Community and Public Health Advisory Committees Meeting

Wednesday, 12th October 2011

2.00pm

Venue

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

AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna **Time: 2.00pm**

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

MANAGEMENT
Dale Bramley - WDHB, Chief Executive
Garry Smith - ADHB, Chief Executive
Debbie Holdsworth - WDHB, Acting Chief Planning and Funding Officer
Denis Jury - ADHB, Chief Planning and Funding Officer
Taima Campbell - ADHB, Executive Director of Nursing
Hilda Fa'asalele - ADHB, General Manager, Pacific Health
Paul Garbett - WDHB, Board Secretary
Naida Glavish - ADHB, Chief Advisor, Tikanga & General Manager Maori Health
Janice Mueller - ADHB, Director Allied Health – Scientific & Technical
Andrew Old - ADHB, Medical Advisor – Funding Division

Apologies: Lester Levy, Garry Smith and Taima Campbell

AGENDA

DISCLOSURE OF INTERESTS

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

PART I – Items to be considered in public meeting

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

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

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES
2.00pm 2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting held on 14/09/11 1

3 DECISION ITEMS
2.05pm 3.1 A Locality Approach for Health Service Planning 13
2.20pm 3.2 Auckland Council – Draft Auckland Plan Submission 21
2.45pm 3.3 Oral Health 35

4 ITEMS FOR INFORMATION
3.00pm 4.1 Mental Health Information Paper 47
3.10pm 4.2 Community/Consumer Engagement 55

5 STANDARD MONTHLY REPORTS
3.30pm 5.1 Primary Care Update 63
3.45pm 5.2 Auckland and Waitemata DHB Planning and Funding Update 71

6 GENERAL BUSINESS

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Professor of Leadership – University of Auckland Business School Chief Executive – New Zealand Leadership Institute Deputy Chair – Health Benefits Limited Independent Chairman – Tonkin & Taylor Chair – Auckland District Health Board Chair – Waitemata District Health Board Trustee, A+ Trust	25/05/11
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Board Member – Health Workforce New Zealand Board Member, AUT Millennium Ownership Trust Chair – Social Services Online Trust Board Member – The Rotary National Science and Technology Trust	28/09/11
Jo Agnew	Senior Lecturer Nursing - University of Auckland Casual Staff Nurse – Auckland District Health Board	21/04/10
Peter Aitken	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd	10/12/10
Pat Booth	Consulting Editor – Fairfax Suburban Papers in Auckland	24/06/09
Susan Buckland	Self employed – Writing, editing and public relations services Professional Conduct Committee member – Medical Council of New Zealand Professional Conduct Committee member – Occupational Therapy Board	7/08/09
Chris Chambers	Employee – Auckland District Health Board (wife employed by Starship Trauma Service) Clinical Senior Lecturer – Anaesthesia Auckland Clinical School Associate – Epsom Anaesthetic Group Member – ASMS Shareholder – Ormiston Surgical	20/04/11
Sandra Coney	Elected Member – Chair, Parks Committee, Auckland Council	02/05/11
Rob Cooper	Board Member – Auckland District Health Board Board Member – Waitemata District Health Board Chief Executive - Ngati Hine Health Trust Advisory Board Member – James Henare Research Centre, University of Auckland Member – National Health Board Chair – Whanau Ora Governance Group	19/01/11
Warren Flaunty	Member of Henderson – Massey, Rodney and Upper Harbour Local Boards, Auckland Council Trustee - West Auckland Hospice Chair - Waitakere Licensing Trust Shareholder - Metlifecare Shareholder - EBOS Group Shareholder – Pharmacy Brands Ltd Shareholder – Westgate Pharmacy Ltd Chair – Three Harbours Health Foundation	01/02/11
Lee Mathias	Managing Director – Lee Mathias Ltd Director – Iris Limited Director – Midwifery and Maternity Providers Organisation Ltd Shareholder/Director – Pictor Ltd Director – John Seabrook Holdings Ltd Governance Advisor – AuPairlink Ltd Council member – NZ Council of Midwives Chair – Tamaki Transformation Transitional Board	14/09/11
Robyn Northey	Project management, service review, planning etc. – Self employed Contractor Board member – Hope Foundation Northern Region Member – Ethics Committee	16/12/10
Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Member - The Families Commission Director - The Transformational Leadership Company	02/02/11
Allison Roe	Shareholder – Optimisewellbeing.com Founding member – Breast Health Foundation Director – Spiritus NZ Trustee – Allison Roe Trust Founder – Takapuna 2020 Community Group Board member – North Shore Hospital Foundation	28/03/11
Co-opted Members		
Dr Tim Jelleyman	Clinical Director, Paediatrics (Child Health Service) Member, Active Clinical Network (ACN) for the Greater Auckland Integrated Health Network (GAIHN) Project	08/09/10

Register of Interests continued…

Board/Committee Member	Involvements with other organisations	Last Updated
Eru Lyndon	Ngati Whatua o Orakei Corporate Ltd Honorary Research Fellow – Auckland University Member – AUT Business School Industry Advisory Committee Te Mata a Maui Law	12/08/11
Alfred Ngaro	Consultant – 4pm Group Ltd Chair – Pacific Advisory Committee Task Force Member – National Task Force for Family Violence MSD Advisory Member – Family and Community Services National Advisory Group Executive Member – Auckland Safer Communities Chair – Tamaki Achievement Pathways Schooling Improvement Elected Trustee – Tamaki College Board of Trustees Member – Tamaki Community Development Trust Member – Tamaki Transformation Board	14/09/11

Auckland and Waitemata District Health Board

Community and Public Health Committee Member Attendance Schedule 2011

Note: Combined Auckland and Waitemata DHB Committees meeting commenced 1st August 2011.

NAME	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Lee Mathias (ADHB Committee Chair , Feb – July 2011 and ADHB / WDHB combined Committees Chair from Aug 2011)	✓	✓	✓	✓	✓	✓	✓	✓			
Warren Flaunty (WDHB Committee Chair, Feb – July 2011 and ADHB / WDHB combined Committees Deputy Chair from Aug 2011)	✓	✓	✓	✓	✓	✓	✓	✓			
Dr Lester Levy (Chair)	✓	✓	✓	✓ WDHB # ADHB	✓	✗	✓	✓			
Max Abbott (Deputy Chair)	✓	✓	✓	✓	✓	✓	✓	✓			
Jo Agnew	✓	✓	✓	✓	✓	✗	✗	✓			
Peter Aitken	✗	✓	✓	✓	✗	✓	✓	✓			
Pat Booth	✓	✓	✓	✓	✗	✓	✓	✓			
Susan Buckland	✓	✓	✓	✓	✓	✓	✓	✓			
Chris Chambers	✓	✓	✓	✗	✓	✓	✓	✓			
Sandra Coney	✗	✓	✗	✓	✓	✓	✓	✓			
Rob Cooper	✓	^	^	^	^	^	✗	✗			
Robyn Northey	✓	✓	✓	✓	✓	✗	✓	✓			
Christine Rankin	✓	✓	✓	✓	✓	✓	✓	✓			
Allison Roe	✓	✗	✓	✓	✓	✓	✓	✓			
Wendy Lai	✓	✗	✓	✓	✓	✗					
James Le Fevre	✓	✓	✓	✓	✓	✓					
Gwen Tepania - Palmer	✓	✓	✓	✓	✓	✓					
Co-opted members											
Dr Tim Jelleyman	✓	✓	✓	✓	✓	✓	✓	✓			
Eru Lyndon (member from 1 August 2011)	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	✓	✓			
Alfred Ngaro (member from 1 August 2011)	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	✗	✓			
Lyvia Marsden	✓	✓	✗	✗	✓	✓					
Tereki Stewart	✗	✗	✗	✗	✗	✗					
Tracy McIntyre	✓	✓	*n/a*	*n/a*	*n/a*	*n/a*					
Deborah Dalliessi	*n/a*	*n/a*	✓	✓	✓	✓					

✗ *absent*
^ *leave of absence*
* *attended part of the meeting only*
# *absent on Board business*

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 14 September 2011

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 14 September 2011 be approved.

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

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community & Public Health Advisory Committees

Wednesday 14 September 2011

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna
commencing at 2.00p.m

COMMITTEE MEMBERS PRESENT:

Lee Mathias (Committee Chair) (ADHB Deputy Chair)
Warren Flaunty (Committee Deputy Chair) (WDHB Board Member)
Lester Levy (ADHB and WDHB Board Chair) (present from 2.09p.m)
Max Abbott (WDHB Deputy Chair)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Pat Booth (WDHB Board member)
Susan Buckland (ADHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member) (present from 2.15p.m)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Allison Roe (WDHB Board member)
Tim Jelleyman (Co-opted member)
Eru Lyndon (Co-opted member)
Alfred Ngaro (Co-opted member)

ALSO PRESENT: Dale Bramley (WDHB, Chief Executive)
Garry Smith (ADHB, Chief Executive)
Debbie Holdsworth (WDHB, Acting Chief Planning and Funding Officer)
Denis Jury (ADHB, Chief Planning and Funding Officer)
Paul Garbett (WDHB, Board Secretary)
Stuart Jenkins (Clinical Director, Primary Care)
Cliff La Grange (WDHB, Finance Manager)
Leani O'Connor (ADHB, Pacific Planning and Funding Manager)
Andrew Old (ADHB, Medical Advisor – Funding Division)
Jocelyn Peach (WDHB, Director of Nursing and Midwifery)
Janine Pratt (WDHB, Group Planning Manager)
Imelda Quilty-King (WDHB Community Engagement Co-ordinator)
Tim Wood (WDHB Manager Funder NGO)

PUBLIC AND MEDIA REPRESENTATIVES:

Deborah Dalliessi, North Shore Community Health Voice
Margaret Willoughby, Rodney Health Link
Lynda Williams, Auckland Women's Health Council
Lorelle George, Waitemata PHO
Nick Brentnall, HealthWEST
Nick Swain, ProCare

APOLOGIES: Apologies were received from Rob Cooper, Taima Campbell, Janice Mueller and Naida Glavish, together with apologies for late arrival from Sandra Coney and Lester Levy. Christine Rankin gave an apology for early departure at 3.45p.m (which did not eventuate as the meeting concluded before then).

PART I – Items considered in public meeting.

WELCOME

The Chair, Lee Mathias, welcomed those present, with a special welcome to Alfred Ngaro and Jo Agnew, both attending a combined meeting of the two Committees for the first time.

DISCLOSURE OF INTERESTS

It has been noted that Alfred Ngaro is also a member of the Tamaki Transformation Board and that one of Lee Mathias's listed interests should read "Director – John Seabrook Holdings Ltd".

There were no other notifications of additions or amendments to interests that had been previously advised by members.

There were no identified conflicts of interest for the open part of this agenda at the commencement of the meeting, however later in the meeting Sandra Coney advised of a conflict relating to Item 3.3 – Auckland Council – Draft Auckland Plan and Potential Future Relationships, in that she will be sitting on the hearing of submissions at the Auckland Council. While she would take no part in the discussion or any decision relating to an Auckland Plan submission, she would like to take part in discussion around future relationships. The Committee agreed that this would be appropriate.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed in the agenda except that Item 3.1 GAIHN Work Plan and Investment Proposals for 2011/12 was taken prior to Item 2.1 Confirmation of Minutes.

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 10 August 2011 (agenda pages 1-19)

Resolution (Moved Lee Matthias / Seconded Warren Flaunty)

That, with the correction of the words "six monthly" to read "six weekly" in the third bullet point on page 6, the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 10 August 2011 be approved.

Carried

Matters Arising:

It was noted that on page 15 of the agenda, in the presentation on Primary Care Strategic Direction attached to the minutes, the chart relating to Integrated Family Networks should also show Pacific providers.

3 DECISION ITEMS

3.1 GAIHN Work Plan and Investment Proposals for 2011/12 (agenda pages 21-63)

Ray Naden, Chair of GAIHN and Andrew Coe, Group Manager, Primary Care & PHOs, Auckland and Waitemata DHBs were present for this item.

The Chair welcomed Ray Naden to the meeting and invited him to provide an update on progress with GAIHN and the background to the investment proposals.

Ray Naden's address to the Committee included the following:

- The decision made in April 2011 to refocus GAIHN on better primary care to reduce the number of acute episodes that result in unplanned hospital admissions. Unplanned admissions are disruptive to families and generally involve more risks, more difficulties and more expense. If people can be kept well in the community, there are major cost benefits for the health system.
- The two core work streams aimed at identifying those individuals at highest risk of acute episodes and better management of those individuals in primary care; and at better primary response to acute events when they occur. Appropriate triage and good advice needs to be available in the community, whereas currently approximately 60% of patients arrive at EDs without having had triage in the community.
- The third work stream around enablers of better primary care, for example utilising the "Shared Care" software to share the healthcare plan for individual patients, which was proving very effective and would be a true enabler around integrated care. Another example is Clinical Pathways to ensure patients are managed in accordance with best practice.
- The fourth work stream involving population prevention programmes, for example against smoking, skin infections and stroke, including increasing public awareness and how to respond.
- The fifth work stream of Alliance support and development and the sixth work stream of systems improvement, involving aligning incentives with what needs to be achieved.
- Overall, he saw the direction being ambitious, innovative programmes, breaking new ground.

In responding to questions, Ray Naden advised:

- That with regard to cost benefit analysis, the approach being taken is:
  - what is the problem we are trying to solve ?
  - what benefits are envisaged ?
  - what is the investment required ?
  - and what is the return on the investment?

  A risk modelling exercise had been agreed on, based around comparing what hospitalisation patterns are to be expected if the programme is implemented, compared to hospitalisation if the programme is not implemented.
- While there were numerous approaches to identifying those people with the highest risk of hospitalisation, the system chosen runs relatively easily and most importantly can demonstrate how effective the programme is at avoiding unnecessary hospitalisations, by predicting what the hospitalisation rate would be for those individuals if there was no programme.
- The Waitemata DHB Readmissions Prevention Project used the same predictive risk tool as the GAIHN Programme, but the difference was that the Waitemata DHB project concentrated on the hospital discharge and the days immediately following that, whereas the GAIHN Programme was a longer term approach, focusing on integrative care long term.
- While he would like to see faster implementation of the programme, he accepted the need for documentation and justification.
- Following the first step of identifying the people for whom the most good could be done, the major issue would be to get all the primary care practices across Auckland enthusiastically engaged in the programme. There are some shining examples of general practices with hospital admission rates far lower than others. There is a need to find out what things some practices are doing well and what others aren't.

Debbie Holdsworth confirmed that discussions had been held around the relationship between the GAIHN Programme and Waitemata DHB's Readmissions Prevention Project. It is

important that both are to use the same predictive tool. What is not known is whether or not the GAIHN use of community data will add to the effectiveness of predicting hospital readmissions. She also agreed with Ray Naden that the interventions would be different.

In answer to a further question concerning when results would be available, Ray Naden said that by the end of June 2012 there should be demonstrable results in terms of the goals set. An example of one of the measures being considered, relating to good triage being provided in the community, was the reduction in number of patients arriving in ED without having been referred.

The Board Chair noted that GAIHN is a partnership and that all parties are in this together, with a responsibility to adopt a collaborative, regional way of working, even if that felt uncomfortable because people are not used to working in that way. It is important to realise that this approach involves a leap of faith as well as commitment.

In answer to further questions, Ray Naden advised that when he had come to GAIHN, it had been unclear where accountabilities lay. He had worked on the basis that what GAIHN had control over it should be accountable for, as opposed to matters it did not control but wished to utilise and build on. In terms of governance, GAIHN is an alliance and all parties share an involvement in that. Accountability is spelled out in the GAIHN Plan approved by the District Health Boards previously.

Resolution (Moved Lester Levy / Seconded Max Abbott)

a) That the report be received.
b) That CPHAC notes the investment requested and that the request will be considered by the Audit and Finance Committee and the Board for Auckland and Waitemata DHBs in support of the continued development and implementation of the work streams and associated projects as summarised in this report.
c) That CPHAC notes that this funding request represents 60% of the agreed funding limit for 2011/12 and that a further funding request will be received in December 2011.
d) That it be noted that confirmation will be sought on whether the Clinical Pathways work stream will need to go to the National Health IT Board due to the amount requested.
e) That it be noted that Waitemata DHB and Auckland DHB will work in a collaborative way with GAIHN to ensure there is no duplication between the GAIHN work and the DHBs' contracts with community and primary care providers, the provider arm and the Northern Region Health Plan.

Carried

Warren Flaunty noted that he had voted against the above resolution.

3.2 Primary Care: An Integrated Strategic Approach – Mergent Health Care (agenda pages 65-73)

Andrew Coe (Group Manager, Primary Care – Auckland and Waitemata DHBs), Dr Stuart Jenkins (Clinical Director, Primary Care – Auckland and Waitemata DHBs), and Dr Jonathan Simon (a West Auckland general practitioner and leader of West Auckland Healthnet) were present for this item.

In answer to questions, Stuart Jenkins commented:

- That there clearly needed to be one system of data collection, and the intention is to achieve that.
- With regard to alignment with GAIHN, integrated networks is one of the GAIHN work streams.

- Integrated Family Health Centres will not amount to community hospitals. The intention is to strengthen primary care to support existing hospitals.
- Integrated Family Health Centres will only be effective if part of Integrated Family Health Networks.
- Models of care and revenue agreements are key to bringing about change.

Jonathan Simon commented that this is not about buildings, but about a change of functionality. Co-location by itself and without a change of functionality is a waste of time. In an ideal world functions would be sorted first, but this is not an ideal world. If a different functionality is not delivered, then in his view this will be losing a key last opportunity to make a major improvement to the health system. In the RFP released on 13 October 2010 one concept had been central, a new model of care and revenue agreement, and this was fundamental. With Integrated Family Health Centres it was essential to go with the early movers, the practices prepared to take a risk. Once established, the other practices around them can be taken on a journey by offering them and their patients access to all the services available in the Centres. This was all part of a slow transformative change.

In discussion it was noted that one of the core drivers of transformational change is to deliver value to the system. Over time this will involve a movement from concentrating on measuring inputs and outputs to measuring outcomes. The Board Chair made the analogy of shifting from a concentration on anatomy to the physiology and psychology of the system.

In answer to a question concerning timing, Andrew Coe advised that this was being worked on with colleagues in primary care. A group had been set up representing all primary care organisations. There was already good engagement with the PHOs and a lot of support from practitioners. What would be essential would be to demonstrate improvements for patients. A detailed plan was being prepared for management teams to review.

Denis Jury referred to the benefits being seen from the merging of the ADHB and WDHB primary health teams, particularly in terms of combined mental effort in resolving the same problems. The Board Chair noted that this was the first move of this type in terms of collaboration and that he was working with the two Chief Executives to identify other areas where there would be added value from that approach.

Resolution (Moved Lee Mathias / Seconded Robyn Northey)

That the Committee:

a) Note that the current and proposed approach to deliver Better, Sooner and more Convenient Primary Care is supported by the sector and will deliver regional consistency.

b) Endorse the integrated development approach as being critical in the timely achievement of improved community and public health outcomes.

c) Endorse the development of a detailed work plan delivered in partnership with the sector.

<u>Carried</u>

3.3 Auckland Council – Draft Auckland Plan and Potential Future Relationships (agenda pages 75-80)

As noted under Disclosure of Interests at the start of these minutes, Sandra Coney advised and the Committee agreed that while she would not participate in the discussion or any decision relating to a Draft Auckland Plan submission, Sandra would take part in the discussion around future relationships.

Janine Pratt (Group Planning Manager WDHB) introduced the report.

With regard to the previous submission from the Metro-Auckland DHBs on 'Auckland Unleashed – the Auckland Plan Discussion Document' (circulated to Committee members as background for this item), the Committee noted that with regard to schools (page 29 of that submission) reference could also have been made to Oral Health Care and possibly to the issue of fluoridation.

On the subject of future relationships, Sandra Coney thanked Dale Bramley for allowing the Auckland Council's Social and Community Forum to meet in the Board Room on 13 September, when the subject for consideration had been health. She said that now there is just one Council for Auckland, there is an opportunity to work better together to realise mutual goals. The Auckland Plan highlights a number of things impacting on health status and has a focus on disparities. There had been a discussion about holding a workshop and inviting District Health Board representatives to attend, to set some mutual goals, through discussion at a governance level.

Dale Bramley and Denis Jury talked of the realisation that there is a common core to process documents from the Council and the District Health Boards in terms of health outcomes sought, and that it will be valuable to work more closely on these documents before they reach the public notification and submission stage.

Other points made in discussion of the item included:

- It is important for there to be an awareness at governance level of what is taking place at officer level between the Council and the District Health Boards - some form of regular update was suggested.
- It would be useful to identify all the Council activity at "ground level" which has a health dimension – often one only becomes aware of this by accident.
- It is important to remember that the Auckland Plan is not a Council Plan, and relies critically on the engagement of the community.

Janine Pratt advised that she was developing a think piece on opportunities to work together with the Council and priorities for that, and planned to bring that back to CPHAC.

With regard to sign off of the proposed joint submission on the Draft Auckland Plan, it was noted that progress with the submission would be reported back to CPHAC on 12 October and a decision on sign off process would be made then.

Resolution (Moved Robyn Northey / Seconded Allison Roe)

a) That the information be received.
b) That the Committee endorse the preparation of a joint submission to the Draft Auckland Plan on behalf of Auckland DHB, Counties Manukau DHB, NDSA and Waitemata DHB.

Carried

4 INFORMATION ITEMS

4.1 Immunisation (agenda pages 81-86)

Dr Tim Jelleyman (Head of Division, Medical for Child,Women and Family Services, Waitemata DHB) presented the report. In answer to questions, he commented that:

- Informed choice required both communicating the span of possibilities to families and respecting their right to decide on immunisation.
- In the case of outbreaks of infectious diseases one of the consequences for those not immunised may be quarantine.

Concerns were expressed at the lack of thought to the needs of children, including their educational needs, when quarantine is applied because of disease outbreaks, for example at Oratia recently. It was noted that to some extent this is a national issue. Tim Jelleyman offered to feed those concerns back to the Auckland Regional Public Health Service.

The report was received.

5. STANDARD MONTHLY REPORTS

5.1 Planning and Funding Update (agenda pages 87-99)

Matters noted included:

- Confirmation that Auckland DHB B4 School Check (page 92 of the agenda) is also on target for August.
- With regard to the Pharmaceutical Society request that Waitemata DHB fund the two Warfarin pilot sites on an ongoing basis until a decision is made nationally to make this a standard practice or not (page 93 of the agenda), the final evaluation report referred to was due the previous week with the Society and it is expected that they are working through it. If the programme is rolled out nationally to all pharmacies, the cost will be $50M on the current funding model.
- In relation to concerns expressed in the media relating to the new drug Dabigtran, it is clear that only certain patients should be transferred to it and there needed to be careful monitoring.

6. GENERAL BUSINESS

There were no items of general business.

7. RESOLUTION TO EXCLUDE THE PUBLIC (agenda page 101)

Resolution (Moved Lee Matthias /Seconded Robyn Northey)

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 10th August 2011 with public excluded	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.

Carried

3.33p.m to 3.36p.m - public excluded session.

The meeting in open session resumed at 3.36 p.m.

The Committee Chair thanked members for their participation.

The meeting concluded at 3.37 p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 14 SEPTEMBER 2011

____CHAIR

Actions Arising and Carried Forward from Meetings of the Community & Public Health Advisory Committees as at 4 October 2011

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
WDHB CPHAC 13/4/11	4.3	Interpreter Service – Next Asian Health Service Update to include information on level of service provided, number of times used and cost.	Sue Lim	CPHAC Nov or Dec 2011	
CPHAC 10/8/11	3.1	CPHAC Terms of Reference – suggested improvements from Chris Chambers to be considered.	Denis Jury, Debbie Holdsworth		Will be included in review of CPHAC in early 2012.
CPHAC 10/8/11	5.1	Reporting from Whanau Ora Providers – suggestion that this might be included with reporting around BSMC to be looked at.	Denis Jury, Debbie Holdsworth		Will be provided in future Primary Health reports
CPHAC 10/8/11	5.1	Mental Health – joint paper to be prepared for CPHAC on mental health residential facilities located in local communities covering location, who is providing, issues and risks, safety and how crises are handled.	Howard Dawson, Clive Benseman	CPHAC 12/10/11	Included in this agenda.
CPHAC 10/8/11	5.1	Child and Adolescent Oral Health – joint paper to be prepared for CPHAC covering statistics for the last 2-3 years.	Vicki Scott, Rachel Mattison	CPHAC 12/10/11	Included in this agenda.

3.1 A Locality Approach for Health Service Planning

Recommendation:

That it be recommended to the Auckland and Waitemata District Health Boards:

That the Boards:

a) Note the background and progress made to date on developing a locality approach in Auckland DHB.

b) Note the linkage with concurrent primary care and community engagement activity, and the actions to align and coordinate across Auckland and Waitemata DHBs.

Prepared by: Dr Janine Jolly (Localities Manager, Auckland & Waitemata DHBs) and Dr Andrew Old (Medical Advisor – Service Integration, Auckland & Waitemata DHBs)

Glossary

AUT - Auckland University of Technology
DHB - District Health Board
NGO - Non Government Organisation
TLC - Tamaki Learning Champions
TTP - Tamaki Transformation Programme

1. Executive Summary

In September 2010, the Auckland District Health Board (DHB) Community and Public Health Advisory Committee (CPHAC) approved a paper outlining a locality approach to the planning and delivery of healthcare[1]. Such an approach was to respond to the demands of communities for a more locally nuanced approach to health service planning and delivery than the existing district wide model. They wanted to feel more involved in decisions and see local services being provided to meet local needs.

This paper provides an update on progress with implementing that plan and bringing the approach together with activity underway in Waitemata DHB, including the development of a Health Links model for the Auckland district.

2. Introduction/Background

Vision

> *"Our locality approach will create the conditions in which people, families/whanau and communities can take greater control over their lives to maximise their health".*

Definitions

A *locality* is defined as one of the Auckland Council Local Board areas[2]. These are geographically defined and encompass all people usually resident in the area. Our *locality approach* has two central and interlinked features: *locality planning* and *locality provision*.

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[1] "A locality approach for Auckland: Changing the way we view the planning and delivery of healthcare". ADHB CPHAC, September 2010
[2] Refer to Appendix 3 for details

Locality planning is a population health approach which puts communities and their experiences of health and healthcare at the centre of planning decisions and, crucially, engages those communities in action to improve health. This concept goes further than consulting local people on planned changes or development, instead seeking to actively engage them to shape and define the public value, that is, what matters most in terms of health priorities. Locality planning is tightly bound to locality boundaries to allow for meaningful data analysis and intersectoral working, and is part of our broader community engagement strategy.

Locality provision is the better co-ordination and integration of health and related services at the locality level via Integrated Health Networks (or similar). Importantly, this encompasses more than traditional primary care, representing instead a microcosm of *all* DHB funded activity, along with primary care and other health and social sector services, operating at a local level.

This paper focuses on locality planning, with the approach to locality provision (via integrated health networks) having been covered in a previous CPHAC paper (September 2011).

Methodology

The approach involves:

- Partnership with local communities including deliberate strategies to connect with local populations in a continuous rather than episodic way.
- Enhanced local government engagement through structured links with elected Local Boards.
- An intersectoral approach with other government and non-government agencies who have an influence on health and its broader determinants.
- Informing integrated health service planning and delivery across the whole spectrum of care, including across traditional DHB service silos, and contributing to the development of clinician-led integrated health networks.

A locality approach provides the opportunity to:

- Engage people and communities in a continuous cycle of planning and improvement allowing them to shape services at a local level thereby becoming a key component of DHB engagement strategies.
- Engage with health providers around local populations and local needs to assist integration of services for patients and communities.
- Plan and coordinate services around a number of primary care practices in a geographical area which allows those practitioners with specialist interests or skills to provide enhanced care for a larger population.
- Provide a logical and efficient means of facilitating the delivery of a wider range of services closer to where people live and/or work, particularly through delivering services in more primary/community based settings.
- Facilitate interaction between NGOs, health promotion services, local government, iwi and other community and non-health specific services that can support the drive to improve health outcomes and health equity.
- Share members of a scarce workforce (such as health promotion, nursing, psychology or podiatry) across a number of practices or settings.
- Improve equity of health outcomes and services access by adapting services to understand and take into account local need.

3. Progress / Achievements / Activity

The Locality Approach pilot blueprint

In this section, we outline the model for locality planning. The process begins with a qualitative and quantitative health needs assessment to ascertain health needs and priorities in the target community. As part of the qualitative process, participants are invited to continue to participate in the process and to identify additional community members or community representatives they think should be involved. Following an analysis of the qualitative feedback, participants are brought together in a forum to hear the results presented and discuss their implications. From this discussion, priorities for action are established in partnership with the community. This feedback, in conjunction with the quantitative information, forms the basis for the development of a Locality Health Plan. The Locality Health Plan is something which is recognised and owned by the locality or community.

The next step is to develop a Locality Health Partnership. This consists of community members and community organisations operating in the Locality and other interested parties such as healthcare providers who operate in the locality. Integral to the success of the model, is the ownership of the locality health plan by the locality health partnership. The formation of the Locality Health Partnership, their constitution, meeting frequency and so on will be undertaken in partnership with the community. Each will be constituted differently depending on the needs of the community and the characteristics of their populations and will be built on existing networks where such exist.

We intend to provide a small sum of money to the Locality Health Partnership to facilitate the progression of one of the health priorities identified in the Locality Health Plan. This finance would not be devolved as such, but would provide resource, similar to a small grant, for community action to be taken on one of their health priorities. This will be known as the Locality Health Fund. The implementation of this Locality Approach template is currently being piloted and will be evaluated in the pilot localities of Maungakiekie-Tamaki and Puketapapa by June 2012.

Qualitative Health Needs Assessment

Maungakiekie -Tamaki

The above model is based on community development principles and as such, we have endeavoured to work with communities and community agencies wherever possible. In Maungakiekie Tamaki, we are working as a partner with Ka Mau Te Wero who is developing and implementing a project called Community Action Tamaki. This is a randomised household survey within Glen Innes, Mt Wellington and Panmure to ascertain what community members feel is good about living in their community and what they identify as areas for improvement. Auckland University of Technology (AUT) is also a partner and is supporting the methodology, which has ethics approval and a number of AUT students are involved in the data collection activity. Ka Mau Te Wero has excellent links within the Glen Innes community and with the Ruapotaka Marae.

Additional needs assessment work has been undertaken through Auckland Council supported community networks such as the Panmure Community Network and the work of the Tamaki Transformation Programme (TTP) in particular, the Tamaki Learning Champions (TLC) group, this is network of early years providers, health professionals and community members, their representatives and the Ministry of Education. Its purpose is to champion the importance of early year's education to ensure that children in Tamaki are healthy and ready to learn. The Maungakiekie-Tamaki Local Board also provided their insights into health needs and priorities in the area through a discussion at their August meeting.

Puketapapa
In Puketapapa, the initial approach to the qualitative data collection has been slightly different. Key community informants have been identified using the Auckland Council supported community network in Mt Roskill. The network facilitator approached the network advertising for informants to come forward to participate in qualitative interviews. Those who came forward participated in face-to-face qualitative interviews, which took the form of 'guided conversations'. At the end of the conversation, participants were invited to suggest other community members or organisations who should be contacted to participate in the data collection. Respondents were also asked if they would like to participate in the development of the Locality Approach in order to obtain consent for further contact. Participants were also invited to comment on the proposed template or blue print for the approach as outlined above.

Findings to date[3]

The qualitative data collected points to the main health issues of these communities being related to low incomes and poverty. This is manifested as issues related to food security, housing, including insecurity of housing tenure, overcrowding and houses which are inadequately heated and insulated leading to attendant health problems. Local 'Healthy Homes' initiatives are targeted at Housing New Zealand provision and do not cover private rental properties which increasing numbers of lower income groups are accessing in order to fulfil housing needs.

"Food - Access to food parcels is very prevalent. Every week I'll take 2 or 3 families to the Salvation Army to get a food parcel".

"Every teacher will have 2 or 3 children in their class who doesn't have any lunch or not enough lunch".

"Houses are cold, damp, mouldy – generally built mid 1940's to mid 1950's – small – designed for small nuclear family. Overcrowding is a big problem. Kitchen/diners are small – 5 person family can't sit round the table at the same time."

High housing costs as a proportion of household incomes exacerbate issues such as food security and access to primary care. This is an issue because of the cost or perceived cost of accessing primary care services, including being worried about a pre-existing debt at a practice, even if there is no cost for the consultation for a child; lack of personal transport resulting in difficulties in getting to appointments and an inability to take time off work to attend appointments.

'The cost of GPs reduces the use of GPs –it's a deterrent. Not for everybody but for some.'

'Cost [for GPs] is a barrier –some parents have an existing debt with the practice so they are reluctant to go in case they are hassled about an unpaid bill. People can't always get time off work and transport is a problem –many people don't have cars'.

'…sometimes parents tell us they can't get to [hospital] appointments –sometimes –if we know –we arrange transport to enable parents to take their children to appointments…it's not the schools role to do that. But it impacts on children's learning'.

Community participants did identify areas of practice which were working effectively for the benefit of the community and which should be continued. For example, the Refugee

[3] The italicised texts are comments made by members of the community network in Mt Roskill about the health issues and priorities in the area. Participants in the network draw from a number of sources such as community members, community groups and organisations, local schools and health professionals, such as school nurses, who work with local residents.

Collaborative was perceived by community informants, who knew about the initiative, to be a positive development which had resulted in primary care being made more affordable and accessible for refugee groups. Other positive comments were received in relation to health programmes aimed at children such as the immunisation programme, the cosmopolitan feel to the area and the community infrastructure such as community centres which could be used as a base for community services.

"The school immunisation programme is a good thing. Lots of children would not be vaccinated if it were not for this programme –parents wouldn't get round to taking them to a GP".

"I've lived in the area since 1985. It's a very cosmopolitan mix. It's changed a lot. It used to be lots of Pacific and Maori now it's South Indian, Middle Eastern, African…."

"The community centre would be a good place to put services…a sense of wellbeing is important –if people don't have a sense of wellbeing their health in compromised. The feel good factor makes a big difference to health generally".

4. Next Steps

Auckland DHB Activity

1. Continue with data collection and the development of the locality health needs assessments and locality health plans as outlined below:

   1.1. Locality Activity (Maungakiekie-Tamaki)
   - Participation in Random Household Survey and other data collection mechanisms
   - Close working relationship with the Tamaki Transformation Programme (TTP) to leverage existing work
   - Qualitative data collection on health needs and priorities gained from Onehunga network and other identified fora as appropriate
   - Feedback on findings and collation of locality health plan.

   1.2. Locality Activity (Puketapapa)
   - Participation in Mt Roskill/Puketapapa community network
   - Identify key community informants
   - Conduct qualitative interviews to inform health needs assessment
   - Conduct focus groups as appropriate
   - Feedback on findings and collation of locality health plan

2. Progress the formation of Locality Health Partnerships either arising from community interest or as part of existing networks, for example, the community networks utilised as part of the data collection, if appropriate. This includes consideration of a Health Links model for Auckland DHB.

   This will involve (but not necessarily in this order)[4]:
   - Issues and aspirations: define the nature of the issues and aspirations to be addressed in each of the localities
   - Membership: identify which agencies and community groups and community representatives need to be invited to join each of the partnerships to secure its potential and community mandate
   - Coordination: Define how the partnerships will be coordinated and how each of its members activity will be integrated with the work of the whole

[4] Taken from Mitchell and Shortell (2000) *The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy and Practice*. The Milbank Quarterly 78(2): 241-289.

- Accountability and role: define the group's role and accountability, including for each of its members (including the DHBs)
- Integrate: link the group's intentions and activity to other activity that is central to the lives of the locality's residents
- Resource: Identify small budget for health promotion and further community engagement –the Locality Health Fund spend to be determined by each partnership.

3. Continue the development and implementation of the pilot blue print as outlined above and undertake process and outcome evaluation to inform next steps. We intend to produce an annual report on learning to date (by July 2012) and a 'how to tool kit' for future locality development (by Dec 2011).
4. Explore the need for governance arrangements as the Locality Approach develops and is implemented to ensure that the approach itself and its learning can be effectively channelled into organisation goals and priorities.

Partnership work with Waitemata DHB

As part of the development of the locality approach, we are committed to working with colleagues in neighbouring DHBs. This is a work in progress but current conversations are around what aspects of the approach may be appropriate for Waitemata DHB, how the Health Links model may be implemented in Auckland DHB and to explore whether the above pilot blue print could also be piloted in Whau and if so under what time frame.

5. Conclusion

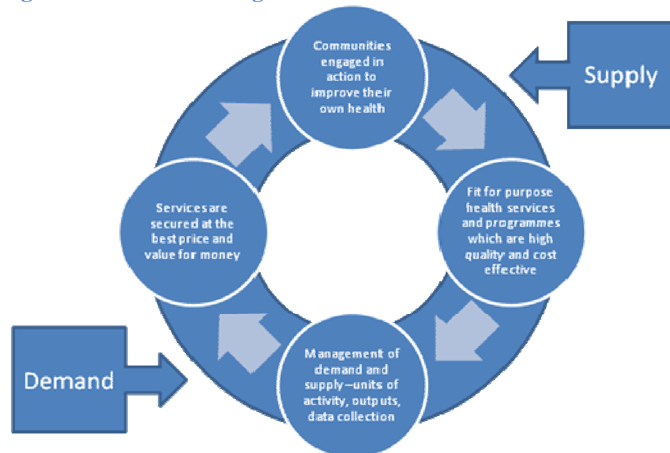
This paper sets out the foundation in the development of the locality approach that has been established. Significant relationship building and management within the two pilot communities has been achieved and the qualitative work on health needs and priorities provides food for thought in terms of work to develop under the auspices of population health and health improvement. The design of the pilot blueprint provides a framework to move forward in the two pilot localities and in partnership with Waitemata with Whau.

Appendix 1

Locality Planning Cycle

The start and the end point of the locality approach is the active engagement of those residents in the locality in understanding, shaping and defining health and healthcare services and in defining public value, that is, what matters most in terms of health priorities.

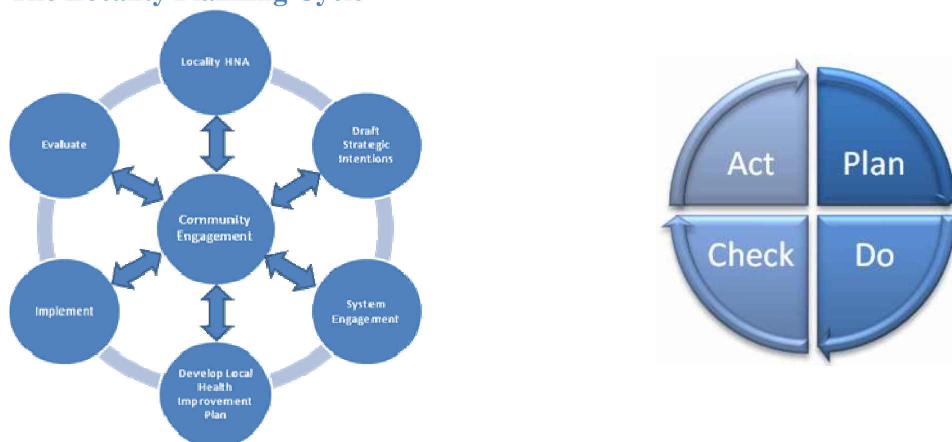
Figure 1: Demand Management Model



The approach is built on principles articulated in a previous ADHB CPHAC paper including maintaining our commitment to the principles of Te Tiriti o Waitangi.

The approach is setup as a cycle with Locality Health Need Assessments (HNAs)[5] informing the development of Local Health Plans that will in turn guide the provision of services to the local population via the developing integrated health networks.

Figure 2: The Locality Planning Cycle



This approach is deliberately designed as a continuous quality improvement cycle consistent with the Deming/Shewart Cycle of Plan – Do – Check –Act (PDCA).

[5] The HNAs are focussed exercises that will build on work completed for the district-wide analyses. In contrast to the district level HNA they include a substantive qualitative component.

Appendix 2

Local Board Arrangements

Ward	Local board	Population estimate*	Subdivisions	Population estimate*	Number of members (% deviation from average population per member**)
Rodney	Rodney	54,100	Wellsford Warkworth Dairy Flat Kumeu	5,550 16,700 6,470 25,400	1 (-7.7%) 3 (-7.4%) 1 (+7.6%) 4 (+5.6%)
Albany	Hibiscus and Bays	88,800	Hibiscus Coast East Coast Bays	42,500 46,300	4 (-4.3%) 4 (+4.3%)
	Upper Harbour	49,000	None		6
North Shore	Kaipatiki	85,900	None		8
	Devonport-Takapuna	57,300	None		6
Waitakere	Henderson-Massey	109,600	None		8
	Waitakere Ranges	49,000	None		6
Whau	Whau	76,400	None		7
Albert-Eden-Roskill	Albert-Eden	98,800	Owairaka Maungawhau	48,900 49,900	4 (-1.0%) 4 (+1.0%)
	Puketapapa	56,100	None		6
Waitemata and Gulf	Waitemata	70,000	None		7
	Waiheke	8,420	None		5
	Great Barrier	820	None		5
Ōrākei	Ōrākei	81,100	None		7
Maungakiekie-Tāmaki	Maungakiekie-Tāmaki	73,000	Maungakiekie Tāmaki	28,500 44,400	3 (-8.8%) 4 (+6.6%)
Manukau	Mangere-Otahuhu	75,900	None		7
	Otara-Papatoetoe	80,300	Otara Papatoetoe	34,200 46,100	3 (-0.6%) 4 (+0.5%)
Te Irirangi	Te Irirangi	128,100	Howick Pakuranga Botany	42,700 41,900 43,600	3 (-0.1%) 3 (-1.9%) 3 (+2.0%)
Manurewa-Papakura	Manurewa	86,600	None		8
	Papakura	44,900	None		6
Franklin	Franklin	64,200	Wairoa Pukekohe Waiuku	20,200 30,300 13,750	3 (-5.7%) 4 (+6.1%) 2 (-3.7%)

* These are rounded 2009 population estimates provided by Statistics New Zealand. Because they are rounded estimates, the total subdivision population does not equal the local board population in some cases.

** '+' denotes under-representation and '-' denotes over-representation

3.2 Auckland Council – Draft Auckland Plan Submission

Recommendation:

a) That the report be received and that the Committee notes that submissions on the Draft Auckland Plan close on 25 October 2011.

b) That the Committee notes further information on the draft submission will be made available at the meeting and that it is requested to resolve how it wishes to formally approve the draft submission.

Prepared by: Andy Roche (Policy Analyst Auckland Regional Public Health Service) on behalf of: Denis Jury (Chief Planning and Funding Officer Auckland DHB), Janine Pratt (Group Planning Manager Waitemata DHB), Doone Winnard (Public Health Physician Counties Manukau DHB), Frank Booth (Service Manager Auckland Regional Public Health Service) and the other members of the Auckland Unleashed Working Group.

Glossary

ARPHS - Auckland Regional Public Health Service
CPHAC - Community and Public Health Advisory Committees
DHB - District Health Board
NDSA - Northern Region DHB Support Agency.

1. Executive Summary

This report provides the Committee with an update on work underway to respond to Auckland Council's (Council's) Draft Auckland Plan.

The report also provides an overview from a health perspective of relevant aspects of the Draft Auckland Plan which was released for public consultation on 20 September 2011.

From the population health perspective, there is much to commend in the Draft Auckland Plan. The Draft Auckland Plan also contains information that will help the DHBs plan for future healthcare facilities and service delivery. The challenge for Council will be to turn good intentions into successful implementation.

A draft submission was not available at the time of this report's preparation, but further information on the content of the proposed submission will be presented to the Committee at the meeting.

The Committee is requested to resolve how it wishes to formally approve the draft submission.

2. Introduction/Background

At its meeting on 14 September 2011, the Committee received a report on Auckland Council – Draft Auckland Plan and Potential Future Relationships.[1] The minutes from that meeting state: *"With regard to sign off of the proposed joint submission on the Draft Auckland Plan, it was noted that progress with the submission would be reported back to CPHAC on 12 October and a decision on sign off process would be made then."*

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[1] Accessible through http://www.waitematadhb.govt.nz/LinkClick.aspx?fileticket=U6FUo-rzCj0%3d&tabid=330&mid=787

The Committee resolved:

1. That the information be received.
2. That the Committee endorse the preparation of a joint submission to the Draft Auckland Plan on behalf of Auckland DHB, Counties Manukau DHB, NDSA and Waitemata DHB.

This report provides an update now that the Draft Auckland Plan has been released.

On 20 September 2011, Auckland Council (Council) released the Draft Auckland Plan.[2] The Draft Auckland Plan is open for public consultation and submissions until 4 pm on Tuesday 25 October 2011.

Auckland Plan Status and Development Process

The Draft Auckland Plan is the second opportunity to comment on Council's proposals for the Auckland Plan. In March, the Auckland Unleashed – The Auckland Plan Discussion Document (the Discussion Document) was released for public submissions. The DHBs and ARPHS responded to this opportunity.[3]

As noted in the September Report to this Committee, the Auckland Plan is not just a Council Plan. While the Plan is prepared and adopted by Council (Sections 79 and 80 Local Government (Auckland Council) Act 2010), the Auckland Plan is a plan for all sectors, including health, in so far as it:

- Sets a strategic direction for Auckland that integrates social, economic, environmental and cultural well-beings.
- Enables coherent and coordinated decision making by Auckland Council and other parties (including health) to determine the future location and timing of critical infrastructure, services and investment.

In the Auckland Plan's preparation Council:

- Must involve central government, infrastructure providers throughout the preparation and development of the plan.
- Endeavour to secure and maintain the support and cooperation of central government, infrastructure providers in the implementation of the plan.

In the National Infrastructure Plan Government has also signalled that consideration of the Auckland Plan will be one of the requirements of good business case development and overall decision making.[4]

From the Council perspective, the Auckland Plan will be the overarching document guiding Council's planning and service delivery which will provide a framework within which other decisions will be taken.

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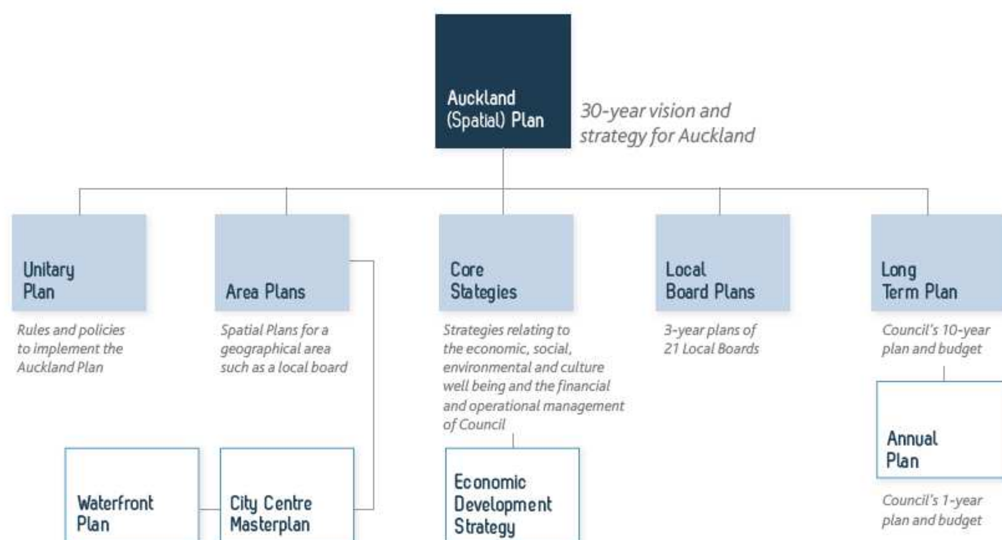
[2] Accessible through http://www.aucklandcouncil.govt.nz/EN/AboutCouncil/PlansPoliciesPublications/theaucklandplan/DRAFTAUCKLANDPLAN/Pages/home.aspx

[3] Accessible on the ARPHS website http://www.arphs.govt.nz/submissions/downloads/2011/20110602_HealthSectorFeedbackToAucklandUnleashed.pdf

[4] National Infrastructure Plan 2011 – Focus on Auckland accessible through http://www.infrastructure.govt.nz/plan/2011/nip-jul11-pt4.pdf



[5]

At the same time as Council is consulting on the Draft Auckland Plan, it is also consulting on its Draft Waterfront and City Centre Masterplans and its Economic Development Strategy.

After submissions on the Draft Auckland Plan close on 25 October, Council will hold oral hearings in November 2011 and then deliberate and adopt the inaugural Auckland Plan on 14 February 2012.

3. Draft Auckland Plan Assessment

At the time of preparing this agenda report, the assessment of the Draft Auckland Plan was still underway.

The Draft Auckland Plan proposes to deliver on the Mayor's vision of the world's most liveable city by setting a number of outcomes for 2040, principles through which to work by and a series of transformational shifts as set out below.[6]

[5] Auckland Council diagram accessible through http://www.aucklandcouncil.govt.nz/EN/AboutCouncil/PlansPoliciesPublications/theaucklandplan/Pages/theaucklandplan.aspx
[6] Draft Auckland Plan Page 24

AUCKLAND'S VISION

THE WORLD'S MOST LIVEABLE CITY – TE PAI ME TE WHAI RAWA O TĀMAKI

OUTCOMES: WHAT THE VISION MEANS IN 2040

A FAIR, SAFE AND HEALTHY AUCKLAND	A GREEN AUCKLAND	AN AUCKLAND OF PROSPERITY AND OPPORTUNITY	A WELL CONNECTED AND ACCESSIBLE AUCKLAND	A BEAUTIFUL AUCKLAND THAT IS LOVED BY ITS PEOPLE	A CULTURALLY RICH AND CREATIVE AUCKLAND

PRINCIPLES: WE WILL WORK BY TO ACHIEVE THE OUTCOMES

WORK TOGETHER	VALUE TE AO MĀORI	BE SUSTAINABLE	ACT FAIRLY	MAKE THE BEST USE OF EVERY DOLLAR SPENT	CHECK PROGRESS AND ADAPT TO IMPROVE

TRANSFORMATIONAL SHIFTS: TO ACHIEVE THE VISION

DRAMATICALLY ACCELERATE THE PROSPECTS OF AUCKLAND'S CHILDREN AND YOUNG PEOPLE	STRONGLY COMMIT TO ENVIRONMENTAL ACTION AND GREEN GROWTH	MOVE TO OUTSTANDING PUBLIC TRANSPORT WITHIN ONE NETWORK	RADICALLY IMPROVE THE QUALITY OF URBAN LIVING	SUBSTANTIALLY RAISE LIVING STANDARDS FOR ALL AUCKLANDERS AND FOCUS ON THOSE MOST IN NEED

The Draft Auckland Plan has chapters on:

Auckland Now	Auckland's Strategic Direction	Auckland's High Level Development Strategy
Auckland's People	Auckland's Maori	Auckland's Arts, Culture, Heritage and Lifestyle
Auckland's Economy	Auckland's Environment	Auckland's Response to Climate Change
Rural Auckland	Urban Auckland	Auckland's Housing
Auckland's Infrastructure	Auckland's Transport	Implementation Framework
Monitoring and Evaluation		

Each chapter provides an overview of relevant issues, a series of priorities and policy directives intended to help deliver on the priorities.

Population Health

Compared to the Discussion Document, the Draft Auckland Plan incorporates a greater focus on issues that impact on health outcomes. Informal feedback from a range of sources suggests that the DHB/ARPHS submission to the Discussion Document was an important influence in changing Council's thinking. Areas of particular relevance to population health outcomes are the Draft Auckland Plan's proposals around:

- Children and Young People
- Raising living standards for all Aucklanders (with a focus on those most in need)
- Housing – affordability and quality
- Public Transport
- Urban Environment.

If the targets contained in the Draft Auckland Plan are achieved, it will have a positive impact on health outcomes and reducing health inequalities. Integration with Whānau Ora initiatives

will be important in relation to Māori health aspirations and outcomes, and the Draft Plan is being reviewed with this in mind.

Service Delivery

Over the 30 year lifespan of the Auckland Plan, Council expects the region's population to increase to between 2.2 and 2.5 million people. Approximately 75% of these new residents are expected to be accommodated within the current urban area. Within the current urban area, a centres classification is proposed to outline the sort of growth and accompanying services (including health services) that is expected within each class of centre. Growth is also proposed in a number of growth corridors. The current metropolitan urban limit will be replaced by a rural urban boundary within which land will be progressively released for Greenfield development (see Appendix region wide development map).[7]

Within the ADHB area, particular mention is made of growth in the following areas:

- CBD population 78,000 (2040) – greater proportion of children, family and elderly
- New Lynn population 20,000 (2030)
- Tamaki population 26,000 (2031)
- Onehunga +3400 homes (2040).

Within the Waitemata DHB area, Takapuna and Warkworth are identified for growth (although no numbers are presented). There are also new Greenfield areas identified for Silverdale and Hobsonville.

Within the CMDHB area the Southern Initiative will focus on the area of the region experiencing the highest socio-economic deprivation and some of the highest health needs. There will also be new Greenfield areas south of Papakura, north of Pukekohe and Waiuku.

The Draft Auckland Plan also sets out Council's proposals for how development and investment will be sequenced. Council's short term focus to 2015 will be on the areas identified (see Appendix first indicative priorities map).

Over the longer term life of the Auckland Plan, Council outlines its indicative timetable for place based projects in a series of maps (see Appendix, second, third and fourth indicative priorities map).[8]

Implementation

Implementation of the plan is dependent on Council decisions / actions and the decisions / actions of a number other entities including the DHBs. There are a number of actions proposed to support each priority and directive in the Draft Auckland Plan.

The implementation actions will be the key ingredient in the success or otherwise of the Auckland Plan in achieving its objectives and is an area where the Draft Auckland Plan is being given close scrutiny.

In the area of social infrastructure provision Council wishes to:

"…work with government, health agencies and the three District Health Boards to ensure that timely investment is made to meet the health needs of the growing population and the changing demographic patterns."[9]

[7] Draft Auckland Plan, Page 37 Development Strategy (Auckland Wide)
[8] Draft Auckland Plan pages 202 & 203
[9] Draft Auckland Plan page 153

The DHBs are specifically referred to in one proposed action in the proposed priority to "Improve the education, health and safety of Aucklanders, with a focus on those most in need" as follows:

"Take an integrated approach to improving health and reducing health inequalities and ensure that urban development encourages healthy living."[10]

There are a number of other areas of the Draft Auckland Plan where health input and support will help achieve the goals of both health and Council.

It will be important, where the implementation actions potentially involve health, that the sector is prepared to support the actions identified.

Monitoring
The Draft Auckland Plan also proposes a monitoring framework against which progress can be assessed and evaluated. A number of these are directly relevant to health:[11]

B4 School Checks	Housing related hospitalisation	Cardiovascular assessment
Water consumption	Air pollution	Greenhouse gas emission
Housing – cost and overcrowding	Wastewater overflows	Healthcare access
Active and public transport	Death and Serious injury from traffic accidents	

4. Draft Auckland Plan Response

At the time this report was written the draft submission from the DHBs and ARPHS was not available for inclusion in the agenda. It is intended to provide a more substantive briefing on the proposed content of the draft submission at the meeting and to have a 'work in progress' draft available to Committee members at the meeting.

The minutes from the Committee's meeting on 14 September notes that the Committee will consider how it wishes to 'sign-off' on the submission at this meeting. Unfortunately the timeframes of the submission process preclude the final draft being presented to a meeting of CPHAC. This is intended to be a regional submission and the CMHDB CPHAC resolved at its August meeting that its Chair will circulate the final draft to the CMDHB Board and invite electronic sign off by the Board. The CMDHB approach may be an appropriate model for use by this Committee.

Council will be holding hearings on the Draft Auckland Plan in November. This provides an opportunity to make an oral presentation to Council. Attendance at an oral hearing is recommended as a way of gaining greater engagement with Council.

[10] Draft Auckland Plan page 214
[11] Draft Auckland Plan pages 240 - 244

5. Conclusion

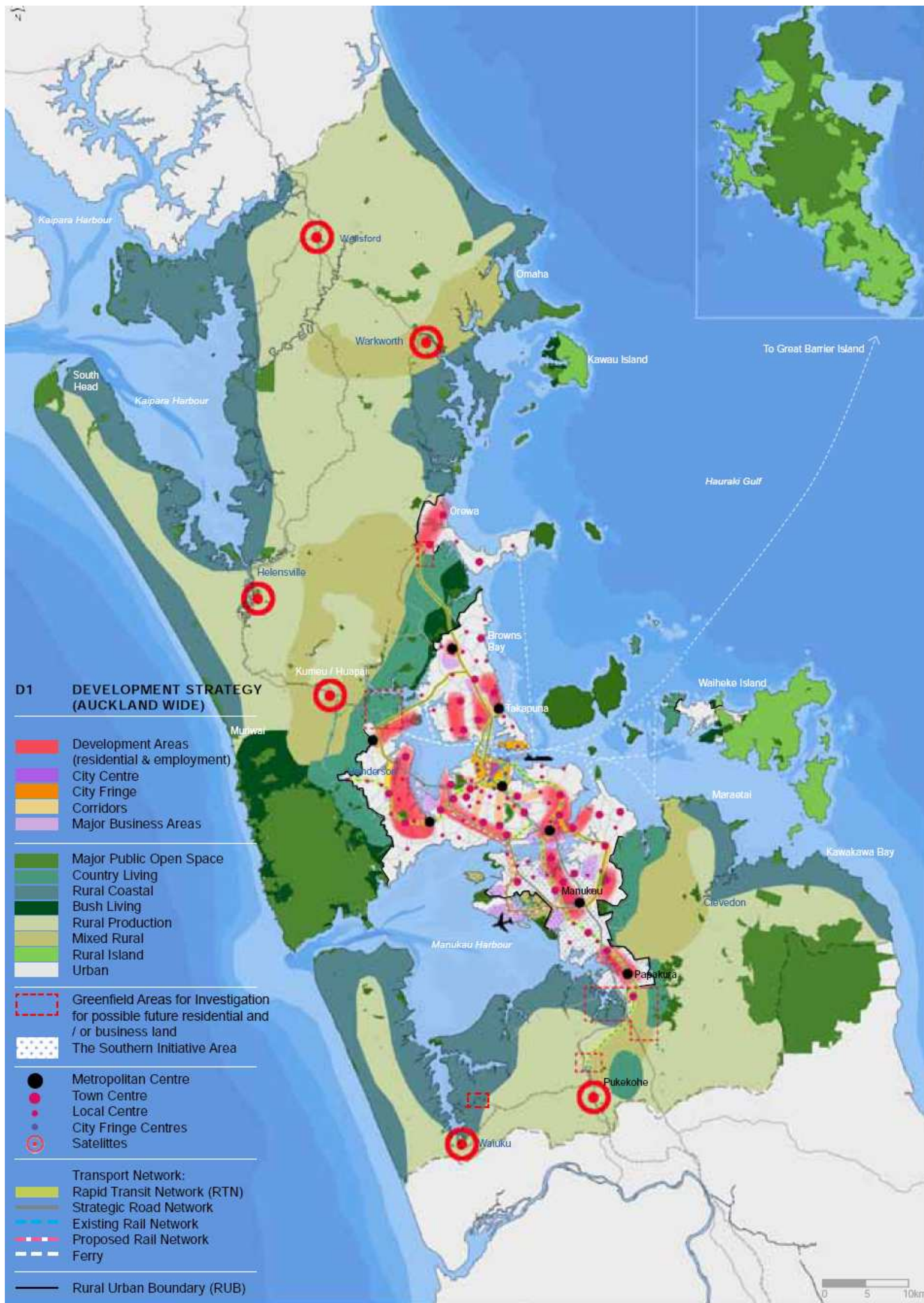
For health the Auckland Plan will complement the Northern Region Health Plan and directly influence the demand for, and preferred location of, health sector facilities and services.

The Draft Auckland Plan contains much that will improve health outcomes and reduce health inequalities and Council is to be commended on its work to date.

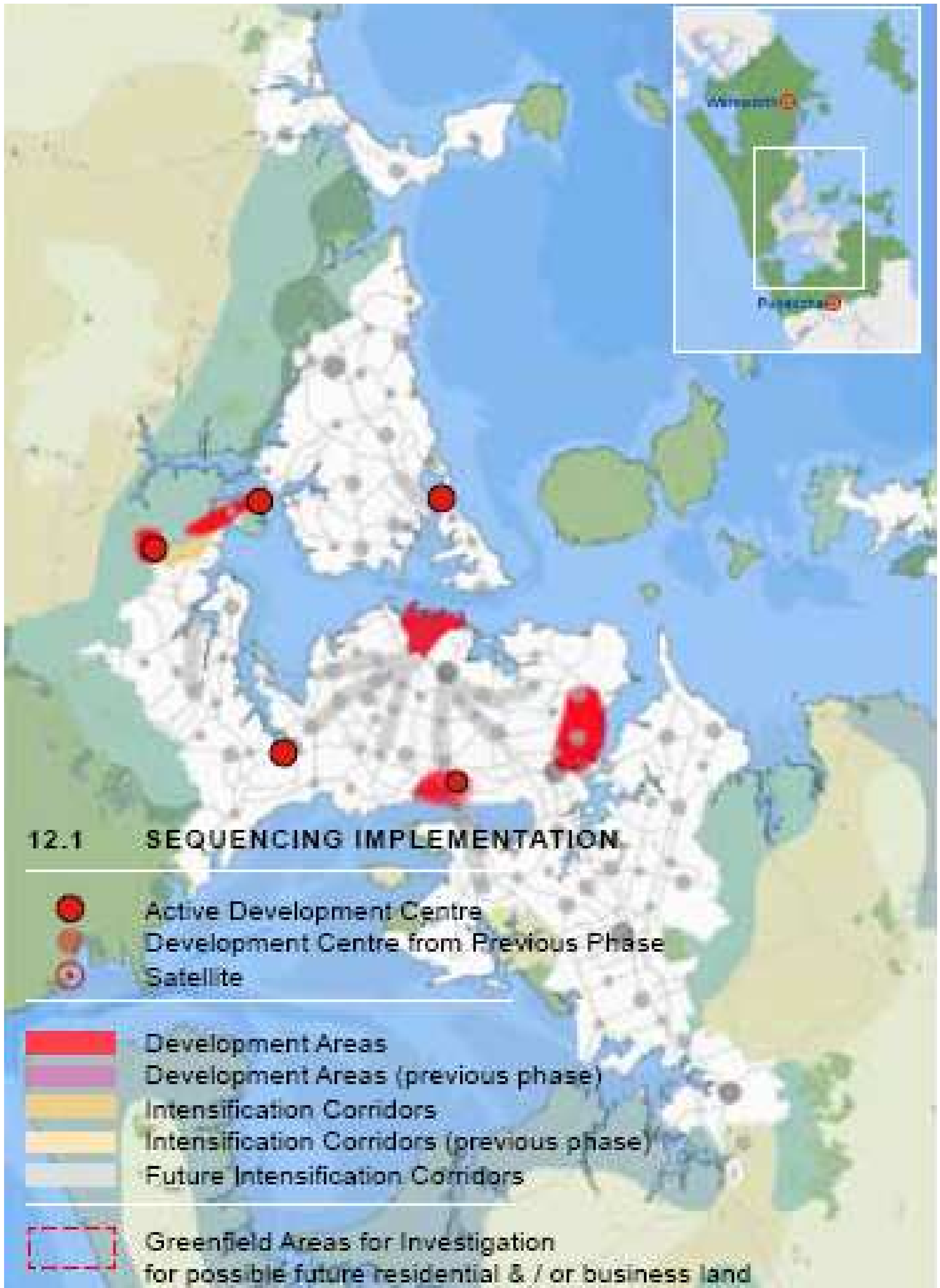
The draft submission for the DHBs and ARPHS will present further ideas and information to Council to support the achievement of relevant Auckland Plan objectives, priorities and directives.

APPENDIX 1

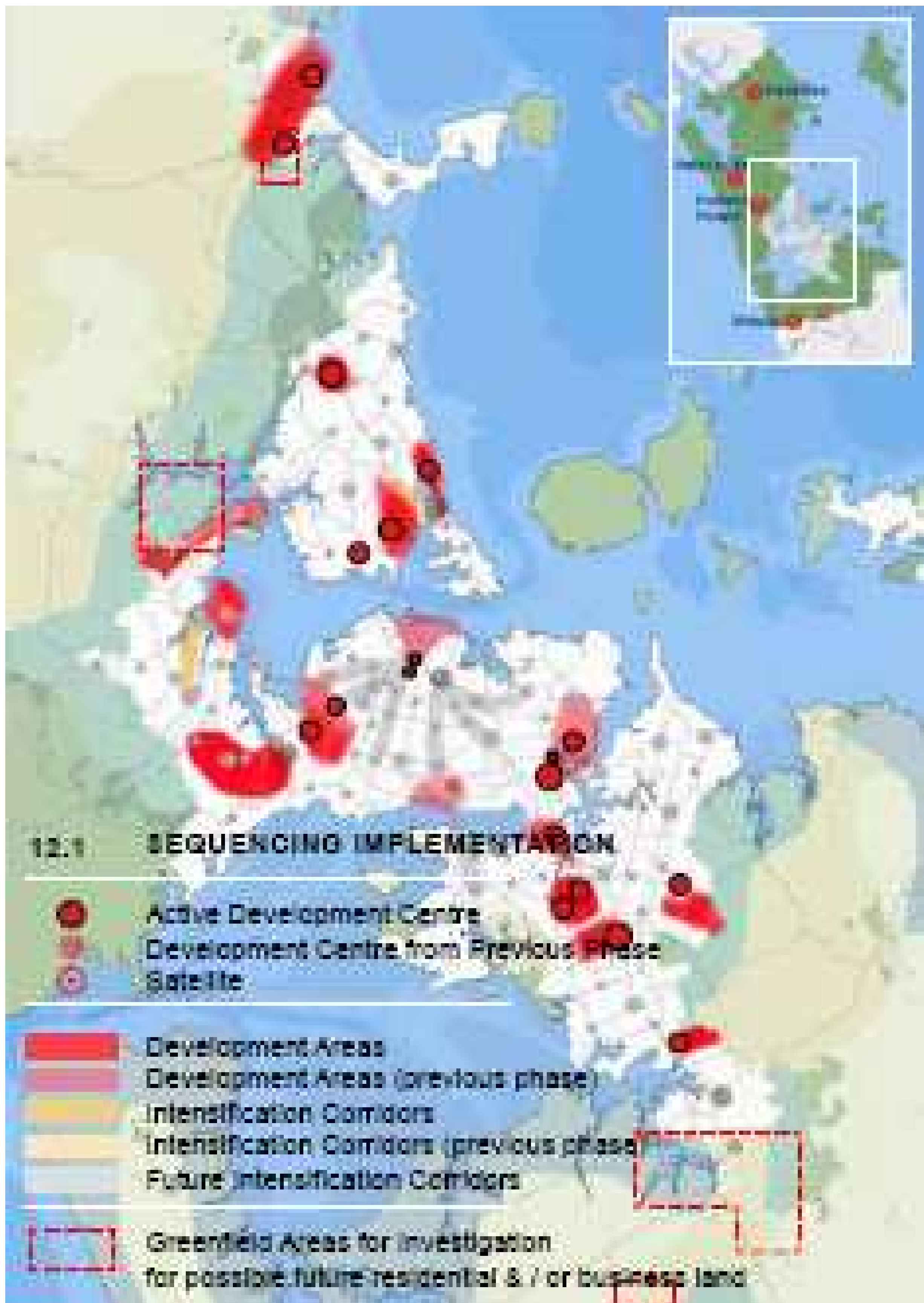
AUCKLAND COUNCIL – DRAFT AUCKLAND PLAN SUBMISSION



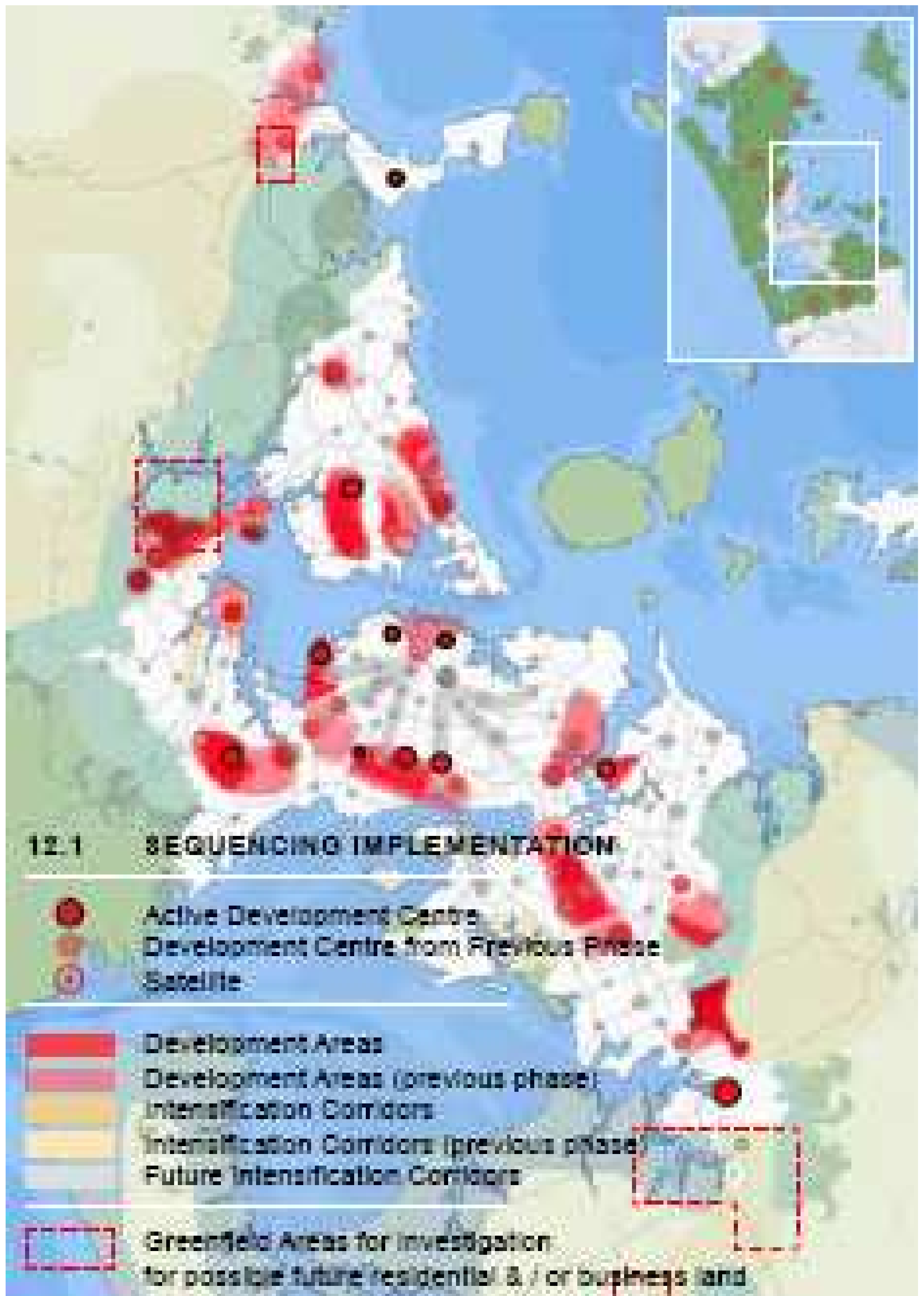
Development Strategy Auckland Wide – Page 37 Draft Auckland Plan



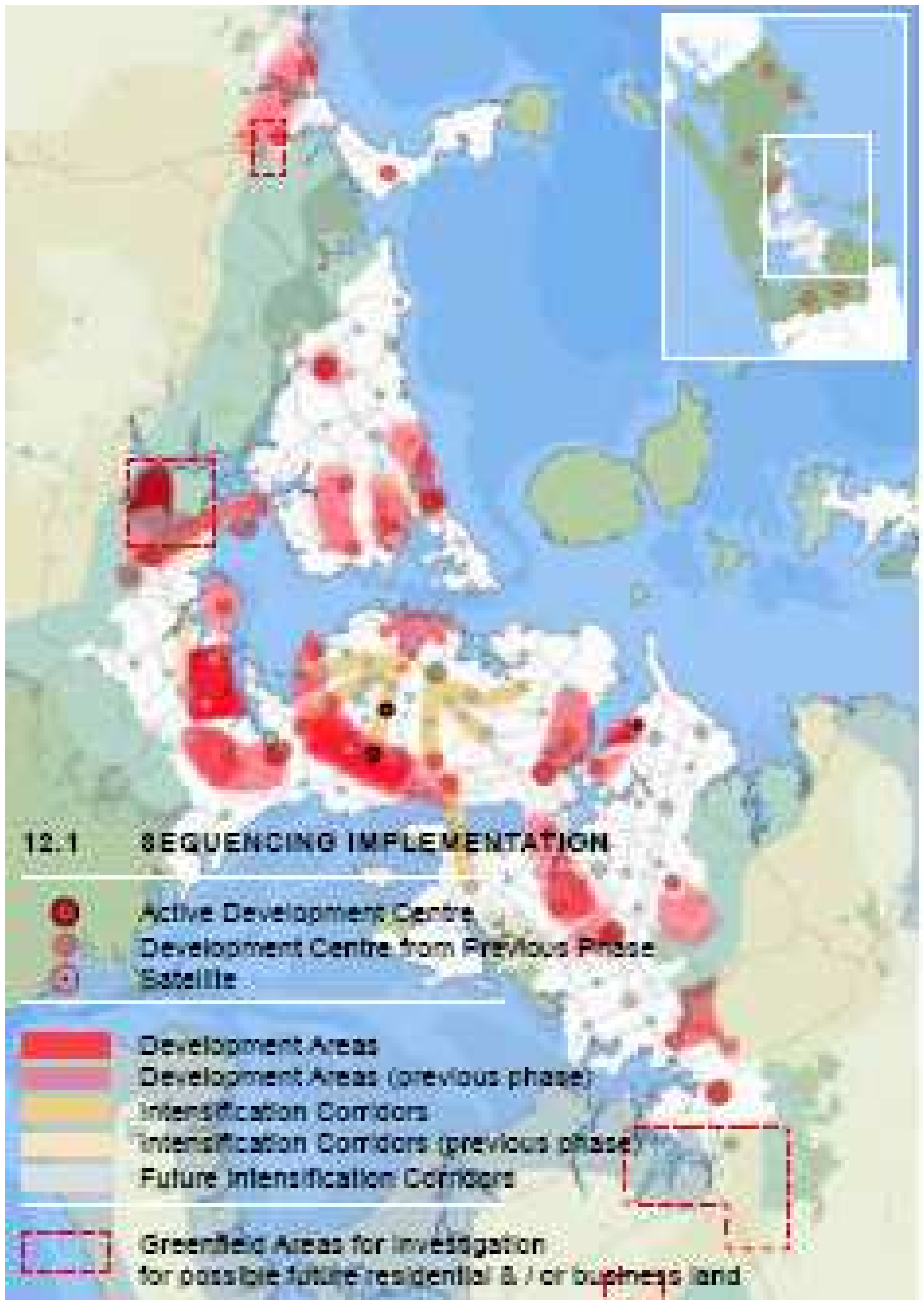
Indicative Priorities for Place Based Projects 2012 Onwards – Page 202 Draft Auckland Plan



Indicative Priorities for Place Based Projects 2015-2022 – Page 202 Draft Auckland Plan



Indicative Priorities for Place Based Projects 2022-2032 – Page 203 Draft Auckland Plan



Indicative Priorities for Place Based Projects 2032-2040 – Page 203 Draft Auckland Plan

3.3 Oral Health

Recommendation:

a) That the Committee notes that the activity under the Oral Health Business Case is progressing to plan and notes:

i) The significant reduction in arrears in the service delivered by Auckland Regional Dental Service (ARDS).

ii) Ministry of Health targets are being achieved or exceeded for the percentage of children caries free at 5 years of age in the Waitemata and Auckland DHBs.

iii) Arrears rates slightly exceed Ministry of Health targets.

iv) The adolescent oral health utilisation rate has reached 61.5% for Waitemata DHB and 71.8% for Auckland DHB. The District Annual Plan (DAP) target is 60% and 68% respectively for 2010/11.

b) That the Committee endorses the:

i) Current and planned activity to be undertaken by ARDS across the region to address the Mean Decayed Missing Filled Teeth (DMFT) score at Year 8 which is slightly below Ministry of Health target.

ii) Current and planned activity to be undertaken across the region to reduce inequalities and increasing access to services for high need groups.

Prepared by: Vicki Scott (Programme Manager Youth and Oral Health, Waitemata DHB), Rachel Mattison (Associate Planning and Funding Manager, Primary Care and Oral Health, Auckland DHB), Helene May (Operations Manager, Auckland Regional Dental Service) and Sathananthan Kanagaratnam (Clinical Director, Auckland Regional Dental Service)

Glossary

ARDS - Auckland Regional Dental Service
Arrears - Children overdue
DHB - District Health Board
DMFT - Decayed Missing Filled Teeth
DNA - Did Not Attend
MoH - Ministry of Health
NDSA - Northern DHB Support Agency
NHI - National Health Index
TDU - Transportable Dental Unit (2 chair dental clinic transported to site by a lowloader)

1. Executive Summary

This report provides an update regarding the:

- Auckland Regional Dental Service (ARDS) including regional adolescent oral health services.
- Implementation of the Oral Health Business Case by Waitemata and Auckland DHB.
- Adult Emergency Dental Care Services (for adults over 18 years with a community service card) funded by Waitemata and Auckland DHBs.

Ministry of Health targets are being achieved or exceeded for the percentage of Children caries free at 5 years of age in the Waitemata and Auckland DHBs.

The adolescent oral health utilisation rate has reached 61.5% for Waitemata DHB and 71.8% for Auckland DHB. The Waitemata DHB District Annual Plan (DAP) target was 60% and the Auckland DHB District Annual Plan (DAP) target was 68% for 2010/11.

2. Background

Auckland Regional Dental Service (ARDS) is the regional provider of dental services for children from birth to 18 years of age. From birth to year 8 (age 12-13) services are provided at some targeted pre-schools, primary and intermediate schools in the three DHBs throughout the Auckland region.

ARDS provides screening, early detection, preventive, restorative and surgical dental services. ARDS also provides a regional adolescent coordination service that facilitates and coordinates the transfer of Year 8 children on to contracted dentists who provide care for adolescents (13-18 years). Waitemata and Auckland DHBs, together with the Northern DHB Support Agency (NDSA) administer the contracts with the Waitemata and Auckland district adolescent oral health providers. Counties Manukau DHB in conjunction with the NDSA manages and administers the contracts with adolescent oral health providers in their DHB area. Those adolescents at high risk of poor oral health, of low utilisation or those who wish to are able to remain with ARDS as a provider.

Any child requiring treatment outside the scope of the School Dental Service or adolescent services, including the use of a general anaesthetic or sedation, is referred to services at Greenlane Hospital.

2.1 Oral health business case

In 2006, the Government announced new funding and a major new direction for oral health services in New Zealand. The Government's vision is 'for high-quality oral health services that promote, improve, maintain and restore good oral health, and that are proactive in addressing the needs of those at greatest risk of poor oral health' *(Good Oral Health for All, for Life – The Strategic Vision for Oral Health in New Zealand, 2006).* There are a number of key action areas through which the vision is to be achieved:

1. Re-orientating child and adolescent oral health services
2. Reducing inequalities in oral health outcomes and access to oral health services
3. Promoting oral health
4. Building links with primary care
5. Building the oral health workforce
6. Developing oral health policy and research, monitoring, and evaluation.

The Waitemata DHB Oral Health Business Case is currently being implemented by ARDS, while Auckland DHB has the responsibility of implementing their own Business Case in the Auckland DHB area. The purpose of the Oral Health Business Cases is to address the above six areas and sets out a proposed plan for improving oral health in the district via new or refurbished facilities, an updated model of care and strategies to address workforce recruitment and retention. The re-orientation of the service focuses on a population-based approach to education, prevention and early intervention. The implementation plan has the re-orientation of child and adolescent oral health facilities in the Waitemata and Auckland DHB districts phased over three years, while oral health service delivery increases are phased over five years.

These business cases address a number of service delivery and infrastructure issues. The improvements include:

- Increased capacity to examine and treat children
- Modern purpose built facilities
- Increased mobile fleet for rural areas and areas of high need for Waitemata DHB, including the purchase of seven new mobile diagnostic vans
- Auckland DHB will be purchasing six new mobile diagnostic vans
- Improved accessibility with increased opening hours
- Better access to sedation facilities, negating the need for some consumers to travel to Greenlane
- Changed model of care to meet individual needs and aim for 'four handed dentistry'. Four handed dentistry is a technique in which a dental assistant works directly with the dental therapist on the procedures being done in the mouth. This model enhances productivity and effectiveness by synergising the transfer of instruments, by minimising the dental therapist's movement and reducing the amount of time the patient spends in the chair.

2.2 Adolescent oral health

ARDS holds the contract for the Regional Adolescent Coordination Service and undertakes the functions of this service for all three metro DHBs.

Twenty one secondary schools in Waitemata DHB (out of a total of 32 secondary schools) have a mobile dental provider at the school. The remaining schools in Waitemata DHB have declined a mobile service on-site. The current environment allows schools to decline the provision of an on-site mobile service. ARDS is now able to obtain oral utilisation data for high schools, which shows poor utilisation for schools without an on-site mobile service. ARDS in conjunction with DHB Planning and Funding are working with schools that have historically declined a mobile service to encourage these schools to opt for an on-site mobile service. This work has a key component of the ARDS adolescent oral health strategy referred to in paragraph 3.4 in this paper. Schools allowing a mobile service to access their grounds have on average, at least a 15% increase in utilisation compared to schools which do not.

Twenty schools within ADHB area (out of a total of 45 secondary schools) have a mobile dental provider at the school. The remaining secondary schools in Auckland DHB do not receive a mobile service. The majority of these schools are potentially too small to make it viable to take a mobile service in. The students of schools where a mobile provider is not received are able to visit a private dentist who holds a contract with the DHB for free adolescent dental services. Further work to increase the school uptake of a mobile provider will continue and be strengthened through the adolescent strategy.

Families also have a choice if they prefer to visit one of the private dentists who hold a contract with Waitemata or Auckland DHB to provide adolescent dental services. This is an option for children attending a school who have declined a mobile service on site. Furthermore a small minority of these families choose to pay for dental services privately. This has been estimated at less that 10% of those eligible for DHB funded oral health care.

2.3 Emergency dental care services

Waitemata DHB

These service is for adults over 18 years with a community service card and provides emergency dental care which is immediately necessary for the relief of pain and infection. Emergency dental care services include:

- Dental examination, diagnosis and advice
- Radiography of the problem area
- Extraction when necessary to treat problem
- Root treatment for anterior tooth, endodontic dressing for posterior tooth
- Treatment of active infection.

Waitemata DHB funds two providers to deliver emergency dental care services to any valid community services card holder over 18 years. The providers have clinics in Takapuna, Henderson, Albany, Glenfield and Wellsford. These services are currently utilised to capacity.

In addition Te Whanau o Waipareira hold a contract with Waitemata DHB to provide emergency and basic dental care services for community services card holders over 18 years and other high needs groups.

Auckland DHB

Auckland DHB currently holds a contract with The People's Centre for relief of pain services for high needs patients and those with psychiatric disability. Like Waitemata DHB, this contract is for adults over the age of 18 years with a community services card.

Patients from across the district also have the option of attending the Relief of Pain clinic at Greenlane Clinical Centre.

3. Progress/Achievements/Activity

3.1 Waitemata and Auckland DHB Oral Health Business Case implementation

The implementation of the Oral Health Business Case is on track overall and has seen some significant progress in the recent quarter particularly regarding the development of facilities.

Waitemata DHB

Clinic/venue	Status
Glenfield Intermediate: four chairs	Open
Henderson Intermediate: six chairs	Open
Edmonton Intermediate: two chairs	Open
Belmont Intermediate : two chairs	Completion due on time 28 Sept 2011
Northcross Intermediate: two chairs	Completion due on time 7 Oct 2011
Silverdale Primary: two chairs	awaiting land re-designation
Forrest Hill Primary: two chairs	awaiting building consent
Birkenhead Primary: two chairs	Site finalised-design/planning in progress
Westgate Shopping Centre: four chairs	Purchase of nominated unit in process - Board approval on 30 Sept 2011
Albany Junior High: three chairs	Site finalised-design/planning in progress
Glen Eden Intermediate: three chairs	Site to be finalised
Transportable Dental Unit	Three units are in situ in West Auckland. A further two due mid November. Fifteen will be completed in total in WDHB area.

Auckland DHB

Clinic/venue	Status
Sylvia Park: two chairs	Open
Pt England: four chairs	Open
Otahuhu: three chairs	Open
Stonefields: three chairs	Open
Balmoral: two chairs	Open
Avondale: three chairs	Open
Blockhouse Bay: three chairs	Construction complete
Royal Oak: three chairs	Construction complete
Ponsonby: three chairs	Construction underway
Wesley: three chairs	Construction underway
May Road: three chairs	Site finalised-design/planning in progress
Orakei: two chairs	Site finalised-design/planning in progress
Waiheke: one chair	Site finalised-design/planning in progress
Greenlane Clinical Centre: number of chairs still to be decided	Site still to be finalised
Level one, one chair diagnostic mobile vans	ADHB currently has four new mobiles operating. Two additional mobiles are due for delivery in April and May 2012 respectively. There will be six new diagnostic mobiles operating in the ADHB area by June 2012

3.2 Pre-School Programme

The following data identifies the percentage of enrolment and examination of Preschool children. The data shows that specific strategies are required to ensure Maori and Pacific families/whanau have equitable access to appropriate services.

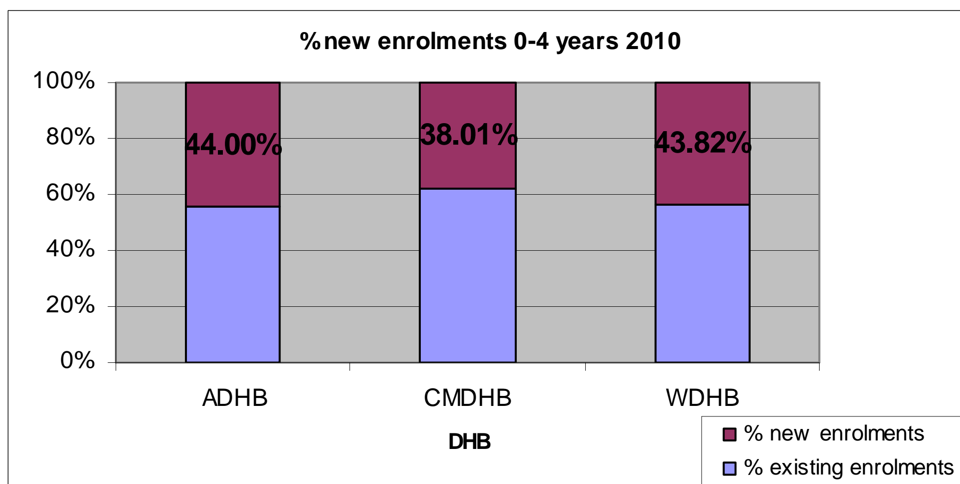
ADHB	Population 2010	Enrolment	% Enrolment	Examined	% Examined out of enrolled population
Maori	4850	2170	44.7%	1157	53.3.%
Pacific	6470	3788	58.6%	1928	50.9%
Other	18330	12450	67.9%	8413	67.6%
TOTAL	29650	18408	62.1%	11498	62.5%
CMDHB	**Population 2010**	**Enrolment**	**% Enrol.**	**Examined**	**% Examined out of enrolled population**
Maori	12880	6105	47.4%	3407	55.8%
Pacific	13820	7654	55.4%	4335	56.6%
Others	15950	11563	72.5%	8407	72.7%
TOTAL	42650	25322	59.4%	16149	63.8%
WDHB	**Population 2010**	**Enrolment**	**% Enrol.**	**Examined**	**% Examined out of enrolled population**
Maori	7630	3791	49.7%	2204	58.1%
Pacific	5260	2613	49.7%	1442	55.2%
Others	25820	18165	70.4%	12746	70.2%
TOTAL	38710	24569	63.5%	16392	66.7%

The 2011/12 Auckland DHB DAP target for pre-school (0-4) enrolments is 73% and for Waitemata DHB is 75%.

One of the key functions of this service is to build relationships with Well-child providers in the area to encourage early enrolment in the service and early referrals from other providers when appropriate. The coordinators visit some early childhood centres in targeted areas. Children are assessed, diagnosed and referred as appropriate. This targeted earlier intervention enables children with high clinical needs to be referred at an earlier age. The programme was evaluated in June 2011 with early data showing increasing enrolments are positive. Analysis of recent data shows that there is a significant increase in new enrolments in the 0-4 age group compared to those aged 5-13 years.

The service has developed a pre-school oral health strategy which will consider a number of different approaches and ascertain their effectiveness and value for money. The strategy will focus on:

- Increasing enrolment and examinations of pre-school children
- Increasing health education to parents and caregivers including active follow up of non - attendance
- Ensuring the targeting of hard to reach populations to ensure the service provided is accessible and appropriate.



The graph above shows that for 0-4 year olds, 44% of Auckland DHB and 43.8% of the Waitemata DHB total enrolments were new enrolments during the 2010 calendar year. This increase demonstrates the considerable effort that has been dedicated to enrolling pre-school children.

3.3 ARDS activity/performance

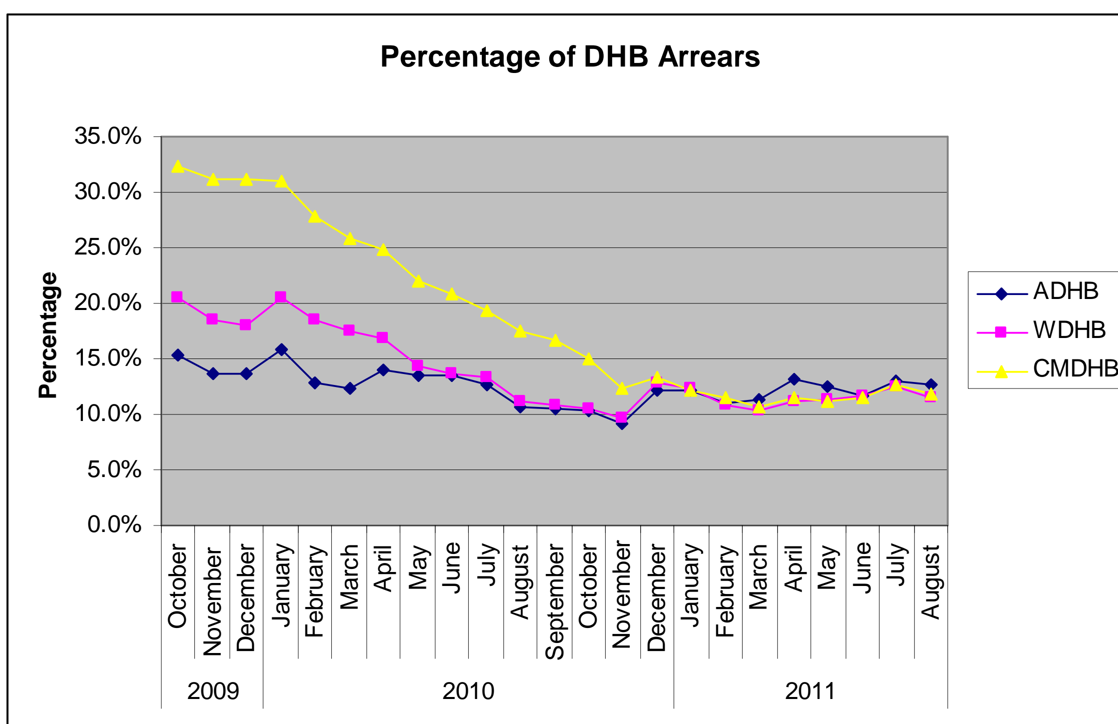
The following information provides an overview of ARDS activity and performance in three areas:

- Arrears
- Caries Free at five years old
- Mean DMFT score at year 8.

Arrears

Arrears data provides information regarding the percentage of children who are overdue for an assessment. The following graph indicates that the oral health services provided by ARDS are becoming increasingly accessible and available and that the number of children overdue for their scheduled examination is decreasing. There are specific areas within the DHB regions that have particularly high arrears rates which impacts on the overall results. This can partly be attributed to the implementation of the Oral Health Business Case i.e. old clinics closing awaiting the opening of new facilities. The graph also demonstrates a significant improvement

in arrears since 2009. The improvement in arrears can be attributed to an increase in oral health clinicians, improved productivity and improved, reliable data collection. The Ministry of Health target is 10% or less.



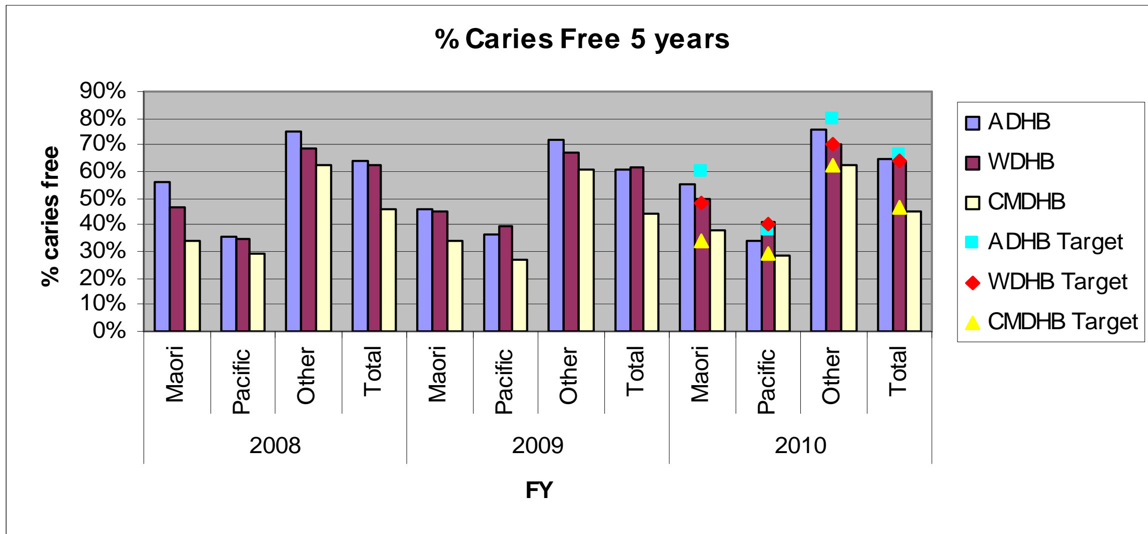
Children caries free at five years old

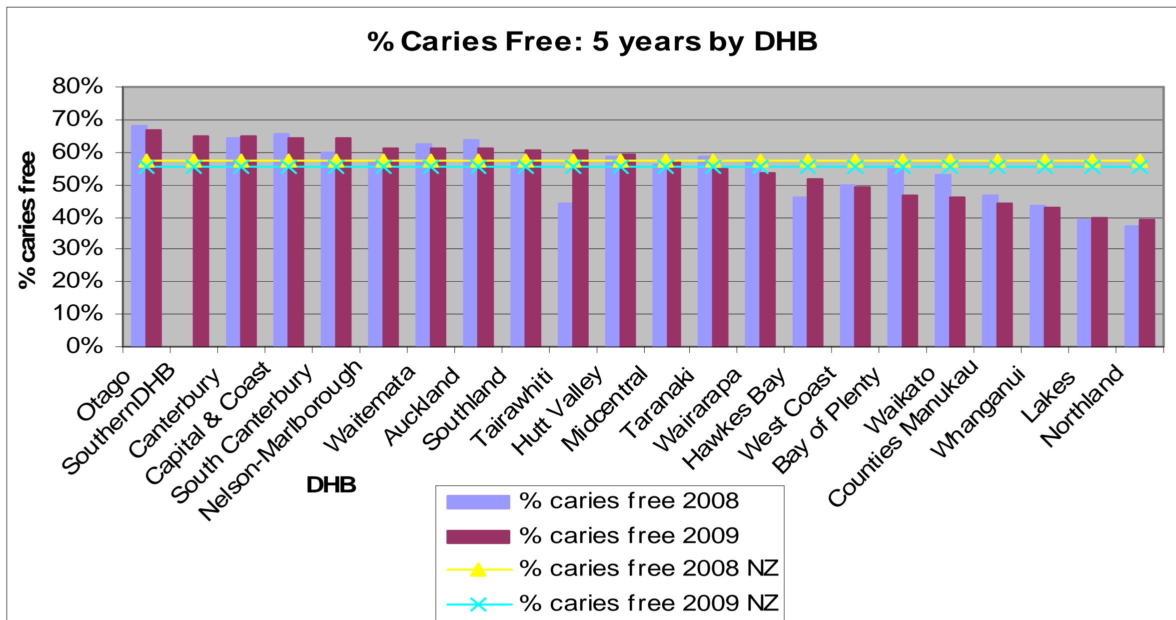
The following provides information regarding the prevalence of oral disease and severity of dental decay in children at five years old. Ministry of Health targets are being achieved or exceeded in this area. Waitemata and Auckland DHBs are in the top third of DHBs for children caries free at age five (National data available up until 2009 only).

Increased enrolment of at risk pre-school children enables early engagement with oral health services. This provides opportunities for intervention aimed at the prevention of oral disease and overall reduces the prevalence of dental decay overall.

The implementation of the Oral Health Business Case will increase accessibility to regular care through clinics that will be open longer and will be responsive to increased numbers of children during the year.

In order to address the requirement for early intervention an additional two pre-school coordinators (1.4 FTE) in the Waitemata DHB region were appointed in March 2010 and July 2010. The coordinators are each supported by a 0.6 FTE Dental Therapist. Auckland DHB has three pre-school coordinators who undertake this role and are also supported by a dental therapist.

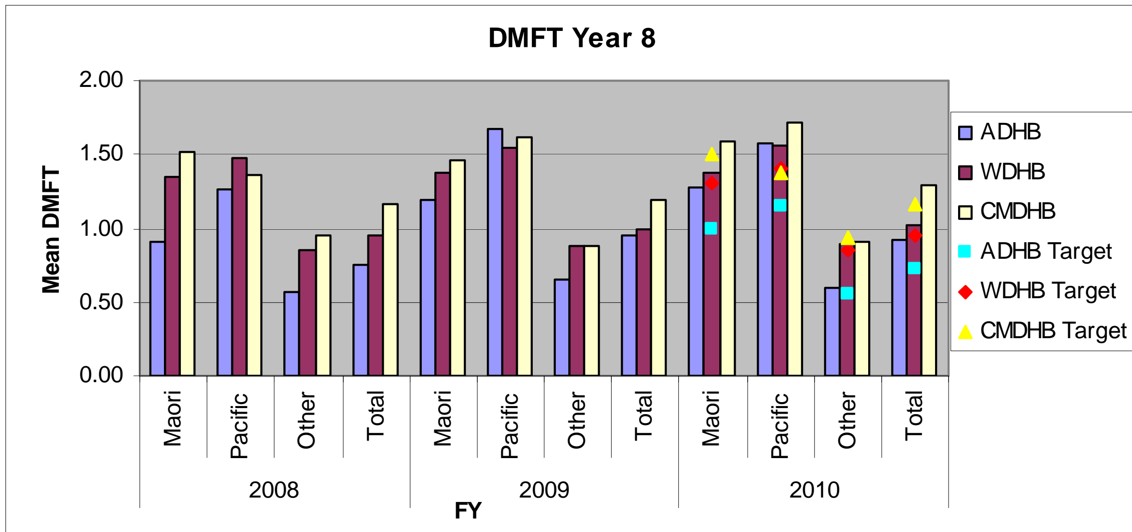


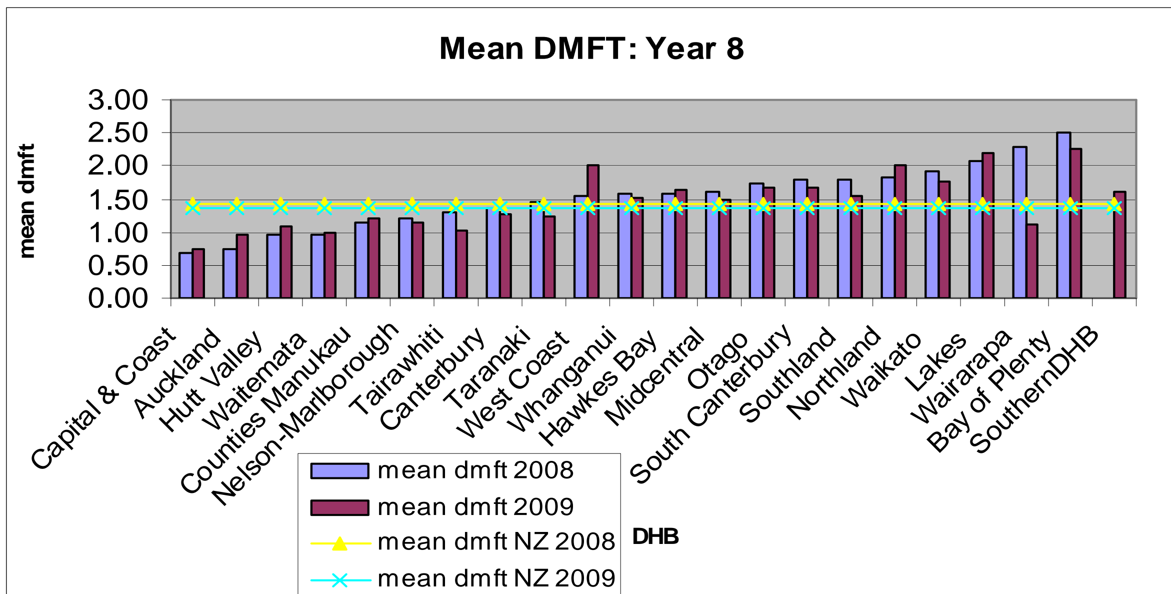


Mean Decayed Missing Filled Teeth (DMFT) score at Year 8

DMFT describes the average amount, or prevalence, of dental caries in an individual. The following provides information regarding the percentage of caries free children and the severity of dental caries in children at the end of their intermediate school Year 8 (12/13 year olds). However ARDS dental service is only one contributor to the overall DMFT status of children in the Waitemata DHB area. Other environmental issues such as unhealthy diet choices and fluoride status contribute to the DMFT status. Waitemata and Auckland DHB's DMFT status of children at year 8 is favourable in comparison with other DHBs (National data available up until 2009 only).

In order to improve DMFT scores ARDS continues to focus on increasing the enrolment of at risk pre-school children. This enables early engagement with oral health services and provides opportunities for intervention aimed at the prevention of oral disease; this contributes to reducing the prevalence of dental decay long term. The implementation of the Oral Health Business Case will continue to facilitate increased accessibility to regular individualised dental care through clinics that will be open longer and will be able to be responsive to increased numbers of children attending.

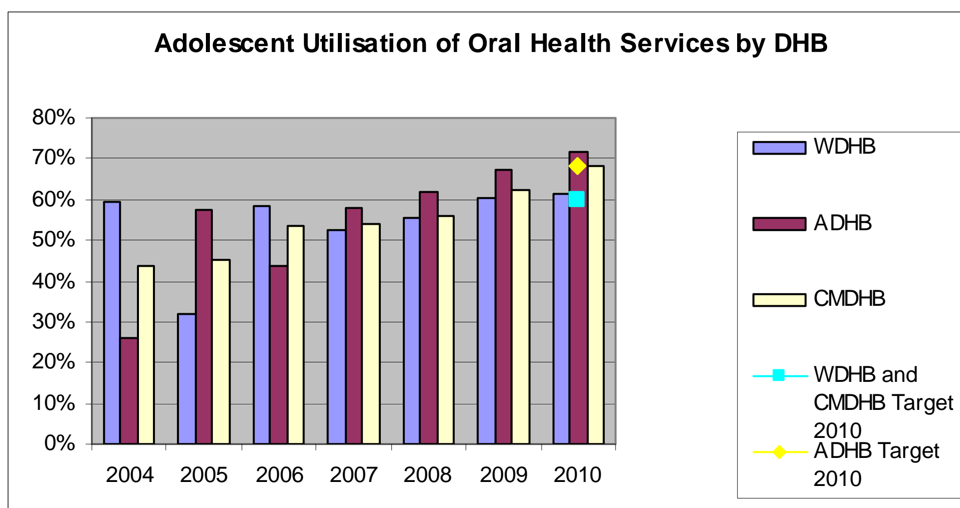




3.4 Adolescent oral health

Work and effort continues to increase the number of schools that accept a mobile oral health service on site and the number of private dentists willing to treat adolescents. The Ministry of Health has just agreed to the ARDS adolescent strategy which included input from the three Auckland Metro DHBs. Key components of the regional strategy include:

- Maintaining and increasing mobile service provision to schools
- Increasing the use of the ARDS mobile service and facilities to meet the needs of those young people not attending school
- Ensuring the targeting of hard to reach populations incorporating a youth specific approach where appropriate.



DHB	Number of adolescents served in 2010	Total adolescent population 2010	2010 Utilisation
Auckland	**17,208**	23,970	71.8%
Waitemata	**22,030**	35,845	61.5%
Counties-Manukau	**24,896**	36,615	68.0%

Overall, in metro Auckland, the increase in adolescent utilisation of oral health care has been substantial. The national target for adolescent utilisation of dental services is 85% by 2013. The adolescent oral health utilisation rate has reached 61.5% for Waitemata DHB and 71.8% for Auckland DHB. The District Annual Plan (DAP) target is 60% and 68% respectively for 2010/11.

In order to improve adolescent utilisation of dental services, ARDS along with the three Auckland Metro DHBs are undertaking the following actions:

- Waitemata DHB holds 80 contracts and Auckland DHB hold 71 contracts with dental practices for adolescent services. Work will be undertaken with these providers to ensure they are accessible and appropriate for young people.
- Waitemata DHB is continuing to work with schools to increase the number of high schools accepting a mobile provider on site.
- Due to improvements in data collection from providers, it is now possible to approach individual high schools with data which shows the proportion of their students who currently access DHB funded oral healthcare.
- Waitemata DHB recently implemented a new process of electronically transferring a child's details from the school dental service to an adolescent provider. A letter to parents informs them of the dentist their child is enrolled with and information on how to change the chosen dentist if they wish. All contracted dentists are provided with a list of the children to be enrolled in their practice.
- Oral health promotion in local papers is undertaken to increase the visibility and profile of the service.

National Health Index (NHI) Number

In August 2010, all adolescent oral health contracted providers in Waitemata DHB were requested to include their clients' NHI number on claim forms. ARDS has worked with the DHB to ensure contracted dentists are providing NHI numbers as required and that those children transitioning into the adolescent service also have NHI numbers.

As this is a new requirement for dental practices, it has required some work to develop the process in order that this can be achieved. Most providers are now including NHIs with their claim forms and Waitemata DHB is working with MoH Sector Services and the NDSA to develop new reporting using the additional information the NHI provides. This will assist with further targeting of oral health adolescent services and will provide a more detailed breakdown and analysis of the Waitemata DHB and regional adolescent utilisation rate.

The process whereby adolescent oral health contracted providers were requested to include their clients NHI number on claim forms has recently been replicated by Auckland and Counties Manukau DHBs.

4. Risks/Issues

Although adolescent service provision has increased and met the DHB DAP target for 2010/11, adolescent utilisation remains below the Ministry of Health national 2013 target of 85% and remains a particular challenge for the Auckland metro DHBs. Auckland and Waitemata DHBs will work with ARDS to increase adolescent utilisation. The development of an adolescent strategy will help to meet the 2011/12 DAP targets. Utilisation is recorded where the adolescent attends the dentist, not their place of residence. It is therefore important to note that DHB adolescent oral health utilisation should not be viewed and considered in isolation from the other regional DHBs, as the coordination of this service is undertaken regionally. The collection of NHI numbers will ensure that the adolescent's DHB of domicile is matched and accurate service utilisation information will be able to be collected.

5. New Service Initiatives

Aligned to and in support of the implementation of the Oral Health Business Cases, ARDS and the three DHB Planning and Funding teams are working collaboratively to develop and implement new service initiatives that will address the issues discussed in this paper.
The initiatives currently underway are:

- Implementation of the regional pre-school and adolescent strategies. Both strategies have been approved by the Ministry of Health.
- Development of a strategy to reduce barriers to accessing service, and consequently decrease non-attendance at dental appointments. The strategy will target the under 5 age group to enable provision of oral health education, detection of caries at early stages, provide preventive and minimal restorative treatment. The strategy will also have a focus on reaching Maori and Pacific children and families/whanau.
- Active employment of community dentists. This role of the community dentist will undertake the work that is outside of the scope of Dental Therapists. By employing a community dentist, the child/adolescent will not have to be referred to a private dentist for work unable to be undertaken outside of the scope of the dental therapist. This will ensure that the child/adolescent has the required work undertaken and that continuity of the service remains.
- Increasing the ratio of Dental Assistants to Dental Therapists to enable four handed dentistry to be implemented, thereby improving productivity and outcomes for children.
- A Pilot of extended hours within the new community clinics will be undertaken during 2012. A survey/feedback is currently being scoped which will provide the service with information regarding optimum clinic opening hours. The survey will determine whether extended hours are required, and if so, what hours would meet the needs of the population.
- Improved integration with other child and youth specific health services across the region with a focus on addressing integration with Maori and Pacific and Primary Care providers.

6. Future Considerations for ARDS

In March 2011, the New Zealand Dental Council went out for consultation on the dental therapy scope of practice to include adult care under direct clinical supervision or clinical guidance. In May, the Council noted a majority support for the proposal and agreed that this change would not compromise patient safety.

The provision of adult care within the dental therapy scope of practice for adult patients (aged over 18 years), depending on the dental therapist's qualifications, can be provided in a team situation under direct clinical supervision or the clinical guidance of a practising dentist or dental specialist. However, currently there are no accredited training programmes for practising under direct clinical supervision.

ARDS and the DHBs will need to consider whether adult scope of practice will be implemented and the timeframes around this. ARDS has indicated that appropriate funding will be required if adults are seen within the service.

7. Conclusion

ARDS and the three DHB Planning and Funding teams are working collaboratively to develop and implement new service initiatives that will address the issues discussed in this paper. The new service initiatives listed in section 5 above have a focus on targeting high needs groups, reducing inequalities and increasing access to services for children and adolescents aged 0-18 years.

Overall both Waitemata and Auckland DHB demonstrate favourable results for children caries free at 5 years old and Mean, decayed, missing and filled teeth (DMFT score at year 8), however the results for both Maori and Pacific children clearly indicate further work is required to ensure the services are appropriate and accessible for the children, adolescents and family/whanau to attend.

Regional adolescent utilisation of oral health services continues to increase. However, further targeting of services is required to ensure adolescents and their families/whanau across the region that do not access dental treatment are informed and able to do so. Waitemata and Auckland DHBs are working closely with the Auckland Regional Dental Service to ensure the target of 85% is achievable.

The oral health business cases are progressing to plan.

4.1 Mental Health Information Paper

Recommendation:

That the report be received.

Prepared by: Howard Dawson (Waitemata DHB Programme Manager), Jean – Marie Bush (Waitemata DHB Programme Manager), Robert Ford (Auckland DHB Programme Manager) and Julie Armstrong (Auckland DHB Assistant Programme Manager)

Glossary

AOD - Alcohol and other Drugs
CADS - Community Alcohol and Drug Services
CAMHS - Child and Adolescent Mental Health Services
CEP - Co-Existing Problems
DHB - District Health Board
EDS - Eating Disorders Service
LCS - Local Co-ordination Service
LGBT - Lesbian, Gay, Bisexual and Transgender
MOU - Memorandum of Understanding
NDSA - Northern Districts Support Agency
NGO - Non Government Organisation
POC - Packages of Care
RFP - Request for Proposals

1. Executive Summary

Over the past 20 years, Auckland and Waitemata DHBs have developed residential rehabilitation provision across the two districts. Waitemata DHB currently funds 10 providers to provide 155 beds in the community at a cost of just over $6 million per annum. Auckland DHB funds nine providers to deliver 203 beds in the community at a cost of just over $11 million per annum.

These services are delivered across the districts and are covered clinically by the Community Mental Health teams of the DHBs. The Community Mental Health teams provide regular clinical review and support. If a client's mental health deteriorates rapidly, then NGO providers also have access to the Community Crisis Teams for support which is available outside of office hours.

Following a recent review of community support and residential service provision, Waitemata and Auckland DHBs have agreed to move from a model based on number and level of rehabilitation beds to a support hours model of care. This will be implemented over the next nine months with the first providers for the change already identified and initial implementation meetings completed.

The Ministry of Health has advised that an agreement has been reached in relation to the court decision regarding payment of minimum wage for staff on sleepover at Intellectually Handicapped facilities. Historically, sleepover shifts have been paid as an allowance for the

shift and not as an hourly rate. The DHBs in the region have sought clarification from the Ministry as to how this decision might affect the Mental Health Sector.

Waitemata DHB has completed a tender for respite services to Adult Mental Health clients. A recommendation has been given by the panel on preferred providers, which is now with the Planners and Funders to consider.

2. Introduction/Background

This paper is to inform the Board on the current provision of Mental Health residential facilities located in Waitemata and Auckland DHBs. It outlines the location of the services and the NGOs providing services. The paper also reviews the risks involved in providing these services and what crisis cover is available to clients in those facilities.

In addition, the paper gives a brief overview of activity within the Mental Health and Alcohol and other Drugs (AOD) services, provided through the Non-Government Organisation (NGO) sector, over the past three months.

Waitemata DHB and Auckland DHB currently fund a wide range of services in the NGO sector. These services include:

- Residential rehabilitation beds – Medium to long term placements with support to help clients achieve independent living.
- Community Support workers – NGO Staff (both qualified and unqualified) who support clients to maintain wellness and to achieve/maintain independent living.
- Residential drug and alcohol treatment beds – services to facilitate client drug and alcohol rehabilitation.
- Kaupapa Maori Services – Culturally appropriate mental health and addictions support for tangata whai ora and whanau.
- Packages of care – Flexible support packages based on client individual needs designed to promote independent community living.
- Advocacy/Peer support services – Client support from support workers who have a personal experience of mental illness.
- Respite services – A short-term residential support for clients with a higher acuity level who are unable to be cared for in their usual home environment but are not requiring an acute inpatient admission.
- Family Whanau support – support and advocacy for family of clients experiencing mental illness.

The total funding to these providers is approximately $65 million across the two Districts. Waitemata DHB’s expenditure is approximately $30 million and Auckland DHB’s is approximately $35 million.

3. Risks/Issues

The Court of Appeal has made a decision on a claim made by the workers/unions that sleepover hours are paid at a rate not less than that defined in the Minimum Wage Act 1983. The claim was made in relation to Intellectually Handicapped facilities where staff was employed to sleepover at the facilities as staff cover.

On the 12 September 2011, the Health Minister Tony Ryall advised that the Cabinet has agreed to provide $90 million towards phasing in minimum wage rates by July 2013, and $27.5 million towards back pay liabilities of the providers in relation to this case.

The agreement reached is that the Government will fund employers to pay 50% of the current minimum hourly wage to workers for sleepovers from 1 July 2011, and then 75% from 1 July 2012, then 100% from 1 July 2013.

The Government will also contribute $27.5 million for back pay, which will be paid at 50% of the appropriate minimum wage for the period 1 July 2005 – 30 June 2011, to past and present employees in respect of all claims lodged to 2 September 2011.

This may set a precedent for Mental Health providers of residential care where similar arrangements for staffing have been in place. The NDSA have been in communication with the Ministry of Health on behalf of the Regions DHBs to ascertain the details of the settlement and understand that the Ministry is in the process of developing a formal statement providing details and implications for Mental Health Providers and DHBs.

Within the region, the DHBs are reviewing models of care with the intention of removing asleep overnight staff from service delivery and moving instead to awake overnight staffing of residential facilities or on-call staffing as appropriate.

4. Residential Rehabilitation Facilities

With the closure of the major mental health institutions in the 1990's, there has been a philosophical and practical shift to caring for clients with mental health issues in the community. This has resulted in the setting up of numerous small facilities and teams to help support and rehabilitate people back into the community.

In the last decade, the philosophy of mental health care has developed further and now follows the recovery model. This model emphasises and supports each individual's potential for recovery. Recovery is seen within the model as a personal journey that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning. It gained impetus due to a perceived failure by services or wider society to adequately support social inclusion, and by studies demonstrating that many can recover.

Waitemata and Auckland DHBs currently fund a number of providers to support clients either in their own homes or in DHB funded residential rehabilitation facilities.

Residential rehabilitation beds are provided in shared homes or units run by NGO providers. They are designated as level two, three or four depending on the amount of support and supervision required (Auckland has only level three and four facilities). The key difference between these levels are the amount of support and supervision required over night, with level two having no staff, level three having staff present but asleep (and may be woken if needed), and level four having awake overnight staff present. The NGO providers have responsibility for the running and maintenance of these facilities. Staff at the units are available at all times to support clients with their needs.

All clients currently in Waitemata and Auckland DHB Residential Rehabilitation facilities are also under the care of the local Community Mental Health Services. The key worker on average regularly reviews them every two weeks, with a formal review with their Psychiatrist at least once every three months.

Summary of Residential Rehabilitation Support across Auckland DHB and Waitemata DHB

	Waitemata DHB	Auckland DHB
Number of NGOs funded	10	9
Number of residential beds	155	203
NGO Providers	• Delamore Support Services • Framework Trust • WALSH trust • Challenge Trust • Connect • Equip • Future Choices • Goodwood Park Trust • Te Kotuku Ki Te Rangi Charitable Trust • Te Ha orange Ngati Whatua Heru Hapai	• Delamore and Reidy • Framework Trust • WALSH trust • Hinemoa Lodge • Richmond NZ • Arahura Trust • Fairleigh Lodge • Affinity • WISH (Waiheke Island) • Odyssey House
Levels of beds funded • **Level 2** • **Level 3** • **Level 4** • **Level 4+** • **Other**	 9 81 45 12 8 dual diagnosis beds (clients with ongoing AOD and Mental Health Conditions)	 0 168 19 6 10 Co-existing Problem (CEP or Dual diagnosis beds)
Location of beds funded	• Ranui • Northcote • Henderson • Te Atatu • Beachhaven • Glen Eden • Massey • Red Beach • New Lynn • Kelston • Browns Bay • Riverhead • Remuera	• Mt Albert • Blockhouse Bay • Grey Lynn • Balmoral • Mt Roskill • Penrose • Herne Bay • Kingsland • Onehunga • Avondale • Royal Oak • Lynfield • Waiheke Island • East Tamaki • Mt Wellington • New Windsor

If a client's mental health status is deteriorating, then the NGO providers advise the clinical teams and the clinical teams would review as needed. If a client deteriorates quickly or outside of normal office hours then the NGOs are able to call the crisis team with access to the on call Psychiatrist, who can if necessary instigate additional support being provided to the facility through respite nursing or admit into the acute wards if necessary.

5. Progress/Achievements/Activity over past 3 months

5.1 Auckland DHB/Waitemata DHB joint update

Package of Care, Community Support Workers, Flexifund, and Residential Rehabilitation

Waitemata and Auckland DHB mental health funders have reviewed the different components of these services including service specifications, descriptions for the Package of Care (POC) and the Flexifund components and amended them to provide a wider ranging and more consistent approach to delivering the service across both DHBs. As most NGO providers span both DHBs, this helps to rationalise their delivery structures.

The contracts will be varied with support hours used as the unit of purchase. This will replace the full time equivalent (FTE) basis currently used.

The region has also undertaken a review of residential beds and will be reducing the number of funded beds and widening the use of a support hours care model. The model funds support hours that are targeted to specific goals. It will also establish the client as the leaseholder of their accommodation. This will enable the client to stay in one place if they wish and have the service delivered around them.

Providers are keen to move to the new model and pilot contracts have been identified to initiate the changeover, with an aim that implementation will be completed by the start of the 2012-13 financial year

The Planners and Funders have met with the all the NGOs on several occasions to outline how this service will be delivered. Overall feedback is very positive.

5.2 Waitemata DHB

Adult Respite Service

Adult Respite services are short term support and supervision provided to any clients aged 18 years and over. It is available to clients who need support outside the home environment but whose acuity is such that they do not require acute inpatient admission.

Waitemata Planning and Funding in conjunction with Waitemata DHB’s Mental Health Services, have reviewed the provision of respite services, which shows that there is benefit in going to tender.

The tender was released on 18 July 2011 and closed on 22 August 2011. The tenders have been reviewed by a panel of experts using the regional contracting guidelines and a recommendation on preferred providers agreed.

Multi-Level Response to Children’s Conduct and Behaviour Problems programme

Waitemata DHB’s Provider Arm/Mental Health and Primary Care Funding Team were successful in their tender application with the Ministry to provide a pilot service to children with conduct and behaviour disorders.

The service is a multi-level response to Children’s Conduct and Behaviour Problems service, which will run as a two year pilot. This initiative is part of the health led deliverables in the Government’s “Drivers of Crime” conduct problems work-stream. The aim of the service is to implement evidence-based parent management programmes through both primary care and specialist settings, and to provide additional mental health and AOD support to the most vulnerable parents through specialist settings.

There are two parts to the service:

1. The further development and delivery of the Incredible Years, evidence based parenting programme, through CAMHS, with a focus on working alongside Special Education.
2. The engagement, through a possible tendering process, of a primary care/community provider to deliver the Primary Care Triple P evidence based parenting programme and to establish and support a network of other primary care/community providers to deliver Primary Care Triple P parenting programmes.

5.3 Auckland DHB update

Iwi Based Solution for Kaupapa Maori Services

Planners and Funders in Auckland have just completed an RFP process for an Iwi Based Solution, Kaupapa Maori provider for a range of community and residential based services. These will include residential rehabilitation for adult and older adult consumers, therapeutic day programme for residents and community referrals, community support for youth, adult, and older adult, housing support, and employment support services for all age groups.

Low Cost – High Impact Projects

Auckland Planners and Funders continue to develop small low cost and high impact services for vulnerable groups. The first of these was Muslim Mental Health Support, which employs a male and female community support worker to provide basic mental health 101 training to Imams in order to raise awareness of mental health problems and encourage access to the support workers and into general mental health services.

Similarly, a project for the Lesbian, Gay, Bisexual, and Transgendered (LGBT) community is close to completion. It included the largest international survey of LGBT consumers of mental health services ever undertaken. The results demonstrate the need for a community based and focussed support worker to facilitate access to LGBT 'friendly' services as a means to reduce suicides and problems for a doubly stigmatised group.

Finally, a project is now well underway looking at the benefits that might accrue from the development and implementation of an online support community for consumers. Such a service would offer continuing support to consumers that are engaged in any way with mental health services. It would provide appropriately monitored and moderated discussion forums and offer a central point for guidance and advice. Such a service has been run successfully in the UK through the auspices of the Tavistock and Portman NHS Trust. The preferred option for development in Auckland is the adoption of the existing package offered by this group, called Big White Wall (www.bigwhitewall.com). Such a service would sit well with the development of services across the continuum of care as it meets a particular need for both generalist and specialist consumers.

6. Conclusion

- The Ministry of Health has been contacted asking for clarification on the recent agreement regarding sleepover payments and its relation to the Mental Health Sector.
- Residential Rehabilitation, Packages of Care and Flexifund agreements have now been reviewed and the consultation process regarding proposed allocation and administrative changes has been completed. Contracts are to be amended over the next nine months after local consultation with relevant NGOs.
- Waitemata DHB's Adult Respite Tender process have been completed. Recommendations for preferred providers have been agreed.
- Waitemata DHB's Multi-Level Response to Children's Conduct and Behaviour Problems tender has been successful. Planning and Funding team now planning an implementation process for Primary Care Triple P component.

- Auckland DHB’s tender process for Iwi Based Solution, Kaupapa Maori provider for a range of community and residential based services completed.
- Auckland DHB’s low cost high impact projects for Muslim Mental Health Support, LGBT support and online support for consumers are being implemented.

4.2 Community/Consumer Engagement

Recommendation:

That the report be received.

Prepared by: Imelda Quilty-King (Community Engagement Co-ordinator, Waitemata DHB) and Tony O'Connor (Engagement and Planning Manager, Auckland DHB)

Glossary

CEA	- Community Engagement Alliance
CEF	- Community Engagement Forum
CMO	- Chief Medical Officer
COO	- Chief Operating Officer
NSCHV	- North Shore Community Health Voice
RHL	- Rodney Health Link
WHL	- Waitakere Health Link

1. Executive Summary

This report provides an overview of the consumer and community engagement mechanisms in place at Waitemata DHB and Auckland DHB and includes progress reports from Rodney Health Link, Waitakere Health Link and North Shore Community Health Voice. The reports reflect activities for the period 1 August to 1 October 2011. Initial background information for new members of the combined CPHAC is also provided.

2. Introduction/Background

Auckland and Waitemata DHBs have committed to improving consumer and community engagement. Both organisations have taken slightly different paths in the development of processes and mechanisms to date. Increased collaboration between the two organisations is providing an opportunity to learn from each other's successes and lesson learned.

This paper traverses some history and background of consumer and community engagement at each DHB to ensure the CPHAC committees have a better understanding of what is in place at each DHB currently, as well as the key achievements for the quarter and future plans.

2.1 Waitemata DHB

In 2007, Waitemata DHB established new arrangements for community and consumer engagement within the combined Planning and Funding Team. These included:

- Continued financial support for the Health Links/Health Voice in each of its three local authority areas. Since 2005, these three community organisations have been contracted to provide information brokerage and information on population health issues between Waitemata DHB and its resident populations. Note these three organisations have previously reported individually to CPHAC and held a rotating "community seat" on the Committee. The reporting has now been incorporated into this report and the Health links / Voice now meet with the Chief Executive Officer regularly.

- The establishment of the Consumer Engagement Alliance (CEA), with a purpose to provide a mechanism to manage the interface between community/consumers (as represented by Health Links/Health Voice) and Waitemata DHB Managers. The CEA was reviewed in 2010 and is now known as the Community Engagement Forum (CEF). The purpose of this forum is to test the underlying assumptions around the decisions we make; to identify and assess any possible unintended consequences on communities/consumers of these decisions before they are taken; and to utilise the resources available in our communities to add value to our decisions and service provision. The forum also provides a platform for discussion between community groups and Waitemata DHB managers. Health links / voice co-ordinators continue to be members of this forum. Recent activities of the forum are noted later in this report.
- The establishment of a Community Engagement Co-ordinator role within the Planning and Funding team. The main focus of this role is to co-ordinate engagement with community/consumers to ensure compliance with the requirements of the New Zealand Public Health and Disability Act 2000 and to ensure alignment with the values of Waitemata DHB. This role is also responsible for co-ordinating the CEA / CEF.

In the 2011/12 Annual Plan, Waitemata DHB has made a commitment to develop and implement a consumer engagement strategy as part of its priority to change the DHB's culture to one of clinical excellence and patient service.

2.2 Auckland DHB

An organisation and environmental scan in mid-2009 showed that there were clear opportunities to improve the way Auckland DHB engages its community and patients. On 29 March 2010, the DHB's Quality, Risk and Audit Committee endorsed the development of a 'Patient and Community Engagement Framework'. The Framework, comprising an online community panel (Reo Ora / Health Voice) and a cohort of consumer representatives, will provide planners and service improvement managers across the DHB with a range of 'tools' that can be used to source reliable and comprehensive knowledge about consumers' views on service quality, planning and health matters. The new engagement mechanisms will complement existing patient and community engagement mechanisms (e.g.: Healthy Village Action Zones, which is a key means of engaging Pacific communities) and capability (e.g.: community development and qualitative and quantitative research expertise) as well as our Memorandum of Understanding with the Te Runanga o Ngati Whatua, which describes the DHB's commitments to a Treaty of Waitangi-based relationship with Ngati Whatua.

3. Risks/Issues

Whilst both Waitemata DHB and Auckland DHB have their own consultation policies and processes in place, at times engagement activity has been managed somewhat independently within business units across the DHBs. However, both Boards and senior management teams have become more interested in refining each DHB's engagement of its patients and community. This interest brings with it an expectation that all parts of the DHBs follow best practice when engaging patients and the wider community. Lifting the DHBs' performance requires a concentration of effort and resource to establish centres of excellence within the DHBs and introduce new, standardised business processes across the organisations. Staff in both DHBs are working collaboratively toward this outcome.

Both DHBs' Public Consultation and Engagement Policies refer to legislation that was repealed earlier this year (specifically the need to consult the public about any proposed change that may be deemed 'significant'). The need to align the Board's Policy with the new legislation presents an opportunity to consider other policy issues and opportunities at the same time, including the Health Quality and Safety Commission's strengthening the consumer voice programme expected to be released in October 2011, and the Ministry of Health's updated

consultation guidelines expected to be released soon after. Next quarter's consumer and community engagement information paper will be accompanied by an updated draft policy for CPHAC to consider for recommendation as Board policy.

4. Progress/Achievements/Activity

4.1 Summary of activities in common

During the last quarter Auckland and Waitemata DHBs have worked together on the following activities:

- Preparing a consumer (i.e. patient and family) engagement programme to inform the Advance Care Planning tools and guidelines
- Providing expert comment on the Ministry of Health's draft Consultation Guidelines
- Via the Auckland Regional Public Health Service (ARPHS), providing expert advice to the authors of and comment on Auckland Council's draft Auckland Plan (some of our submission's text and diagrams appear in the draft Auckland Plan) (refer separate agenda paper)
- Planning for future collaborative engagement processes
- A localities approach is being developed, including a proposed model, drawing on the 'HealthLinks' approach, to enable an enduring dialogue between the DHB and representatives of its communities of place. (refer separate agenda paper)
- Community engagement about Primary Care
- Planned attendance at the Quality Health and Safety Consumer engagement workshops on 3 and 4 October 2011
- Reviewing Health Links model for Waitemata DHB and Auckland DHB.

4.2 Waitemata DHB

A consumer/community engagement intranet site for Waitemata DHB staff is being developed and is currently in draft format with plans to "go live" in November. This site will be a resource for staff wishing to explore best options for consumer and community engagement for service planning/design and delivery and will provide a mechanism for ongoing conversations, training and resources for engagement with consumers and community.

Membership of the Ministry of Social Development's Auckland North and West Community Response Forum is providing opportunities for Waitemata DHB to work with Local Board staff, Police, and other community leaders to explore the needs of the communities of Auckland North and West. Waitemata DHB's representatives are Imelda Quilty-King for Auckland North and Linda Harun, General Manager Child Women and Family for Auckland West.

The Community Engagement Forum meets monthly and during the last quarter the Forum members have been engaged in:

- Developing consumer resources for the Shared Care Planning Project
- Signage policy discussions
- Developing a draft Community Engagement Strategy (aligned with the DHB's Quality Strategy) to bring together all of the positive community engagement activity undertaken to date, and to identify opportunities for improvement in how we involve our communities in healthcare decision-making
- Consumer and Patient Centred Planning
- Increasing the use of consumers in the development of patient information pamphlets, brochures etc (health literacy)
- Bowel Screening Community Awareness Raising Planning
- Elective Surgery Centre (ESC) to incorporate consumer/community input

- Consumer/community nominations for judging Health Excellence Awards 2011.
- Liaison and consumer input into Advanced Care Planning.
- Interfacing with project team from Elective Surgery Centre (ESC) to position consumer and community input.

Two further topics that ensure enthusiastic discussions are parking (access for consumers), and consumer/community interface with project leads within Facilities Department.

Over the past two months Rodney Health Link, Waitakere Health Link and North Community Health Voice have all held their Annual General Meetings. Board members Warren Flaunty and Sandra Coney attended the Waitakere Health Link AGM. Staff also attended, with Dr Andrew Brant (CMO) the guest speaker at Rodney and Alan Wilson (COO) guest speaker at Waitakere. Audited accounts show that all three groups will require increased resourcing if Waitemata DHB expects them to continue to provide the outputs that they are currently delivering. Part of our review of community engagement models will include identifying and resourcing specifications for this area of work.

4.2.1 Rodney Health Link (RHL)

The Rodney Health Link mission statement is:

- To work at all times to benefit the health and well being of the communities whom we represent
- To work collaboratively with the community and other agencies
- To challenge inequality and seek opportunities to empower others.

The following health issues/services are the current priorities for Rodney Health Link.

- Auckland Regional After Hours Project
- Health of Older Adults (especially the SSOA project)
- Child/Youth/Families
- Mental Health Services
- Respite Care
- Drug and Alcohol abuse
- The movement of patients in and out of the area to hospital out-patient Clinics.

Rodney Health Link holds an annual planning day every November, at which time their goals and priorities are reviewed and updated. Due to the ever changing environment and the rural/urban mix of the Rodney /Hibiscus Coast areas, these priorities need to be constantly checked to ensure they meet the ever changing health needs of the community.

Achievements

During 2011, Rodney Health Link (RHL) has been involved with many Waitemata DHB and community projects including:

- Participation in the Planning Day held in January 2011.
- Quality and Engagement strategy forums in July/August 2011.
- Breast Screen Aoteroa community engagement re location of the new mobile unit to ensure a fully digital mobile service for Rodney.
- Assisting with focus groups and community awareness for the Bowel Screen Pilot.
- Participation in the newly formed Rodney Council of Social Services (RODCOSS) through the appointment of the Rodney Links co-ordinator to the Executive Board to represent health. RODCOSS has already two public consultations planned on the Auckland Spatial Plan and The Green Paper for Vulnerable Children.

- The appointment of a Local Board member from Rodney and Hibiscus and Bays local Board to sit on RHL's Board
- Rodney Health Link's bi-monthly newsletter continues to draw encouraging comments from the customers who receive this either by email or a paper copy.

4.2.2 Waitakere Health Link (WHL)

Waitakere Health Link works to ensure better health outcomes for our communities' residents within the old Waitakere City boundaries.

Waitemata DHB Health Excellence Awards - Waitakere Health Link provides the lead on health literacy work currently being undertaken for Waitemata DHB. An example of this work has been entered into the Health Excellence Awards for 2011 in the form of a poster featuring "Consumer Health Literacy Review" on the Waitemata DHB's Waitakere Emergency Department brochure it reviewed earlier in the year.

Waitakere Health Link has also assisted, along with Rodney Health Link and North Shore Community Health Link, in sourcing and nominating consumer judges to the Health Excellence Awards Project team.

NGO Open Day at Waitakere Hospital

NGOs in Waitakere network meetings have brought to our attention the need for NGOs and the secondary sector to better align patient services upon discharge. Our intention is to improve secondary/primary communication for the benefit of the patient upon discharge from hospital. To this end, Waitakere Health Link are hosting a "NGO Health Network Open Day" in the foyer at Waitakere Hospital on Monday 31 October, showcasing NGOs providing health support and services in the West, to raise awareness of their services and network with Waitemata DHB staff and community.

This opportunity is proving very popular with NGOs enthusiastic to participate. To date, there are already 35 NGOs registered to attend.

Achievements

- Waitakere Hospital ED 24/7 – Providing free local access to 24/7 at Waitakere Hospital was a goal for Waitakere Health Link since its inception in 2000, and it acknowledges the Waitemata DHBs commitment and dedication of staff to ensure its success.
- Health Literacy – Identifying the opportunity to enable Waitemata DHB to communicate more effectively with the community it serves, together with Rodney Health Link, have provided a monthly 'Consumer Health Literacy Reference Group' to review printed information. Printed information reviewed in the last quarter were: Insulin booklet, Heart Failure Action Plan, Paracetamol, Test Safe Connect Care poster and leaflet, outpatient letters and leaflet, skin surgery survey, Warfarin leaflet, WHL health excellence poster, Waitemata DHB Feedback/complaints poster, bowel screening pilot power point, patient satisfaction survey and letter.
- Relationship with Council - Established working relationships with new Council and have local board members on our executive committee to ensure communication across health and council sectors.
- Foundation Purchases – WHL advocated to the West Auckland Hospital Foundation that holds money fundraised for Waitakere Hospital to purchase a child ventilator for the Emergency Department, Hi/Low Cot and a Phototherapy Blanket for maternity.
- Relationship with Maori Project – used existing funding to strengthen WHL's relationship with the Maori community working with Social Workers at Massey High School to deliver two Hauora Maori and Sexual Health Workshops.

- Continue to disseminate health information into the community through a variety of mediums including: meetings, 700 newsletters posted monthly, monthly E-news, website, media and recently Facebook.
- Continue to network with stakeholders across sectors in the community, participate on Waitemata DHB steering/advisory groups, seminars, workshops, consultations and provide feedback.
- Advocate for and source Consumer Representatives on to Waitemata DHB steering groups and committees.
- Sourcing a consumer representative to be a guest speaker at a primary health care post graduate lecture.

4.2.3 North Shore Community Health Voice (NSCHV)

North Shore Community Health Voice is a community-driven organisation committed to improving healthcare and wellness in North Shore City.

Engaging with our Community

North Shore Community Health Voice is also contracted to produce regular newsletters, attend NGO forums and community meetings to disseminate information and to hear back directly from communities on what has impact and meaning for them.

At the 2011 Annual General Meeting in early September, the future of North Shore Community Health Voice was discussed given the changes promoting collaborative social service delivery and in local government boundaries, which have provided a new challenge for community organisations working in Auckland North. A process involving the local community and NGOs is underway to determine the future form of the organisation.

Achievements

- North Shore Community Health Voice has joined the executive of the North Shore Community of Social Services (NSCOSS) as a representative of the health sector in community.
- The North Shore Community Health Voice coordinator and a Board member representing the mental health sector are members of the new National board of the "Consumer Collaboration of Aoteroa" (a group of sector representatives to advance the role of the consumer voice in health).
- Participation and membership of the Northern Cancer Network Consumer Reference Group, including the Cancer Patient Diary project, consumer representative roles and training programmes, Webhealth directory of services, survivorship forums and reviewing quarterly Northern Cancer Network reports.
- Signage and way finding consumer voice into the pathways for the Emergency Department (ED) and Assessment and Diagnostic Unit (ADU) at North Shore Hospital.
- Community representation in the North Shore Hospital Cafeteria Project Group tender and selection process.
- Asian Community Engagement stakeholder survey for North Shore - an initial report was requested by the Waitemata DHB with major contribution from eight key North Shore agencies.
- Consumer representatives were identified and accompanied to Advance Care Planning workshops, Primary Care Nursing Advisory Group meetings, and Long Term Condition conference and workshop.
- North Shore Community Health Voice in partnership with the former Harbour Health held a community forum for the NGO sector on "Locality Planning - Concepts and the PHO Consolidation – What will this look like for the Community?

4.3 Auckland DHB

To target the DHB's patient and community engagement activity, a 'Patient and Community Engagement Strategy' is being developed and its implementation will begin during the 2011-12 year (as noted in the DHB's Annual Plan). This strategy will include identifying measures of success over the longer term (i.e. a few key results areas that we will monitor on how well we are engaging patients and communities in service improvement and planning activity) and will guide the DHB's journey toward Healthcare Excellence, which involves keeping patients at the centre of our planning and service improvement activity.

Staff from Quality, Planning and Funding and the Programme Office are collaborating to develop the strategy and are talking with Waitemata DHB to progress opportunities for shared activity wherever possible.

Specific examples (i.e. this is not a comprehensive list) of patient and community engagement activity at Auckland DHB over the period canvassed by this paper include:

- The (soft) launch of the Reo Ora Health Voice website. The launch has not been widely publicised at this stage to allow 'live testing' of the website, survey and email facilities and the internal support/administrative processes.
- Implementing an 'Experience-Based Design' survey to inform the redesign of the Greenlane Surgical Unit, Ward and Day-Stay. The survey outcomes influenced the decision as to how the reception area should be reconfigured
- Developing an 'Experience-Based Design' process to inform the redesign of the 'Pre-admit' process
- A process has been recommended for involving patients and other stakeholders in the development of Community-based Dialysis Units
- A survey was run to gather young-peoples, parents and sector-stakeholders' views to inform the development of a draft Child Health Improvement Plan. The draft plan is currently out for consultation.
- Reporting on the Patient Journey Research programme, which involved interviewing a cohort of patients about their experience of the 'journey' from home/ place of domicile through to the point of admission into an Auckland City Hospital ward.

5. Conclusion

The relationships between Waitemata DHB and Auckland DHB (and Counties Manukau DHB) community / consultation staff are strong, which enables alignment of approaches and learning from each other.

There was a wide range of community engagement activity undertaken during the last quarter which has helped make our health services more responsive to the needs of patients and communities. Our engagement activity has also focused on influencing other organisations that impact on health outcomes (e.g. Auckland Council). There will continue to be a wide range of engagement of consumers, communities and leading social sector agencies through to the close of the 2011 calendar year.

The past quarter has included work to develop our community and consumer engagement capability. There is an intention to develop the localities approach as a means of engaging communities across both Waitemata and Auckland DHBs and agreement to update the DHBs' Engagement Policies to align with and factor in wider policy matters and opportunities.

5.1 Primary Care Update

Recommendation:

That the report be received.

Prepared by: Andrew Coe (Group Manager – PHOs & Primary Care, Auckland & Waitemata DHBs)

Glossary

ACN - Active Clinical Network
ALT - Alliance Leadership Team
ARAHN - Auckland Regional After Hours Network
BFG - Better Sooner More Convenient Funding Group
BSMC - Better sooner more convenient primary health care
COPD - Chronic Obstructive Pulmonary Disease
DAP - District Annual Plan
DHB - District Health Board
DVT - Deep Vein Thrombosis
FFP - Flexible Funding Pool
HP - Health Provider
IFHC - Integrated Family Health Centre
ISG - Implementation Support Group
PHO - Primary Health Organisation
PPP - Public Private Partnership
RFF - Regional Funders Forum
SIA - Services to Improve Access
TIA - Transient Ischaemic Attacks
TPK - Te Puni Kokiri
VLCA - Very Low Cost Access
WALHN - West Auckland Local Health Network

1. Introduction

This report gives an overall update on matters relating to Primary Care for September. It includes:

- Progress on the implementation of Better, Sooner, More Convenient (BSMC) primary health care
- Progress on the three business cases
- Whanau Ora
- Progress on the regional annual plan projects to improve primary/ secondary system efficiency.

Localities planning is provided as a separate agenda item.

2. Implementation of Government's BSMC Primary Care Strategy

Regional Progress to Date
The Metro Auckland DHBs collectively continue to make progress with implementation of the regional components of Government's Better Sooner More Convenient Primary Health Care (BSMC).

Progress with PHO Consolidation
There are no more planned PHO mergers that the DHBs are aware of. North Waikato PHO, which operates in CMDHB, is still expected to join the National Hauora Coalition, but it is not submitting its register as expected for quarter 3 and discussions are continuing.

3. Business Cases

3.1 GAIHN

Funding
A CPHAC paper was presented in September outlining GAIHN's Investment Proposal. The paper requested that CPHAC notes the investment sought by GAIHN. The Investment Proposal request also needs to be considered by Auckland and Waitemata DHBs' Audit and Finance Committees in November. The quantum being sought is $475K from Waitemata DHB and $310K for Auckland DHB. The primary care team are working with GAIHN management to ensure the request for funding is sufficiently detailed for our respective Audit and Finance Committees to approve. This will include a review of work streams to ensure no duplication of work being done elsewhere, in addition to the phasing of the financials and contingency in the event one of the partners withdraws.

The GAIHN Alliance Agreement has been signed by Auckland PHO, East Health and ProCare; the DHBs are yet to sign. Once this is done, Sector Services will be instructed to prepare the PHO Variation and maximisation of Care Plus can begin. The Ministry of Health will however only release the maximised Care Plus funds once the ALT has agreed on how this funding will be spent and that the DHB has contracted appropriately for this.

A Transition Plan for the Regional Annual Plan Projects to GAIHN has been developed and is being implemented. The Transition Plan was circulated to BFG via email for sign off. Waitemata PHO has still not yet confirmed their partnership in GAIHN. The proposed process for signing the document will continue for the other PHOs. Waitemata PHO can be added into the GAIHN Alliance Agreement at a later date if necessary.

Concern has been raised across the Regional Governance table around the governance of the business cases due to confusion around Ministry and DHB involvement. GAIHN currently only has funding to sustain it until 30 November if current outstanding invoices are paid.

3.2 National Hauora Coalition (NHC) (ADHB only)

Monthly meetings between NHC, CMDHB and Auckland DHB are ongoing. Auckland DHB is continuing to provide the monthly reporting through to DHBs while Shirley Miller is on extended leave.

The Alliance Agreement has been signed by all five of the DHB partners; however it was still pending the final year two implementation plan from the NHC.

The PHO agreement requires reporting by the PHOs; the NHC reporting is to be tailored to meet the needs of Host and Partner DHBs. Proposed changes to the DHBs' Operating Policy Framework require DHBs to report to MoH on use of SIA, HP funding etc (to become FFP).

A first draft of the Transition Plan was circulated, however it is not likely it will be agreed by the proposed date of 1 October. The plan includes the Flexible Funding Pool (FFP) start date, the timeframe for moving to 100% contribution and a broad plan of key business case activities.

The DHBs agreed to pay the management fee savings to NHC in two parts, the first 50% to be paid towards the transitional costs and the second portion to be paid on an agreed plan of local activities. This was being invoiced directly to DHBs but it has now been agreed by all parties that this will go through CMDHB as the host DHB. Numerous teleconferences have been held over this month to agree the process for setting targets at both a local and national level for the PPP as well as for the setting of baseline data and measurements for implementation plan targets. There has also been some confusion in the role of the MoH and DHBs' level of governance in this process. A further meeting to confirm the targets is planned for the first week in October.

Following some issues with the change of VLCA register for a number of associated practices in the West, a meeting occurred on Thursday 22 September between the Group Manager for Integrated Primary Care and key members of the NHC. Planned future activity, linkage with other business cases and the role of NHC in the clinical network in the west was discussed.

3.3 Alliance Health + (AH+) (ADHB only)

Recruiting for the new Clinical Director which was due to be completed by mid September is still underway.

Regular monthly meetings are now scheduled between Alliance Health +, CMDHB and Auckland DHB, but mainly to discuss PHO operational issues. A meeting occurred with the CEO of Alliance Health + on 28 September to discuss the progress on the transition plan. A paper has gone to RFF requesting more resources to support the AH+ business case. A decision on this will be made in October. The AH+ Board were due to sign off their year two implementation plan on 30 September and this will then be sent to the DHBs.

No further updates have been received for September as yet, below is the update given in August.

AH+ have decided to reconcile both BSMC and Whanau Ora strategies and activities to avoid duplication. This means the current infrastructure will need to evolve to accommodate this transition. Year 2 Implementation captures this intent. AH+ has been advised by TPK that the outcome of the Whanau Ora business case will now come out in October.

AH+ has recently established an outcomes framework blueprint that will include the following performance measures:

- Clinical Indicators
- Whanau Indicators
- Providers Indicators.

AH+ is currently developing Information Systems Strategic Plan (ISSP) which will enable both BSMC and Whanau Ora to integrate. Currently testing some of the concepts with high degree of success.

AH+ has been advised that Southseas will transition current operations into an Enhanced GP/Community Health services in Otara. The refurbishments will begin in October 2011 and be completed by February 2012. Mt Wellington Integrated Family Health Centre (IFHC) has completed its physical refurbishments and will be officially launched in October 2011, with Ministerial Officials to open the centre.

The nurse leader is currently developing a nurse led service network to promote consistency of performance in the practices but also support areas of nurse led innovation. The East Bays Nurse led clinic is open and has established a short term initiative to follow up on CVR High risk patients. It also provides a triage service. This capability did not exist before BSMC. AH+ has assisted Mangere Family Doctors with funding to run a cervical smear campaign which includes capacity to undertake after hours contacts for hard to reach.

AH+ has been given one-off funding from TPK to run navigation services for 46 families over the next six months. This is viewed as demonstration site initiatives so the learning from this experience can best inform the development of a navigation function for AH+.
AH+ has delivered a three day workshop on Results Based Accountability (RBA). National Hauora Coalition, NGOs and Government agencies attended. TPK funded this activity. AH+ now have 15 certified RBA Trainers.

AH+ is actively participating in the Metro-Auckland Afterhours Taskforce space at a regional level. AH+ have had several meetings with the Chair of the Taskforce as well as a follow up meeting with Synergia to gain a good understanding and background of developments to date in the after-hours project.

AH+ and NHC have signalled intent to formalise their alliance in relation to this work programme given its effect on high needs populations it serves.

4. Whanau Ora

No update at the time of this report. This will be provided in future reports.

5. Improve Primary – Secondary System Efficiency: The Regional Annual Plan projects

5.1 Regional After Hours

The Regional Afterhours network went live on Monday 5 September 2011. A communication plan is being updated and proposals have been received from Media/PR agencies to manage the communications process and were considered by the Taskforce in late September.

A governance sub-group has been established. It is proposed that a formal entity not be established for the project and that a partnership/leadership group provides clinical/managerial oversight. The governance sub-group is considering:

- Alliancing principles and governance
- Partnership/leadership
- Clinical and managerial oversight.

It is recommended that the Taskforce continues on an interim basis until it is replaced by an agreed governance structure. Terms of reference for the Taskforce have been developed to clarify its role and responsibilities.

Contracting arrangements are being considered to reflect what has been agreed in the letter of agreement between all the parties. Bilateral agreements (or contract variations) will be put in place between individual DHBs and providers. A contracting mapping exercise is being undertaken by the DHBs to determine how contracts will be administered in the future. It is likely that the new ‘reduced copayments’ contract with the A&M Consortium will be held by a lead DHB (to be agreed by the DHB GMs Planning & Funding).

The A&M consortium has requested an advanced payment to cover the cashflow associated with them giving a reduced co-payment to high-need patients from 5 September. A&Ms are currently carrying this cost until contracts are in place on 31 October and this is not sustainable for some of them.

Service KPIs are being developed, with DHB clinical input, to inform the service evaluation in March 2012. These KPIs are based on those that were developed in the ARAHN proposal. The logistics of A&Ms identifying eligible patients, when they turn up for treatment, is being considered by the Taskforce. The DHBs are considering this issue and will make recommendations.

Key pieces of work currently underway include:

- Branding for the project
- Governance structure that will take over from the Taskforce
- Agreeing the future contracting arrangements (to reflect the letter of agreement)
- Agreeing the clinical KPIs and clinical indicators (1-day event planned to progress this)
- Scope the delivery of overnight services from Auckland, North Shore and Waitakere Hospital EDs in preparation for an evaluation of the after-hours model in March 2012 (this is an internal ADHB/WDHB piece of work that falls outside of the AH Project).

Both Auckland and Waitemata DHBs have received an afterhours OIA request from the Leader of the Opposition's Office. The OIA requests all correspondence (including emails) between the CEO or the CEO's office and the Minister of Health or his staff since 1 January 2011 regarding the work done by the Auckland Regional Afterhours Taskforce to make afterhours care in Auckland more accessible and affordable. Legal advice on the OIA will be sought and an aligned response will be drafted.

Risks:

- Not enough quality data to inform the Afterhours evaluation in March 2012. This will be mitigated by careful selection of KPIs so that relevant data is captured.
- The Afterhours network will attract people away from their GP medical home because it is cheaper and/or more convenient for patients. This will be mitigated by monitoring GMS claw backs for relevant patient categories to assess the impact on general practice.

5.2 Access to Diagnostics

The roll-out of ProExtra to CMDHB is progressing well. As at 20 September, 45 CMDHB practices have been trained and installed and ProCare are on track to achieve 65 practices trained and installed by 31 October 2011.

An identified risk is that non ProCare Practices that use MedTech as their Patient Management System (PMS) is not able to access the web-based forms that are included in this programme, as they do not have a license agreement with MedTech. MedTech licensing discussions have been led by Paul Roseman (ProCare) and Johan Vendrig (Health Alliance Chief Information Officer) to reach a suitable agreement with MedTech. An interim licence for non-ProCare practices in ADHB remains in place, however the rollout of ProExtra into non ProCare CMDHB practices that use MedTech (approx 29 practices) by December 2011 is dependant on having a suitable MedTech license in place. A revised agreement has been developed and a meeting is set up for the first week of October to progress discussions.

5.3 Minor Skin Surgery – Skin Lesions

The results of the GP opinion survey have been finalised and disseminated throughout the region. Overall, the results were very positive towards the programme, and the specific results and suggestions will be considered by the Reference Group at their November

meeting. As at 29 September 2011, 43 patient satisfaction surveys have been returned and feedback is extremely positive. At the request of the Reference Group a review of the current price paid to contract GPs under the Regional Minor Skin Surgery scheme was undertaken in July and August.

A final report has been developed and circulated to the Reference Group and there is agreement that there should be a modest increase to the price paid to contract GPs, but the group has varying views on what is considered a moderate increase and when the price change should take immediate effect. Further discussion will continue when the Chairs of the Reference Group and Clinical Governance are back at the end of October.

As at 31 August 2011, 146 of the 200 target volumes have been achieved, leaving a variance of -55 YTD. However, the referral numbers vary month to month and we expect to see an increase in the referrals numbers as the scheme becomes more known and the confidence in the system increases.

5.4 Clinical Pathways

A Project Plan and Resourcing Plan for development and implementation of pathways have been presented to ACN and Alliance Leadership Team and were signed at their 23 August meeting. Operational implementation teams for TIA, COPD and DVT clinical pathways are now meeting. Additional resourcing requirements have been identified to fully implement these pathways, which will need to be subject to the development of business cases as these resources are not currently within DHB budgets.

5.5 Acute Demand / Primary Options for Acute Care

The 2011/2012 contract and volumes have not been formally confirmed. Contract negotiations were to be finalised for 1 October 2011, but this has been delayed.

Reporting for period ending August 2011 (NB: referral numbers are at this date incomplete due to the reporting prior to the month end): Preliminary figures for August 2011 show a total of 1433 referrals, YTD 3053 referrals. 88% of all referrals were managed without admission in primary care.

5.6 Summary of Annual Plan Targets

Initiative		**Auckland Metro Volumes Actual**		**Auckland Metro target to end June 2012**
		Month (August)	**Year to date**	
Acute Demand / POAC		1,433	3,053*	Note 1
Access to Diagnostics	**Annual Plan Target 1** The rate of referrals that do not meet the clinical triage criteria	13.5%	13.5%	20%
	Annual Plan Target 2 The volume of DHB-funded GP-requested diagnostic radiology procedures performed in the community will increase by 10% on 2010/11 volumes by 30 June 2012.	1,298	2,461	10,396

1. The 2011/12 contract and volumes have not been formally confirmed. Contract negotiations were to be finalised for 1st October 2011 however have been delayed.

6. Localities and Clinical Networks

A Clinical lead for each of the three Networks North, Central and West, has been identified. Both Sapere and Synergia (ISGs) have been contracted by the Ministry to support the development of this work. The first meetings of the Central and North Network are scheduled to take place in October/November this year. The West Network (WALHN) has already met a couple of times and is well supported by both local primary and secondary care clinicians. A detailed implementation plan for the three clinical networks will be presented to CPHAC in November.

Further work is being undertaken to scope the space that Waitemata DHB will lease in the planned New Lynn IFHC development, which will open in early 2013. Determining DHB space requirements, based on future models of care that will be developed through the WALHN, is challenging. Sapere Research Group (ISG) will be used to explore which DHB services could be delivered from IFHC settings in the future and how IFHC integration can achieve BSMC services for patients.

Work is also progressing on both the due diligence on the lease for Whanau House and also the transition of DHB services that will be delivered from the Whanau House to achieve better sooner more convenient health services to individuals and whanau.

7. Other

Unspent Funds

The Ministry of Health has written to all District Health Boards (DHBs) regarding the management and use of PHO cash reserves and we are required to report to the Ministry our action plan on the appropriate management and use of PHO cash reserves.

An initial request was sent to all of the PHOs back in early August to advise them of this requirement. To date, we have only received responses from ProCare and HealthWEST. A follow-up email reminder has been sent by the MoH regarding reports being expected by 20 October for all PHOs and for GAIHN.

Letters have been drafted to go out to the PHOs, which will be followed up by face to face meetings. There will be an approach to deal with those organisations that no longer exist; these include all the old Waitemata DHB PHOs and Te Hononga. A different letter, which will include a requirement for plans going forward, will be sent to those continuing PHOs.

5.2 Planning and Funding Update

Recommendation:

That the report be received.

Prepared by: Denis Jury (Chief Planning and Funding Officer, Auckland DHB), Debbie Holdsworth (Acting Chief Planning and Funding Officer, Waitemata DHB), Julie Helean (Manager, Planning and Service Development, Auckland DHB) and Janine Pratt (Group Planning Manager, Waitemata DHB)

Glossary

DHB - District Health Board
HSGs - Health Service Groups
IMAC - Immunisation Advisory Committee
NHB - National Health Board
SLA - Service Level Agreement

1. Summary

This report updates the Committees on Auckland DHB and Waitemata DHB's Planning and Funding activity for the month of August. Primary Care has been moved to a separate regular report (refer separate paper).

2. Summary of activities in common

2.1 Planning

The focus of planning attention at Auckland DHB is now on the Health Service Groups (HSGs). To date, cardiology and cancer have run planning sessions to develop health improvement plans. These longer-term plans lay the foundation for annual objectives and ensure that the newly formed HSGs are focused on activity across the continuum. These Plans will evolve over time as more health needs assessment data is brought into the picture. There is also considerable work still required to progress those many areas where HSG activity intersects.

At Waitemata DHB, leadership and strategic direction for the development of the 2012/13 annual plan and budget is provided through the Planning Taskforce. The Taskforce's current focus is on ensuring the many planning mechanisms at a national, regional and local level are joined up within the DHB. This is particularly with regard to service reviews, regional activities, prioritisation of services and the Business Transformation savings programme in preparation for the detailed financial and non-financial planning scheduled for October / November.

The National Health Board (NHB) has formed a steering group of DHB planners across the country including Auckland and Waitemata DHB planners. This steering group will assist the NHB to work up a sound planning package for the 2012-13 year. This work is in its early stages but will aim to have an agreed planning package for the DHBs in November. Annual Plan work for 2012-13 also involves the updating of our Northern Region Health Plan.

The metro-Auckland DHBs are commenting on the Auckland Plan. The development of the Auckland Plan (led by the Auckland Council) allows an opportunity for health to assist local government in improving the city and realising aspirational goals for the longer term. The submission work on health, feeding into the Auckland Plan, is being led by the Auckland Regional Public Health Service (refer separate paper).

2.2 Public Health Activities

Measles Outbreak

The Auckland region has been experiencing an increasing number of measles cases (187) since May with numbers spiking substantially in the last three weeks. Prior to 13 September there was an average one case per day, since then an average four cases per day. No deaths have been reported. The hospitalisation rate is around 11 percent. While an ESR report concludes that "a generalised invasion of measles is unlikely to occur" (29 September 2011) a regional response plan has been prepared and is due to be approved by the regional Health Executive Coordinating Group (HCEG).

The plan entails shifting the emphasis from the public outbreak response of managing cases and contacts towards a stronger primary care response to increase immunisation coverage rates in the community. The primary care response led by the DHBs would involve stronger public messaging and a 'call to action' to people aged 4 – 40 years. Getting two doses of MMR vaccine (28 days apart) will be promoted. Should the number of cases continue to increase, primary care would be asked to actively recall their enrolled population, unless immunity can be established. In addition, the scheduled dose given at 15 months of age would be brought forward to 12 months, with a second dose 28 days later. The scheduled dose at four years of age would also be brought forward, but no earlier than 28 days after the first dose. Primary care would use active calling, such as 'txt to remind' systems to augment 'call to action' communications. Primary care would be supported through mobilisation of available authorised vaccinators in DHBs and IMAC. Frontline DHB healthcare staff are being actively encouraged to ensure their own immunity through vaccination. This message will also go out to primary care early in the first days of October.

3. Waitemata DHB Update

3.1 Funding

Age Friendly Cities

Waitemata DHB in conjunction with AUT is hosting Dr Alexander Kalache. Dr Kalache heads the International Centre for Policies on Ageing in Brazil, and is a special adviser for global ageing to the New York Academy of Medicine and a member of the Advisory Board of the World Demographic and Ageing Forum.

For the last forty years, Alexandre Kalache has combined his medical, epidemiological and gerontological training with research, advocacy and activism on global ageing issues. Under his leadership, the World Health Organisation launched the Active Ageing Policy Framework and the global movement on Age-Friendly Cities. His expertise and advice is keenly sought from all corners of the world by national, state and municipal governments, universities, think-tanks, civil society and private bodies as well as intergovernmental agencies and importantly, the media.

Dr Kalache will give a public lecture on Monday 14 November 2011, 2 pm at AUT University, AF116, North Shore Campus, 90 Akoranga Drive, Northcote.

Recovering Historical Debt

The Government has directed most agencies to ensure that outstanding debt is recovered where possible. The National Health Board has initiated a sector wide approach and is working closely with the DHBs. We are currently obtaining an understanding of the level of historical debt in the Waitemata area.

3.2 Funder Finance

Funder Non Government Organisations (NGO)

The August core result for Funder NGO was $70k favourable to budget for the month and $98k favourable for the year to date. Included in this result is expenditure to Auckland DHB for the settlement of PHO service costs resulting from GP practices changing PHO membership after IDF budgets had been finalised. These payments are as determined by the Collaborative Agreement methodology and are covered within the Funder NGO budgets.

Utilisation trends relating to NGO demand services are still too early to determine with confidence but it is noted that they are mostly tracking as expected. Home Based Support Services expenditure is a notable exception, tracking higher than for the same two month period last year. These services are however prone to irregular claiming which affects expenditure comparisons, especially in the early months of a financial year.

Funder Inter District Flows (IDFs)

The August core result for Funder IDFs was on budget for the month and for the year to date. This is because medical and surgical inpatients IDF utilisation is still to early to determine and is currently being accounted for to budget (six to eight week lead time required for coding completion). Also, as advised in the NGO section above, the changes in IDF costs resulting from movements in PHO practise memberships and/or enrolments growth are accounted for and covered within NGO budgets.

Funder Consolidated

The August consolidated core result for Funder was $70k favourable to budget for the month and $98k favourable for the year to date.

4. Auckland DHB Update

Child, Youth and Women's Health

Immunisation

Provisional NIR data as at 30 September 2011 shows 92% overall coverage of all 2 year olds fully immunised. Maori coverage at 86% is lower than last month, however is likely to increase with confirmed data. With Pacific coverage at age 2 at 93% these unconfirmed results still indicate only a minimal equity gap. Coverage of other ethnicities at age 2 are: Asian 95%, NZE 93% and Other 85%.

The Ministry of Health is intending to introduce additional timeliness coverage targets at 6 months and eighteen months. Coverage at these milestone ages is currently relatively low:

- All ethnicities at 6 months 77% (NZE 81%, Maori 61% (a 4% increase over last month), Pacific 70%, Asian 86% and Other 78%). There is evidence that if a child receives their first immunisation on time, they are likely to continue to be timely with their immunisation events.
- All ethnicities at 18 months 83% (NZE 86%, Maori 72%, Pacific 79%, Asian 91% and Other 83%).

The Ministry of Health has advised that a contract for Immunisation District Facilitation ($100,000 p.a.) previously held by the Immunisation Advisory Centre is being devolved to Auckland DHB. This will support Auckland DHB's current work developing a more integrated approach to immunisation activities. Involvement of the other Auckland region DHBs in this is being discussed.

B4 School Check programme
National data supplied by the Ministry of Health on DHB B4SC programme performance in August showed ADHB as being on target year to date and the best performer of the eight largest DHBs. This is a significant improvement on performance in 2010/11.

Agreement has now been reached with Plunket to become an additional provider of Checks and performance is expected to improve further once they begin undertaking Checks.

Auckland DHB Child Health Plan 2012 – 2017
The draft ADHB Child Health Plan is currently available for wide public and staff consultation. It has been through a robust development process driven by a Steering Group with wide intersectoral representation and significant targeted consultation has already occurred e.g. a number of hui with Maori facilitated by He Kamaka Oranga have been undertaken.

Rheumatic Fever
Rheumatic Fever rates in the Auckland area have increased significantly in recent years with Maori and Pacific children disproportionately affected. The Auckland area had 64% of patients with Rheumatic Fever in 2009. As of July 2011 there were 1,100 'active patients' across Auckland with the majority in the Counties Manukau area. However ADHB has a number of 'hot spots' with high numbers of children diagnosed with the disease, mainly in the Glen Innes/Tamaki area.

Budget 2011 allocated $12 million over four years for a Rheumatic Fever elimination programme ($8 million for sore throat programmes in targeted schools and $4 million for health promotion activities and general practitioner training). The funding for sore throat swabbing in schools has now been allocated with Counties Manukau receiving approximately 30% of the available funds and Auckland DHB none. Information about the funding allocation method is being sought.

Bethany Centre
Following a comprehensive review, the Salvation Army has decided to close the Bethany Centre which has provided antenatal and postnatal residential services for young unsupported pregnant women for about 100 years. The heritage listed building is no longer 'fit for purpose' and cannot be altered and in addition they intend to implement a new model of care. This is likely to be based on small community-based centres providing more intensive care, however unfortunately there will be a gap in service provision for this group of very vulnerable women. The Salvation Army have notified an intention to exit the current contract with Auckland DHB.

Funding of Sexual Assault Services
Auckland DHB is the lead DHB (on behalf of Auckland, Waitemata and Northland DHBs) for a contract ($171,000 p.a.) with Auckland Sexual Abuse Help Foundation (ASAH) for the provision of crisis call out services. These services provide support for women undergoing forensic medical examination and police interviewing following a sexual assault or rape. In 2009 the Accident Compensation Authority (ACC) exited a contract with ASAH for a telephone support service and crisis counselling ($356,000 p.a.) as they did not have a legal mandate to bulk fund organisations. These services and the service funded by the DHBs are inextricably linked. At the time the Ministerial Taskforce for Action on Sexual Violence was expected to provide direction and decisions regarding a consistent national multisectoral funding model for service providers in this very fragmented sector. ADHB took a leadership role and provided a proposed framework for such a model. In the event the Taskforce had no clear outcomes and consequently ADHB has facilitated agreement in the last two years for "one-off" emergency funding packages to cover the shortfall created by ACC involving Child, Youth & Family (CYF), the Ministry of Health, Police and ADHB. The current 'emergency' funding package expires on 31 January 2012.

Over the last two years philanthropic funding has also dried up due to the recession and this is an organisation that has difficulty in fundraising in a very competitive environment. ADHB has

again taken the initiative and facilitated a meeting at a national level involving CYF, Family & Community Services, ACC, Police and the Ministry of Health in order to encourage the development of a national multi-sector funding agreement for sexual assault services. It is acknowledged by the involved agencies that funding these services is a multi sector responsibility, that the sector is fragmented and vulnerable and there is a need to work together to find a solution. In the meantime a further "emergency" funding package for 2012/13 will be pursued.

Maternity Service Specifications
The Ministry of Health has published a suite of new draft maternity services service specifications. Both ADHB and Counties Manukau DHB had indicated concerns regarding a proposed change to the definition of post natal care that could have major capacity implications for DHBs whose systems depend upon transfer of women and babies to a primary maternity facility for post natal care. The Ministry of Health has acknowledged these concerns and agreed some changes and on this basis ADHB and Counties Manukau DHB have agreed to endorse the service specifications. The Ministry will also write a letter to the two DHBs acknowledging the need for transition time.

Performance Improvement: Oral Health
The key activity in the oral health portfolio is the implementation of the Child and Adolescent Oral Health Business Case (OHBC).

The Auckland DHB CEO formally opened Avondale Intermediate Clinic on 30 September. Construction is underway at Royal Oak, Wesley and Blockhouse Bay Intermediates with completion planned over the next three months.

The CEO IDF Forum met to discuss the oral health IDF arrangements between Auckland and Waitemata DHBs as this is the key issue that has been holding up the signing of the SLA. An agreement was reached at this meeting. The SLA can now be finalised.

Health of Older People-Residential care
The month has been dominated by the announcement that Seaside Sanctuary on Waiheke Island is closing, which has been met with a significant amount of angst from (some) families, as well as interest from the community, media and politicians.

The closure is being managed, and potentially presents opportunities for a small number of clients to take advantage of the new flexible funding arrangement introduced through the HBSS project, either at home or in small group home situations.

The provider is being supported by ADHB to manage media and political issues that arise. A further community meeting with key stakeholders is scheduled for next Tuesday, and will focus on looking forward to a more sustainable solution for the provision of aged care into the future.

Live Within Our Means: Month's Funding Issues
A verbal update on any developing funding issues will be given.