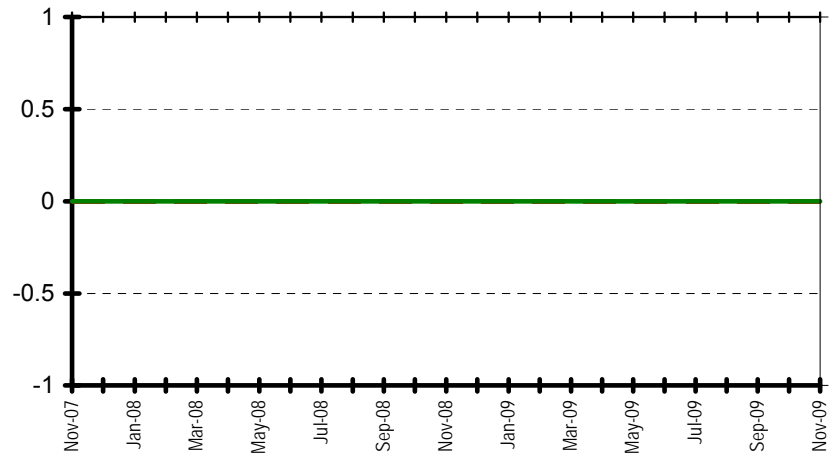
L44.d Number of TB investigations - Pacific



L45. Number of other (non-TB) disease investigations - Total



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IMPROVEMENT ACTIVITIES

7.1 DAP Projects Report

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

High Level Strategy	Objective	Strategies to achieve objectives	
Reduce inequities in health status	Maori	<ol style="list-style-type: none"> 1. Reduce Maori DNA rates. 2. Increase enrolment of Maori in PHOs 3. Rangatiratanga - Maori Health Equity Framework 	
	Pacific	<ol style="list-style-type: none"> 1. Healthy Village Action Zone (HVAZ) evaluation 2. Implement and monitor revised KPIs for HVAZ Parish Community Nurses 3. Healthy Village Action Zone leadership and coordination 	
Improve outcomes in priority areas	Children & young people	<ol style="list-style-type: none"> 1. Achieve agreed Ministry of Health immunisation targets (focus Maori & Pacific) 2. Increase PHO/primary care involvement in managing immunisation 3. Practice level reporting 3. Practice nurse NIR training 4. Maori immunisation initiative 	
		<ol style="list-style-type: none"> 1. Improve oral health outcomes for children 2. Auckland DHB wide oral health promotion 2. Implement new service model 	
	Older People	<ol style="list-style-type: none"> 1. Streamline access to older people's services 2. Create a single point of entry to services 2. Develop clinical triage according to need (direct referral to community support) 3. Establish new Home Based Support Services 4. Increase packages of care available 5. Restorative care process implemented 	
	Mental Health	<ol style="list-style-type: none"> 1. Increase effectiveness across primary, secondary & tertiary services 2. Eating Disorder Services 2. Reconfigure Maori Mental Health Services 3. Reconfigure current level 3 & 4 residential rehab services 4. Implement share care project (PROGRESS+) Primary /secondary integration 	
	Palliative Care	<ol style="list-style-type: none"> 1. Implement revised service model to align with client need 2. Unbundle current resources 2. Restructure programs to achieve effective use of general and specialist services 3. Increase the input of primary care teams in palliative care services 	
	Prevent & manage long term conditions	Strengthen community participation and action	<ol style="list-style-type: none"> 1. Work with Healthy Village Action Zones initiative to spread lessons 2. Plan the approach to maximise community engagement 3. Achieve target for cardiovascular risk screening
		Support whanau and self resilience	<ol style="list-style-type: none"> 1. Increase efficiency, capacity and options of self-management approaches
Proactive planned coordinated care		<ol style="list-style-type: none"> 1. Run a GP clinical network for long term conditions that develops planned care 2. Increase retinal screening capacity 3. Develop care pathways for people with long term conditions 	
	Intensive support for people with high needs	<ol style="list-style-type: none"> 1. Pilot case management 2. Increase the percentage of people utilising cardiac rehabilitation 3. Develop workforce for Kaupapa Maori cardiac rehabilitation 	

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

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

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

High Level Strategy	Objective	Strategies to achieve Objective
Manage Revenue	Ensure revenue received for services provided	<ol style="list-style-type: none"> 1. IDF annual agreements ensure we are paid for what we do. 2. Participate in National pricing process
	Reduce Administration Cost	<ol style="list-style-type: none"> 1. Improve HR payroll processing and leave management 2. Reduce back office cost (regional shared services) 3. Manage administration of M&A FTE cap
Improve Productivity	Improve Clinical Effectiveness	<ol style="list-style-type: none"> 1. Improve clinical resource utilisation 2. Reduce variation in Clinical Practice
	Health Service Process Improvement	<ol style="list-style-type: none"> 1. Implement improvement programs to reduce waste, improve flow and enhance the patient experience.
	Achieve procurement savings	<ol style="list-style-type: none"> 1. Leverage national/regional procurement initiatives 2. Refine procurement strategy 3. Deliver direct treatment cost savings 4. Deliver indirect treatment cost savings 5. Monitor and collect rebates within contracts for supplies and services
	Optimise stock holding	<ol style="list-style-type: none"> 1. Revisit replenishment parameters 2. Improve supply chain systems and processes
Manage Cash	Sustainable Cash Management Plan	<ol style="list-style-type: none"> 1. Asset Management Plan alignment with the Long Term Services Plan 2. Improve prioritisation process for new capital 3. Long term financial modelling process is implemented

Goal Level Summary Report (Community and Public Health Advisory Committee)

DAP Projects

Total Projects: 32

DAP GOAL	Number (#)	Started (#)	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1) Lifting the Health of the people in Auckland City	25	25	8	2	4	7	2	0	24	1	0	25	0	0	25	0	0	2	0	0	0
2) Performance Improvement	7	7	5	0	1	1	0	0	6	1	0	7	0	0	7	0	0	0	0	0	0
3) Living within our Means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	32	32	13	2	5	8	2	0	30	2	0	32	0	0	32	0	0	2	0	0	0
Totals %	100%	100%	41%	6%	16%	25%	6%	0%	94%	6%	0%	100%	0%	0%	100%	0%	0%	6%	0%	0%	0%

High Level Summary Report

Goal 1 Lift the Health of the people in Auckland City

DAP Projects

Total Projects: 25

DAP HLS	Number (#)	Started (#)	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1.1 Reduce inequalities in health status	5	5	1	0	1	3	0	0	5	0	0	5	0	0	5	0	0	0	0	0	0
1.2 Improve outcomes in priority areas	14	14	4	1	3	3	2	0	14	0	0	14	0	0	14	0	0	1	0	0	0
1.3 Prevent and manage long term conditions	6	6	3	1	0	1	0	0	5	1	0	6	0	0	6	0	0	1	0	0	0
Totals #	25	25	8	2	4	7	2	0	24	1	0	25	0	0	25	0	0	2	0	0	0
Totals %	100%	100%	32%	8%	16%	28%	8%	0%	96%	4%	0%	100%	0%	0%	100%	0%	0%	8%	0%	0%	0%

Goal 1 Lift the Health of the people in Auckland City

No comment has been added against this goal.

Objectives:

Objective	Objective Owner	Comment
1.1.1 Increase Maori access to services	Naida Glavish (ADHB)	This objective has 3 major DAP projects, DNA reduction, Increasing Maori enrollments in PHO and the Maori health outcomes Framework. All projects have significant challenges given the current health sector constraints. However all projects are currently on track.
1.1.2 Build healthy Pacific Communities	Hilda Faasalele (ADHB)	COngoing engagement with Pacific communities. Pacific Summit held on Oct 1st to engage and gain input by Pacific into ADHB District Strategic Plan. Consultation on ADHB Pacific Action Plan. Analysis of feedback of feedback in progress.
1.2.1 Achieve agreed Ministry of Health children and young people's immunisation targets (focus Maori and Pacific)	Denis Jury (ADHB)	Good progress continuing
1.2.2 Improve oral health outcomes for children and young people	Denis Jury (ADHB)	Continuing good progress -mobiles deliver in Dec and build tenders about to close.
1.2.3 Streamline access to older people's services	Denis Jury (ADHB)	Good progress and work continuing on funding models
1.2.4 Increase effectiveness of mental health services across primary, secondary and tertiary services	Denis Jury (ADHB)	Good progress across all projects -regional management of Eating Disorder Service Implementation satisfactory
1.2.5 Implement revised palliative care service model to align with client need	Denis Jury (ADHB)	Good progress, but with changes to timelines to coordinate with secondary service devolvement work.
1.3.1 Strengthen community participation and action	Celia Palmer (ADHB)	To date one project is funded under this objective and this is progressing well. There are other projects which could be potentially linked to this objective e.g. HVAZ. Further projects should be planned to fully deliver on this objective
1.3.2 Support whanau and self resilience	Naida Glavish (ADHB)	There are no DAP projects against this objective at present.
1.3.3 Proactive planned coordinated care	Celia Palmer (ADHB)	There is no funding attached to the care pathways project yet this has huge potential to deliver on the objective. It may be that this can be linked to the devolution work in order to make sure the work is linked to some resource otherwise it will not be able to deliver .
1.3.4 Intensive support for people with high needs	Denis Jury (ADHB)	Progress good
1.1.3 Increase refugee population access to services	Denis Jury (ADHB)	Focus continues on uptake of primary care interpreting pilot.

Exceptions:

There are no projects to display

High Level Summary Report

Goal 2 Performance improvement

DAP Projects

Total Projects: 7

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

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performance in clinical quality& professional governance	1	1	1	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
2.7 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.8 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.9 Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	7	7	5	0	1	1	0	0	6	1	0	7	0	0	7	0	0	0	0	0	0
Totals %	100%	100%	71%	0%	14%	14%	0%	0%	86%	14%	0%	100%	0%	0%	100%	0%	0%	0%	0%	0%	0%




Goal 2 Performance improvement

No comment has been added against this goal.

Objectives:

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

Exceptions:

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

PAPERS

8.1 Primary Care Business Cases

8.2 DAP and SOI Update

8.3 Youth Health Improvement Plan Finalisation

8.4 Review of Funding Contracts Using the Results Framework

PAPER IN PUBLIC EXCLUSION

8.5 Health Select Committee Response

8.6 Auckland Regional Public Health Service Funding

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Community and Public Health Advisory Committee Paper

Date	Wednesday 27 January 2010
To	Community and Public Health Advisory Committee
From	Dr Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 09 630 9943 ext 8071 Mobile: 021 306 044 Email: denisj@adhb.govt.nz
Author	Andrew Coe, Manager PHOs and Primary Care Auckland District Health Board Level 8, Building 13, Greenlane Clinical Centre Email: acoe@adhb.govt.nz Mailing: Private Bag 92-189, Auckland 1142 Phone 09 630 9943 Ext 4085 Mobile: 021 242 3923
Functional Group	Planning and Funding Functional Group
Subject	Primary Care Business Cases
1	<p>Purpose To provide CPHAC with an understanding of the primary care business cases being developed with regard to;</p> <ul style="list-style-type: none"> - scope - key features - finances - implementation
2	<p>Recommendations You are requested to;</p> <ul style="list-style-type: none"> - Note each business case in the context of reviewing and approving for ADHB support at the 17 February CPHAC meeting, - Provide feedback on the business cases to the proposers on any ADHB requirement; - Update ADHB 3 February Board meeting.
3	<p>Background In November 2009 ADHB was advised by the Ministry of Health that in its area where three respondents to the request for "Expressions of Interest" in the further development of primary care provision. The successful respondents were;</p> <ol style="list-style-type: none"> i) Maori PHO Coalition ii) Alliance Health+ (Pacific Coalition) iii) Greater Auckland Integrated Health Network (GAIHN) <p>These organisations are now well advanced with the development of business cases for their proposals and these are required to be submitted to the Ministry of Health by 1 March 2010.</p> <p>Each group will provide a brief written summary (to be provided separately by 25 January) and will be at the 27 January meeting to present and discuss their business case.</p>

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COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE Paper

Date	Wednesday 27 January 2010			
To	Community and Public Health Advisory Committee			
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denisj@adhb.govt.nz			
Author	Julie Helean Ext 4390 jhelean@adhb.govt.nz Ajit Arulambalam Ext 26560 ajita@adhb.govt.nz			
Functional Group	Planning and Funding Functional Group			
Subject	2010-2011 District Annual Plan			
1	<p>Purpose The final planning package has now been released with instructions on health targets and the other requirements for the Annual Plan and the Statement of Intent. This paper updates the backgrounder provided to Committee members at the November 2009 meeting.</p> <p>Key areas of focus outlined in the DAP guidelines include:</p> <ul style="list-style-type: none"> • the six health targets and Ministry signals re the Minister's expectations • DHBs living within current budget constraints • development of Performance Improvement Actions (PIAs) • productivity performance and quality improvements, specifically hospital productivity improvements in wards, theatres, and day surgeries • service coverage changes including the impact of regional plans • local priorities where significant to overall business • agreed DHB performance measures • complete an Information System Strategic Plan Activity Sheet <p>Given the expected impact from the three primary health care EOIs underway, the Annual Plan will also need to cover the likely impacts in the 2010-11 year from the changes proposed in the respective business cases.</p> <p>Given the requirement to submit a draft District Annual Plan and Statement of Intent in mid March 2010, the Board and Committees will need to give full consideration to these documents at their February 2010 meeting, with Board approval requested at the March meeting. Draft material will be circulated to Committee and Board members as a hard copy early February, with the intention that the content be discussed in depth at the CPHAC February meeting.</p>			
2	Recommendations	DAP	DSP	Budget
	That the Committee note the updated time-frame for submitting the DAP and SOI to the Ministry of Health			
	Committee members note the health targets for 2010-11 and other plans under construction			
	The Committee note the preliminary analysis of the Funding Envelop			
3	<p>Minister's Letter of Expectations The Minister's Letter of Expectations has not yet been released. However the Ministry of Health signal that these will continue the focus on ensuring that health services deliver better, sooner and more convenient care for all New Zealanders. It is therefore anticipated that the Minister's expectations for 2010-11 will include:</p> <ul style="list-style-type: none"> • exhausting all options to make sufficient efficiency gains and build enough financial headroom into 			

District Annual Plans to ensure DHBs can deliver agreed financial results

- achieve all the targets in the agreed timeframes
- work closely with primary and community providers to develop new models of care that help keep people well, reduce avoidable hospital admissions and readmissions, shift hospital services to primary settings when appropriate and improve referral and prescribing practice
- improve retention of permanent clinical staff, reduce vacancy rates and strengthen clinical leadership and clinical networks
- identify and implement those productivity improvements, quality improvements, procurement and shared back office functions that will deliver a significant improvement in hospital productivity and service safety and quality to generate additional savings in 2010-11
- identify those services that can have the largest impact on improving Māori health status and report against the set of headline indicators that will be announced during 2010
- work with the Ministry and the National Health Board to implement cabinet decisions relating to national services, regional service planning, workforce, IT and national shared services functions.

Health Targets

The core targets set for the 2009-10 year are retained for 2010-11.

Shorter stays in Emergency Department	95 percent of patients admitted, discharged, or transferred from Emergency Department within six hours
Improved access to elective surgery	The volume of elective surgery increased by an average 4,000 discharges per year (compared with the previous average increase of 1,400 per year)
Shorter waits for cancer treatment	Everyone needing radiation treatment have this within 6 weeks by July 2010, and within 4 weeks by Dec 2010
Increased immunisation	90 percent of two year olds fully immunised by July 2011; and 95 percent by July 2012
Better help for smokers to quit	90 percent of hospitalised smokers provided with advice and help to quit by July 2011; and 95 percent by July 2012 80 percent of patients attending primary care provided with advice and help to quit by July 2011; 90 percent by July 2012; and 95 percent by July 2013
Better diabetes and cardiovascular services	Increased percent of: <ul style="list-style-type: none"> • the eligible adult population have had their CVD risk assessed in the last 5 years • people with diabetes attend free annual checks • people with diabetes have satisfactory or better diabetes management

There are now a reduced number of performance measures which DHBs must achieve in addition to the six national targets for health. Although targets are set by the Ministry of Health, Auckland DHB may negotiate these where appropriate.

Implementation of Better, Sooner, More Convenient primary health care	DHBs involved in the development of business cases with successful Expression of Interest providers are required to report on progress of the implementation of those changes as agreed to in their District Annual Plan
Local Iwi/Maori engagement and participation in DHB decision-making, development of strategies and plans for Maori health gain	Report demonstrating, across seven key aspects, local Iwi/Maori engagement and participation in DHB decision-making, development of strategies and plans for Maori health gain
Improving mainstream effectiveness	Report providing information on the activities undertaken to improve mainstream effectiveness ensuring clinical safety and effectiveness for Maori
Waiting times for chemotherapy treatment	Report providing wait times data including an exceptions report where wait times exceed 6 weeks
Improving the health	The average number of people in Auckland DHB, seen per year

status of people with severe mental illness through improved access	(rolling every three months) for: <ul style="list-style-type: none"> child and youth aged 0-19, for Maori, Other, and in total adults aged 20-64, for Maori, Other, and in total older people aged 65+, for Maori, Other, and in total
Improving mental health services using crisis prevention planning	Report on crisis prevention planning <ul style="list-style-type: none"> number of adults and older people (by Maori, Pacific and Total) with enduring serious mental illness who have been in treatment for two years or more since the first contact with any mental health number of children and young people (by Maori, Pacific and Total) who have been in secondary care treatment for one or more years number and percentage of long-term clients with up to date crisis prevention/resiliency plans
Report alcohol and drug service waiting times and waiting lists	Narrative report on: <ul style="list-style-type: none"> name and location of service(s) with the longest waiting time and waiting list explain variances of more than 10% in waiting times or waiting lists explain/identify targets that the DHB may have for reducing waiting times and or waiting lists Waiting times reported by Maori and Other ethnicities
Delivery of Te Kokiri: the Mental Health and Addiction Action Plan	Summary report on progress made towards Implementation of Te Kokiri: the Mental Health and Addiction Action Plan
Oral health – Mean DMFT score at year 8	Report providing oral health DMFT data Total number of permanent teeth of year eight children, Decayed, Missing (due to caries), or Filled and the total number of caries free children at the commencement of dental care, at the last dental examination, before the child leaves the DHB Community Oral Health Service (by ethnicity breakdown)
Children caries free at 5 years of age	Report providing oral health caries free data Total number of caries free children and the number of primary teeth decayed, missing (due to caries), or filled at the first examination after the child has turned five years, but before their sixth birthday Data by Maori, Pacific and Other
Utilisation of DHB funded dental services by adolescent from Year 9 up to and including age 17 years	Total number of completions and non-completions for adolescent patients plus additional adolescent examinations with other DHB funded dental services (e.g. Community Oral Health Service, Maori Health providers and other contracted providers) Ethnicity breakdown by Maori, Pacific and Other Adolescents are from Year 9 up to 17 years
Improving the number of children enrolled in DHB funded dental services	Report providing oral health enrolment data Total number of children enrolled with DHB funded dental services under age five years Ethnicity breakdown by Maori, Pacific and Other
Family violence prevention	Report confirming audit score targets are met Data provided to DHB by the Auckland University of Technology (AUT) Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit

For 2010-11 there is a new requirement for additional savings-focused Performance Improvement Actions. These will be linked to the Ministry's Performance Improvement Actions and demonstrate that Auckland DHB is committed to achieving sector wide savings. Auckland DHB specific Performance Improvement Actions are still under development and will take the form of specific actions linked to the objectives below:

- Health targets delivered to agreed level and on time
- New models of care focused on innovative use of workforce
- Improved Hospital Productivity: hospital wards, theatre use and emergency department
- Primary Care Implementation Plan - strengthen focus on chronic disease management and reducing avoidable hospitalisation
- Contain rate of employment cost growth
- Maximum use of settings to enforce plans and deliver improved value against price, quantity and standards

4 Funding Envelope

For 2010-11, Auckland DHB has received \$46m more in real terms than for the current year. Population Based Funding share has dropped due to higher increases in other DHBs (with relatively higher need population segments), leading to a 3% increase in population base funding (i.e. \$27m increase). At the same time, top slices in real terms have reduced by \$21k.

Inter District Flow prices have increased from \$4,318 to \$4,410 per case-weight. This means that there is an overall net revenue increase to Auckland DHB of \$19m (this is subject to change due to ongoing discussion between DHBs).

	PBF	Top Slice	IDF In	IDF Out	total
0910 Base Funding	\$892,314,573	\$36,956,920	\$554,265,237	-\$96,961,096	\$1,386,575,634
SMO Funding Return to base	\$1,497,934	-\$1,497,934	\$-	\$-	\$0
Reduction in the SMO settlement	-\$1,012,753	\$-	\$-	\$-	-\$1,012,753
Reduction in the Human Papillomavirus Immunisation pro	-\$559,000	\$-	\$-	\$-	-\$559,000
2010/11 Starting Point	\$892,240,754	\$35,458,986	\$554,265,237	-\$96,961,096	\$1,385,003,881
Increase in Base	\$27,821,231	\$-	\$-	\$-	\$27,821,231
Increase in Topslice	\$-	\$1,280,881	\$-	\$-	\$1,280,881
Change in IDF Inflows	\$-	\$-	\$22,991,972	\$-	\$22,991,972
Change in IDF Outflows	\$-	\$-	\$-	-\$3,995,594	-\$3,995,594
Dec 09 Release	\$920,061,985	\$36,739,867	\$577,257,209	-\$100,956,690	\$1,433,102,371
Corection to phncw and AT&R IDFS inflows	\$-	\$-	-\$1,307,630	\$-	-\$1,307,630
Corection to phncw and AT&R IDFS outflows	\$-	\$-	\$-	\$489,034	\$489,034
Dec 09 Release with corrections	\$920,061,985	\$36,739,867	\$575,949,579	-\$100,467,656	\$1,432,283,775

Nationally, demographic growth has been allowed at a 1.89% increase, and cost increase of 1.73% (total increase to all DHB funding is 3.6%). It is likely that additional funding will be made available by the Ministry of Health from the eventual transfer of its non-devolved funding (e.g. public health, etc).

Per capita expenditure on community pharmaceuticals has been funded so that the level of future spend (and the assumed use by patients over 2010-11) will be maintained at the existing level. This means an increase nationally of \$10m to \$704m from \$694m (2009-10).

DHBs are expected to restrain cost growth, reduce waste and improve productivity. The Minister's expectations are that Auckland DHB will maintain core services (in line with the national Quality Policy Framework, National Service Coverage and Service Schedules). The DHB must also 'demonstrate' service growth that is in line with demographic trends. Accordingly, the Funding Envelope has noted that 'first contact patient care' should be funded to meet population growth; and that savings will need to be achieved from PHO management fees and others.

The full costs of renegotiated agreements for various collective employment contracts that will expire in 2009-10 and 2010-11 will need to be absorbed within base funding.

5 Summary of objectives for 2010-2011

As in previous years, the Annual Plan is constructed around a driver diagram that helps us manage the hierarchy of objectives from the high level strategic direction to the actions at the service delivery level. Again, we cluster objectives under three goal areas. The three tables below show the first cut at objectives to meet strategic goals. Included, are those priority actions over and above our business as usual which we have dedicated funding for.

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

High level strategy	Objective	Strategies to achieve objectives
---------------------	-----------	----------------------------------

Reduce inequities between groups: Maori, Pacific, high need neighbourhoods	Increase local access to services in high need neighbourhoods	Prioritise the development of Integrated Family Health Centres in high need areas as a priority Provide support for Whanau Ora strategies Integrate the Healthy Village Action Zones with the Integrated Family Health Centres Reduce DNA rates
Improve outcomes in priority areas		
Children and young people	Achieve immunisation targets	Implement Auckland DHB's immunisation strategy, working with other sectors Work with EOI (primary care) respondents on actions to improve immunisation rates Support the Maori coalition to deliver their work with Tamariki
	Improve the oral health of children	Auckland DHB wide oral health promotion Implement the new service model for oral health
Older people	Complete implementation of Home Based Support Services and restorative homecare initiatives	Complete the funding methodology for home based services Work with primary care (EOI) respondents and primary care to align with homecare services
	Quality improvement in residential care	Work with related Aged Residential Care partners to pilot the EDEN philosophy
Mental health and addictions	Increase effectiveness across primary, secondary, tertiary services	Expand primary mental health, linking initiatives to include accessibility to a range of therapies Complete the reconfiguration of Maori mental health services Complete the reconfiguration of levels 3 and 4 residential rehabilitation services
Long term conditions	Strengthen community participation and action	Work with EOI respondents to ensure locality networks and integrated family health centres encourage and act as a catalyst for community participation and action.
	Integration of specialist and generalist services	Pilot models of working across specialist and generalist services that provides a better patient experience. Work towards joined up care plans and advanced care planning
	Empowering primary care	Work with EOI respondents to <ul style="list-style-type: none"> Empower primary care to take a greater role in managing long term conditions especially mental health, diabetes, cardiovascular disease and COPD. Increase access to diagnostics
	Support whanau and self resilience	Increase information available to individuals and their whanau Provide a range of options that will enhance self-management and resilience. Consider piloting the use of coaching services to support people with long term conditions Continue to develop smoking cessation services

Goal 2. Performance improvement: Sooner, Better, More Convenient

High level strategy	Objective	Strategies to achieve objectives
Efficiency and effectiveness across the health care system		
Primary healthcare	Provide efficient and effective coordinated care in the neighbourhood	Establish Integrated Family Health Centres in areas of high need
	Improve access to afterhours primary care, including palliative and residential care	
Improve primary-secondary system efficiency	Improve access and efficiency of service delivery	e-referrals, health event summaries and electronic outpatient letters Increase access to diagnostic testing in primary care Transfer some services to primary/community (devolution)

		<p>Transfer some services to primary/community (devolution)</p> <p>Implement a shared care planning platform between primary and secondary care</p> <p>Pilot a model(s) that better integrates specialist and generalist services</p>
	Reduce acute demand	<p>Improve the acute capacity management</p> <p>Support for GAIHN and other EOI initiatives – likely to include changes to after hours and Primary Options</p>
<p>Improve quality of hospital care while improving productivity (eliminating waste)</p> <p>Measure: Hospital quality and productivity scorecard</p>	<p>Improve cardiac surgery throughput</p> <p>Improve performance against the ED 6 hour measure from 70 to 95%</p> <p>Improve acute operating room productivity. Waiting time for acute surgery from A to B.</p> <p>Improve quality and safety of patient care</p> <p>Health service improvement to improve quality of care and productivity</p> <p>90% of hospitalised smokers will be given assistance to stop smoking (national target)</p> <p>Reduce waiting times for oncology and BMT</p>	<p>Cardiac surgery project. Complete implementation of the 10 workstreams</p> <p>Implement changes from Children's and Adults acute flow projects</p> <p>Implement the productive operating theatre</p> <p>Consolidate and implement the NQIP projects</p> <p>Increase consumer involvement in improvement (e.g. Consumer Council)</p> <p>Implement early warning score system. DAP or FG</p> <p>Implement releasing time to care across Adult and Mental Health services</p> <p>General Medicine</p> <p>Orthopaedics</p> <p>Radiology</p> <p>Paediatrics general surgery.</p> <p>General surgery.</p> <p>Concord</p> <p>Ophthalmology (as part of GSC)</p> <p>Implement Tobacco Control Plan and 'ask about the elephant' campaign</p> <p>Improve service scheduling process and use of day stay</p> <p>Complete the Northern region 2009-2019 strategic plan for sustainable delivery of radiation oncology</p> <p>Tumour stream model implementation</p>
<p>Reduce waiting times and increase intervention rates</p>	<p>Increase intervention rates from A to B</p> <p>National targets and Auckland DHB volume targets</p>	<p>Greenlane Elective Services Commissioning</p> <ul style="list-style-type: none"> • Improve DOSA rates • Improve Pre-Admit process
<p>Improve leadership capability</p>		
<p>Clinical quality and professional governance</p>	<p>Clinical leadership model. Improve against the reporting framework</p>	<p>Implement a 'Leadership for improvement' training and mentoring programme.</p> <p>Implement Leadership Walkaround project</p> <p>Embed KPI reporting and benchmarking in clinical structures</p>
	<p>Implement sector-wide clinical networks</p>	<p>Participate in the cancer, cardiac & other clinical networks</p> <p>Support the development and implementation of national clinical networks</p> <p>Support the development of locality based primary and secondary networks</p>
	<p>Improve quality and safety of care</p>	<p>Implement NQIP medication safety, infection, prevention and control, mortality review, incident management</p>
<p>Strengthen the health workforce</p>	<p>Improve clinical staff retention. Turn over reduced from A to B</p>	<p>Define, train and implement new workforce roles</p> <p>Review performance-based incentive programmes</p> <p>Improve the ease of application and entry</p>
	<p>Increase the percentage of Maori and Pacific employees in the workforce</p>	<p>Implement the Tamaki Project</p>
<p>Information</p>		

management	Improve resilience and availability of core IT systems	Implement the resilience improvement plan Phase 3 and 4 delivered on time
	Improve corporate records and knowledge management. Achieve level 1 PRA compliance	Improve capability to manage corporate information
Planning	Regional Information Strategic Plan	Regional Strategic Plan developed in alignment with NZ HIS 2009 Auckland DHB Health Services Planning

Goal 3. Live within our means

High level strategy	Objective	Strategies to achieve objectives
Breakeven position maintained		
Manage revenue	Ensure revenue received for services provided	Reconfigure Renal Services in response to Waitemata DHB transfer Manage revenue risks and opportunities arising from implementation of the National Health Board Participate in the National Pricing Process, particularly risk arising for 2011-12 paediatrics tertiary adjuster Manage service reconfigurations financial impacts within Vote Health parameters
Achieve productivity gain	Manage costs within budget	National/ Regional Shared Services Align HR systems regionally (Payroll and Taleo) Reduce back office cost (national and regional shared services) and align processes in HR and FMIS Manage the FTE cap for management and administration staff Manage leave and sick balances (FTE or Admin) Improve HR payroll processing and leave management Manage IR negotiations against financial risk MECA negotiations
	Achieve procurement savings	Leverage national /regional procurement initiatives Progress procurement strategy (national and regional) and supply chain processes National Air Ambulance ECMO
	Manage Direct Treatment Costs	Reduce waste and clinical variation Improve the use of clinical resources Improve flow and enhance the patient experience
Sustainable Balance Sheet		
Manage cash	Sustainable cash management	Asset Management Plan (AMP) alignment with the Long Term Services Plan Cash/Financing Plan alignment with AMP and Long Term Services Plan

5	<p>Primary Health care EOIs</p> <p>Work on the GAIHN EOI business case has advanced over the last month with a second summit scheduled for January 28th. While the second summit hopes to present draft material for wider discussion there will not be final material to bring into the district annual plan by the close off date of 10 February. CPHAC members considering the 2010-11 Annual Plan presented at their 17th February meeting will receive draft material relevant to the three regional EOIs but this is likely to be very draft.</p> <p>The overlap of DAP and EOI deadlines means that the DAP will not be able to include specific re the first year actions committed to under the EOIs. Auckland DHB can however make a commitment to working as a partner through the EOI process and to implement those actions required of it in year one. We will ensure that the DAP wording re primary health care development is common to the three Auckland DHBs.</p>
6	Other Regional Implications

	<p>In addition to planning for their district health needs, there is a requirement for DHBs to reflect Regional Service Planning in their District Annual Plans. As in previous years there is good alignment between the Northern region DHBs in areas of common interest .e.g. mental health, public health, regional service planning, Treaty relationships.</p> <p>The Auckland DHB works closely with other key stakeholders in the development of the Planning documents, particularly, Tihi Ora MaPO, NDSA, provider arm and other provider, stakeholder groups, DHBNZ, and the Ministry of Health.</p> <p>Given the recommendations from the Ministerial Review Group, there will be considerable regional work associated with the development of the District Strategic Plan, including alignment with the Regional Clinical Services Plan.</p> <p>Our Relationship Manager at the Ministry of Health is Richard Schmidt. Richard works closely with the four northern DHBs to make sure that problems are resolved promptly and that there is a good flow of information with clear lines of communication/accountability.</p>																								
7	<p>Issues and Risks</p> <p>There is a requirement to commit to Performance Improvement Actions with saving targets calculated. There will also be more of a focus on comparing the performance of DHBs via a national report card.</p> <p>While DHBs are required to breakeven year on year with no changes to service coverage, there will need to be careful consideration of all contracts in the 2010-11 year to ensure we are getting the best value for money.</p> <p>The usual practice of having various iterations of the planning documents reviewed by the Ministry will be replaced by one review period in March. This requires that the document, and all supplementary templates, be in final form by the 12 March handover date.</p> <p>The preparation of the Price Volume Schedule is changing to a new system of using actuals for the previous year to forecast planned volumes for the year ahead.</p> <p>The Annual Plan and Statement of Intent no longer link closely to our 2006 District Strategic Plan. Our District Strategic Plan needs to be updated to align with government policy and to show the growing focus on agreed regional goals and regional planning. Ministry requirements re District Strategic Plans are due to be released in February.</p> <p>Although the Statement of Intent conforms to the Ministry of Health guidelines and template, the mapping of finances against the four output classes will be difficult. This is a new requirement which needs considerable analytical work.</p>																								
8	<p>2010-11 Revised Timeline: Annual Plan and Statement of Intent</p> <table border="1" data-bbox="197 1368 1453 1783"> <thead> <tr> <th></th> <th>Annual Plan</th> <th>Statement of Intent</th> </tr> </thead> <tbody> <tr> <td>Jan/Feb 2010</td> <td>Minister's Letter of Expectations sent to DHB CEOs</td> <td>SOI Guidelines sent to DHBs</td> </tr> <tr> <td>Feb 2010</td> <td colspan="2">National workshop of DHBs to discuss DHB DAP/SOI</td> </tr> <tr> <td>12 March 2010</td> <td>Completed draft District Annual Plan submitted to Ministry. Includes: <ul style="list-style-type: none"> ▪ Annual Plan as a word document ▪ Annual Plan financial templates </td> <td></td> </tr> <tr> <td>19 March 2010</td> <td></td> <td>Completed draft SOI submitted to Ministry</td> </tr> <tr> <td>13 April 2010</td> <td>Ministry provides formal feedback on the draft DAPs to DHBs</td> <td>Ministry provides formal feedback on the draft SOIs to DHBs</td> </tr> <tr> <td>26 May 2010</td> <td>Final Board approved DAP submitted to Ministry</td> <td></td> </tr> <tr> <td>28 May 2010</td> <td></td> <td>Revised SOI submitted to Ministry</td> </tr> </tbody> </table>		Annual Plan	Statement of Intent	Jan/Feb 2010	Minister's Letter of Expectations sent to DHB CEOs	SOI Guidelines sent to DHBs	Feb 2010	National workshop of DHBs to discuss DHB DAP/SOI		12 March 2010	Completed draft District Annual Plan submitted to Ministry. Includes: <ul style="list-style-type: none"> ▪ Annual Plan as a word document ▪ Annual Plan financial templates 		19 March 2010		Completed draft SOI submitted to Ministry	13 April 2010	Ministry provides formal feedback on the draft DAPs to DHBs	Ministry provides formal feedback on the draft SOIs to DHBs	26 May 2010	Final Board approved DAP submitted to Ministry		28 May 2010		Revised SOI submitted to Ministry
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9	<p>Appendices available on request</p> <p>Nil</p>																								

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Community and Public Health Advisory Committee Paper

Date	Wednesday 27 January 2010		
To	Community and Public Health Advisory Committee		
From	Dr Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: ext 8071 Email: denisj@adhb.govt.nz		
Author	Carol Stott, Planning and Funding Manager, Children, Youth and Women's Health. Phone: ext 4341. Email: carols@adhb.govt.nz Ruth Bijl, Projects Manager, Children, Youth and Women's Health, Planning and Funding. Phone: ext 27920. Email: RBijl@adhb.govt.nz		
Functional Group	Planning and Funding		
Subject	Youth Health Improvement Plan finalisation		
1	Purpose		
	<p>In May 2009 you approved public consultation on a draft Youth Health Improvement Plan. This paper describes how that feedback has been incorporated into a final draft Plan. Finalising this Plan will reflect the importance of and recognition for young people's needs in ADHB. While no new funding is anticipated to deliver against the Plan it is expected that benefits will accrue to youth as a consequence of stating youth health priorities, clarifying expectations and encouraging youth friendly health services provision. You are requested to:</p> <ul style="list-style-type: none"> - Approve finalisation and dissemination of the ADHB Youth Health Improvement Plan. 		
2	Recommendations		
		DAP	DSP
	Approve finalisation and dissemination of the ADHB Youth Health Improvement Plan.		
3	Description of Solution (Option)		
	It is proposed to finalise the Youth Health Plan. This will be accompanied by a launch in April 2010.		
4	Background		
	<p>The draft Youth Health Improvement Plan you approved for consultation was well received. The quality of submissions from 15 submitters was high. Several were generally supportive of the plan and commended the process used to develop it. They all provided feedback as to how the plan could be improved, the issues on which the plan should be focused, and what should be done to ensure its implementation was a success. Overall, the feedback highlighted some key issues to be addressed or given greater emphasis:</p> <ul style="list-style-type: none"> - Healthy sexual development (not only focusing on heterosexual development and/or sexually transmitted infections) - Minimising the cost of, and maximising access to clinical services, especially in primary care 		

	<ul style="list-style-type: none"> - Clinical leadership and knowledge about youth health - Preventing violence and provision of support for victims - Mental health and well-being (by supporting stable relationships, a sense of belonging and achievement and connectedness) - A safer, more supportive social environment - Better information through more youth accessible channels, including clearly sign-posting pathways for accessing health services. <p>There were also some common points of view about the keys to making the Youth Health Plan a success:</p> <ul style="list-style-type: none"> - Strengthen the linkages between ADHB and other agencies advancing Youth health, including current providers, NGOs and educational institutions. - Engaging youth in the development of youth services. <p>In response to the consultation feedback the Plan has been revised, in particular by the inclusion of a set of defined outcome measures. These will be refined over time but highlight the key domains and encourage a systematic approach to monitoring performance of the health and associated systems for our young people. We expect to report to you on this more in the future.</p>
5	<p>Options Considered</p> <p>Due to ADHB's current funding constraints and the general economic climate, consideration was given to leaving the Plan in draft. However, it was felt that this approach could be damaging in terms of relationships with the large number of people and organisations who provided input into the Plan. In addition, it is considered that many initiatives may improve youth health without requiring additional funding. Even publishing the Plan can be expected to help focus attention on the needs and expectations of young people. For these reasons, finalising and publishing the Plan was deemed appropriate. Launching the Plan will be used as an opportunity to celebrate the workforce who are committed to meeting the needs of young people living in Auckland as well as to reinforce best practice in youth health for specialist youth health and generalist health practitioners.</p>
6	<p>Issues and Risks for Chosen Option</p> <p>Publishing the Plan may create expectations that additional funding will be delivered to youth health initiatives. This is not proposed at this time, although may be considered in the future.</p>
7	<p>Budget Implications</p> <p>There are no budget implications. Minor costs (less than \$5,000) associated with disseminating and launching the Plan will be delivered within existing funding.</p>
8	<p>Regional / National Implications</p> <p>There are no regional or national implications although it is hoped that this Plan will contribute to regional and national planning strategies for youth health.</p>
9	<p>Appendices available from the Author on request</p> <ul style="list-style-type: none"> - Final Draft Youth Health Improvement Plan - Consultation feedback report.

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Community and Public Health Advisory Committee Paper

Date	Wednesday 27 January 2010		
To	Community and Public Health Advisory Board		
From	Denis Jury Chief Planning and Funding Officer Greenlane Clinical Centre Phone: 8071 Email: denisj@adhb.govt.nz		
Author	Paul Bohmer, Manager Population Health		
Functional Group	Planning and Funding		
Subject	Review of Funding contracts using the Results Framework		
1	Purpose This paper is to update CPHAC on progress to review contracts held by Planning and Funding, in order to ensure alignment with our objectives and to try and ensure the most efficient use of health resources.		
2	Recommendations CPHAC is asked to:		
	1. Note this paper and attached draft assessment tool		
		DAP	DSP
	1	X	X
3	Description of Solution (Option) CPHAC has already been informed of ADHB Planning and Funding Team's intention to review contracts in order to maximize use of our scarce health resources This paper presents a proposed tool against which to assess contacts held by Planning and Funding that are under our control. The criteria used in the tool are the same as those used in our prioritisation process, which has been well tested in previous decision making regarding allocation of resources. To date letters have been sent to potentially affected providers of service informing them that a process is to be undertaken.		
4	Background ADHB is facing a financially tight situation with this year's budget and indicated relative budget reduction in the next financial year. In order to maximize use of our health resources it was proposed to the last CPHAC meeting that all contacts held by Planning and Funding, and paid for from the ADHB budget (as opposed to e.g. direct Ministry funding), will be reviewed against a framework. This update informs CPHAC of progress to date. In order to be as fair as possible to potentially affected providers, the P&F team will need to work to a timeline to ensure adequate notice of any changes is communicated to providers in good time (at least 3 months notice). A proposed timeline and responsibility chart is attached:		

TIMELINE, ACTIONS & RESPONSIBILIY CHART		
Date	Action to be completed	Responsibility
6 Jan 10	Meet with CMDHB and WDHB to discuss	Paul
27 Jan 10	Paper presented to CPHAC meeting	CPHAC / Denis
Mid-March 31 March	<i>Stakeholder engagement step 2</i> Notice is sent to affected providers by P&F manager involved. All P&F managers to ensure communication regarding service change has been received in writing by affected providers .	Tony P& F managers P& F managers
April 2010	Preparations and discussions with affected parties as required <i>Stakeholder engagement step 3</i>	P& F managers Tony
May 2010	Preparations and discussions with affected parties as required	P& F managers
30 June 10	Contracts expiring on the day and that have been given notice will cease	P & F managers
1 July 10 onwards	Contracts identified as requiring some changes will have specs / amalgamation / other arrangements put in place progressively as reviews are completed	P & F managers
5	<p>Options Considered</p> <p>A “do nothing” option is untenable as we are facing a relative decrease in funding and it will not be possible to continue the current level of service delivery within in available funding.</p> <p>An alternative would be to assess all contracts for performance and terminate services not performing well. This would reduce waste but not ensure best use of resources in maximising our health outcomes.</p> <p>Another alternative would be to use an alternative framework but this will require substantial work to develop and will delay decisions regarding possible service reductions.</p>	
6	<p>Issues and Risks for Chosen Option</p> <p>Providers who are identified as requiring major service change or service reduction or curtailment may be unhappy and use the political and other routes to lodge objections to the process and/or outcome of the process.</p> <p>To mitigate the risk, it is intended that providers will be kept informed of the process and that the process will be as transparent, fair and equitable as possible. The potential use of an independent panel will reduce the risk, more so if there are outside people on this panel.</p>	
7	<p>Budget Implications</p> <p>No request is being made for funding this initiative at this time. The process may identify potential savings, may be cost neutral or may identify some potential gaps in funding and service delivery.</p>	
8	<p>Regional / National Implications</p> <p>We have discussed this process to some extent with WDHB and CMDHB who are keen to align processes and communication as closely as possible. CMDHB has already embarked on a large piece of work to review all services across NGOs, primary care and the Provider Arm. The have shared their methodology and a number of templates with us.</p> <p>Some regional decisions will need to be taken at the Regional Funding Forum (RFF) in regards to decisions about providers that work across more that one DHB and also services that have inter-district flow (IDF) implications.</p>	
9	<p>Appendices available on request</p> <p>Draft assessment tool and scoring sheet.</p>	

CONFIRM

9.1 Action Points for next CPHAC Meeting

9.2 CPHAC Feedback to Board

Use Forms at beginning of Meeting Pack

10

GENERAL BUSINESS

11

APPENDICES

11.1 Planning and Funding Contract Review Process

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Auckland District Health Board

Planning & Funding Contract Review Process

Draft v3 for CPHAC, Jan 2010

Purpose

This document serves to outline the process to be used by the Auckland District Health Board (ADHB) Planning and Funding (P&F) Team to review contracts held by the P&F division (excluding Mental Health contracts) in order to make better decisions regarding the effectiveness and efficiency of services delivered through the contracts

Back ground

Indications are that ADHB will face a substantial relative reduction in funding in the 2010/2011 financial year. This will require a process for relative funding cuts to the pool of resources available for the funding of health services.

The P&F team manages a range of contracts with the Provider Arm and with the NGO sector and these contracted services will likewise require review.

The P&F team is committed to a transparent and informed process that will make best use of the limited resources. The P&F team will comply with legal and other requirements and will inform contracted service providers of the outcome of the process in a timely manner.

Proposed methodology

It is proposed that multistage process be adopted:

Phase 1

A spreadsheet of contracts has been developed. This will allow contracts to be viewed from multiple angles through use of pivot tables. Essentially non negotiable contracts will be highlighted so that a complete picture of all contracts may be obtained.

Phase 2

Using the spreadsheet, all current contracts will be examined. Those services obviously not performing or not fitting with our strategic direction may be given notice of termination at the end of the current contract term, provided such notice is given at least three months before the contract termination date.

Phase 3

All remaining contracts will be assessed and scored using an adaptation of the prioritisation tool that has been used by the P&F team for allocation of new resources. Contracts will be progressively reviewed, especially as they come up for renewal, to determine:

- Current fit with objectives
- Efficiency and effectiveness of the services provided

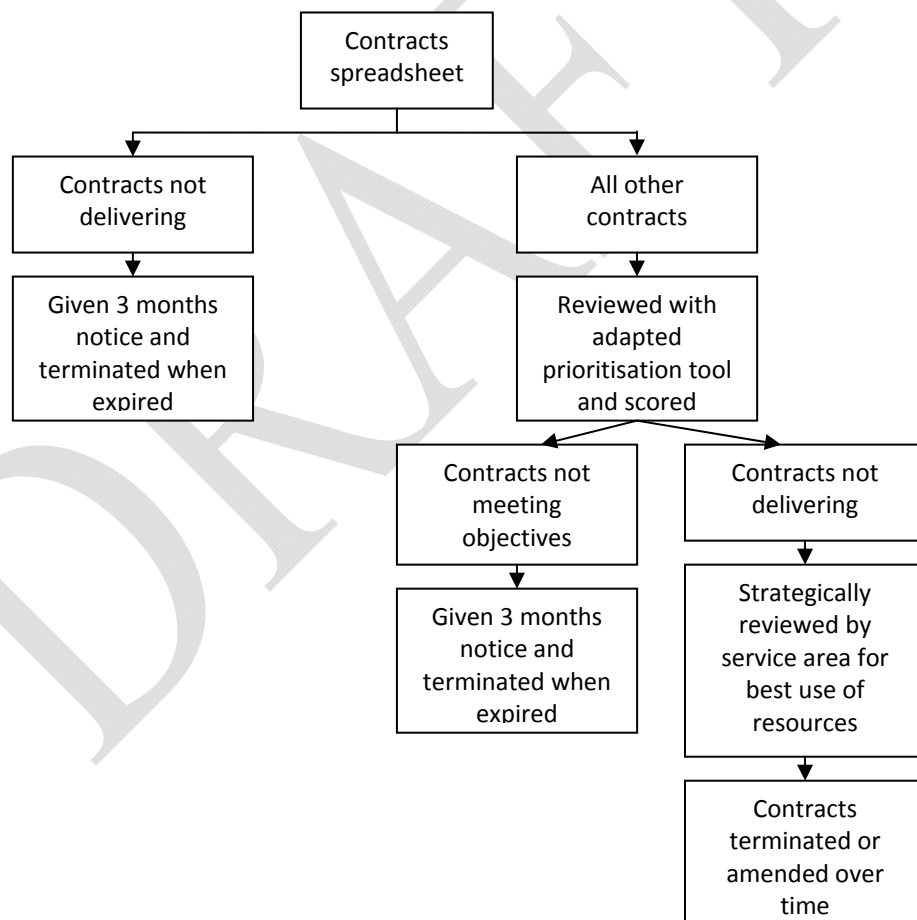
- Whether there are overlaps in service provision
- Opportunities to re-align contracts for more targeted service delivery
- Opportunities to amalgamate or streamline services to better deliver on desired outcomes.

It is proposed for this work that contracts will be grouped according to service, for example, all immunisation related contracts will be looked at in a bunch.

A copy of the proposed tool is attached as Appendix 1. The scoring template to be used is attached as Appendix 2. This will provide a ranked list of contracts against the specified criteria. A decision may be made to give notice to very low scoring contracts.

We may seek external validation of aspects of the work, for example, from people at School of Population Health.

This is show diagrammatically in this flow chart:



Legal and other issues

[To be checked by ADHB Legal including any obligations, etc]

The P&F team acknowledges that certain legal and other requirements, for example, direction from the Minister or Ministry of Health, will require that some contracts

are excluded from this process. These services will be highlighted on the spreadsheet of contracts as essentially non negotiable contracts.

Legal advice

Legal advice to date confirms that three months notice must be given for non-renewal of a contract and that contracts can not be exited before their expiry date other than in exceptional circumstances, for example serious performance issues or mutual agreement between parties to terminate the service.

Maori partner involvement

Tihi Ora will need to be involved at the earliest stage of this process.

Consultation

It has been suggested we should have a three-stage stakeholder engagement process shared across the Auckland metro DHBs, if not more widely (the 4 Northern DHBs or all DHBs?). This would consist of:

1. An external expert advisory group to assess a) the process followed and b) the tools used.
2. The same external expert advisory group to assess a) the proposed set of contracts selected for disinvestment and b) the set selected for continuation.
3. Engage the consumers of services proposed to move through to disinvestment to ensure they have alternative choices to ensure disinvestment would not be counter-intuitive, including but not limited to a cost-saving point of view.

See timetable over for where these engagement steps fit into the project timeline.

Communication

We will need some good communication work at an early stage. Someone will need to draft up press releases and info packs so that we have high quality expertise around the messaging, especially the debate re rationing. This is pretty skilled work and we likely need help here.

Risks

There are a number of potential risks. These include:

- Consultation requirements and timeframe to complete this
- Complaints to the Minister
- Negative public perceptions
- Lack of regional consistency

Risk mitigation

In order to mitigate risks as far as possible the following are proposed:

- Appropriate consultation (see above)
- Openness and transparency
- Use of our validated prioritisation tool, adapted for use for this process
- Sharing information and process, as far as possible, with Waitemata and Counties DHBs I have engaged with WDHB and CMDHB who agree that it would be good to coordinate as far as possible - both have suggested this be raised at next RFF meeting.)

- An appeals process

Timelines

In order to be as fair as possible to potentially affected providers, the P&F team will need to work to a timeline to ensure adequate notice of any changes is communicated to providers in good time (at least 3 months notice). A timeline and responsibility chart is attached:

TIMELINE, ACTIONS & RESPONSIBILIY CHART		
Date	Action to be completed	Responsibility
6 Jan 10	Meet with CMDHB and WDHB to discuss	Paul
27 Jan 10	Paper presented to CPHAC meeting	CPHAC / Denis
Mid March 31 March	<i>Stakeholder engagement step 2</i> Notice is sent to affected providers by P&F manager involved All P&F managers to ensure communication regarding service change has been received in writing by affected providers	Tony P& F managers P& F managers
April 2010	Preparations and discussions with affected parties as required <i>Stakeholder engagement step 3</i>	P& F managers Tony
May 2010	Preparations and discussions with affected parties as required	P& F managers
30 June 10	Contracts expiring on the day and that have been given notice will cease	P & F managers
1 July 10 onwards	Contracts identified as requiring some changes will have specs / amalgamation / other arrangements put in place progressively as reviews are completed	P & F managers

Appendix 1: Tool for assessing contracts (based on prioritisation tool)

PLEASE NOTE: Use a minimum font size of Arial 10. As a rough guide your template should be no more than 3-4 pages long. Do not exceed 5 pages.

Address each of the subtopic areas unless not appropriate to the service, in which case state not applicable and a brief description as to why not applicable.

Description of contracted service for review

Name of person completing this template – include name, contact details and email address:	
Date of completion of this template	
Name of provider	
Agreement name	
Agreement number	
Type of provider, e.g. NGO, etc.	
Annual value of Agreement (GST exclusive)	
Number of FTEs employed to deliver the service	
Termination date for contract	
Brief description of the project, programme or service <i>What is the purpose and objective(s) of the project, programme or service?</i> <i>To which population group/s does it deliver? Is the service delivering to the Region / is it part of a National Agreement?</i> <i>Any critical impact on the population serviced if this contract is terminated?</i> <i>Any impacts on other programmes/services if this service is terminated?</i>	

Template criteria – please complete ALL sections to the best of your ability

1. Alignment to our strategic direction (either nationally, regionally or locally) and to the health outcomes we are seeking for our population
Does the service focus on the ADHB population? Does it align to the current direction of 'better, sooner, more convenient' Does it align to the Minister's health targets Does it support any of Our Health 2020 objectives? Is the service acceptable to service users and key stakeholders? Does the service appropriately consider of Maori, Pacific and other high needs populations? Does it demonstrate collaboration? Is it in line with the strategic funding environment that supports reconfigurations in primary

care?
2. Whanau ora
<p>Has the service reflected active Maori involvement in planning, development, delivery and decision-making? (You may wish to incorporate findings from audit reports to answer this)</p> <p>Has it improved the health status of Maori and whanau, or improve independence of Maori with disabilities?</p> <p>Has it reduced health status inequalities between Maori and Pakeha?</p> <p>Does it demonstrate how Maori cultural concepts, values and practices are safeguarded? (Again, you may wish to use findings from audit reports here).</p> <p>Have family / whanau been involved in service delivery?</p>
3. Equity
<p>Has the service demonstrated improvements in inequalities in health status?</p> <p>Has the service demonstrated improved service delivery for Maori and other high needs groups?</p> <p>Does it specify the health status inequalities, service gaps or access issues that the service has been trying to address in general and for Maori and Pacific people in particular?</p> <p>Has the service advanced the New Zealand Disability Strategy</p> <p>Has the service provided ways for measuring reductions in inequalities?</p> <p>Has the service demonstrated use of the health equity assessment tool (HEAT)? (see the HEAT tool and information on the Ministry of Health website at: http://www.moh.govt.nz/moh.nsf/indexmh/health-equity-assessment-guide)</p>
4. Effectiveness (includes evidence or informed judgement that the service is working)
<p>Is there strong evidence that the service has directly addressed the identified problem(s) / issue(s) in a timely manner (expected within timeframe – for example public health type outcome may be longer term whereas a clinical service may be expected to have a more immediate timeframe)?</p> <p>Is there a demonstrated scientific / medical justification for the service?</p> <p>Has the service demonstrated a significant increase in the health status of the population and / or the standard of care?</p> <p>Has the service consistently provided monitoring reports? (The Agreement Management System (AMS) can provide information here. Ask Simon for help if required).</p>
5. Population impact / impact
<p>Has the service demonstrated that the problem / issue being addressed is significant for the people of Auckland City?</p> <p>Has the service demonstrated a significant impact on the health status of the people of</p>

Auckland City?

Does the service have an impact on a significant proportion of the population?

6. Resources value for money

Have all possible funding streams available being considered in the funding of this service?

Have all costs, workforce, resources, been managed appropriately? (Audit reports may be provide some useful information around financial management systems etc.)

Does the service demonstrate cost effectiveness (amount of change in health status / quality per amount invested)?

Where appropriate Is the cost benefit of this service clearly linked by evidence to the service objectives?

Does this service demonstrate added value to current and / or other initiatives in the area?

7. Feasibility

Has the service demonstrated measurable results in a timely manner?

Has the service been fully implemented as intended? (Audit reports may be able to provide useful information).

Has the service met identified key milestones? (Check audit reports).

Has the service demonstrated how risks to the success of the service have been identified and addressed? (Audit reports focussing on implementation of the risk management plan or business plan may help)

Does the service have provision for continual project evaluation and modification as necessary?

Has the service demonstrated how collaborative action has assisted with implementation or running of the service?

What would be the longer-term sustainability of this organisation if funding were withdrawn?

8. Acceptability

Has the service consistently met the values and expectations of the people / community for whom it has been provided?

Does the service demonstrate that it is accessible to all members of the community and to Maori, Pacific and other high needs groups in particular? Has the service considered and addressed any safety issues?

Has it demonstrated how stakeholders involved in any collaborative issues or actions have been engaged and are supportive (this must be demonstrated as a real engagement not just assumed because its targeted at a particular group that it has actually been acceptable)?

Have there been any complaints against this service provider? (Audit report checks that providers have complaints processes and means for client feedback in place)

9. Risks

What are the possible short, medium or long term impacts if this contract was terminated (consider unintended consequences, impacts on other services)?

10. Other considerations? (not to be scored but for noting in final decision making)

Are there other significant issues for consideration regarding this service?
What significant opportunities are available to improve the way in which this service currently addresses the health needs of Maori, Pacific and high needs groups?

DRAFT

Appendix 2: Scoring sheet for assessing services against criteria

Each category of the template should be evaluated and rated using only the rating of 0 – 5 as follows (there are to be no alternative scores used, for example 0.5):

5 – Service meets all of the specified criteria very comprehensively and is a leader in the field

4 – Service meets the specified criteria very well

3 – Meets the specified criteria well

2 - Meets the specified criteria somewhat

1 - Meets the specified criteria poorly

0 – Does not meet the specified criteria at all

Or only 0 – 3 as score?

Service assessed

Contract number	
Contract name	

Criteria scoring

Category	Rating
1. Alignment to our strategic direction (either nationally, regionally or locally) and to the health outcomes we are seeking for our population* Comments	
2. Whanau ora Comments	
3. Equity Comments	
4. Effectiveness (includes evidence or informed judgement that the service is working)	

Comments	
5. Population impact / impact Comments	
6. Resources/value for money Comments	
7. Feasibility Comments	
8. Acceptability Comments	
9. Risks Comments	
10. Any other considerations? Comment	
Score allotted to the proposal by the prioritisation group	Final score (out of maximum of 30- 50 points)
Final recommendations and comments of the P&F team	