Community and Public Health Advisory Committee Meeting

Wednesday 15 June 2011

2:00pm

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

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

Community and Public Health Advisory Committee

For discussion with Board

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

Community and Public Health Advisory Committee
Action Points

MEETING DETAILS	
Date and Time	

Agenda Item	Detail	Responsibility	Action

1

KARAKIA

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

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

Well Being to All.

2

ATTENDANCE AND APOLOGIES

3

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

An "interest" can include, but is not limited to:

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

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

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

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

IMPORTANT

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

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

ADHB BOARD AND COMMITTEE (CPHAC) INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lester LEVY (Chair)	University of Auckland Business School New Zealand Leadership Institute Health Benefits Limited Tonkin & Taylor Waitemata District Health Board A+ Trust	Professor of Leadership Chief Executive Deputy Chair Independent Chairman Chairman Trustee			31 May 2011
Jo AGNEW	Senior Lecturer Nursing, Auckland University Casual Staff Nurse ADHB		Salary Salary		21 April 2010
Peter AITKEN	Pharmacist Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/ Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
Judith BASSETT	Nil				9 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	Writing, editing and public relations services	Self-employed	Fees	Writer, editor and public relations services	7 August 2009
	Medical Council of NZ	Professional Conduct Committee member	Hourly fee	Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes	
	Occupational Therapy Board	Professional Conduct Committee member	Hourly fee	Lay member of PCC to assess complaints and determine outcomes	
Dr Chris CHAMBERS	Employee, Auckland District Health Board Wife employed by Starship Trauma Service Clinical Senior Lecturer in Anaesthesia Auckland Clinical School Associate, Epsom Anaesthetic Group Member, ASMS Shareholder, Ormiston Surgical				20 April 2011

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	25 February 2011
	James Henare Research Centre, University of Auckland	Board Member	No fee	Advisory	
	Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust Fee (to Ngati Hine Health Trust	Assists in the development of Government's Whanau Ora policy	
	National Health Board	Member	Fee (to Ngati Hine Health Trust		
	Waitemata District Health Board	Member			
Lee MATHIAS	Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting	31 May 2011
	Iris Limited	Director	Fee	Director, company provides services to people with multiple physical disabilities especially cerebral Palsy	
	Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited	Provider of business and professional services to midwives and other maternity services providers	

	Pictor Limited John Seabrook Holdings Limited AuPairlink Limited NZ Council of Midwifes Tamaki Transformation Transitional Board	Shareholder, Director Director Governance Advisor Council member Chair	Fee No fee Fee Fee Fee	Biotech start-up focussing on diagnostic products Estate of late husband Provider of early childhood education services contracted to the MoE. Statutory Authority	
Robyn NORTHEY	Self employed Contractor Hope Foundation Northern Region Ethics Committee	Project management, service review, planning etc. Board member Member	Fee Nil Fee	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	16 December 2010
Gwen TEPANIA-PALMER	Waitemata District Health Board Manaia PHO Ngati Hine Health Trust Te Taitokerau Whanau Ora	Board member Board member Chair Committee member	Fee Fee		18 May 2011
Ian WARD	Principal/Director C -4 Consulting Limited				4 May 2011

4

CONFIRMATION OF MINUTES

- WEDNESDAY 18 MAY 2011

Community and Public Health Advisory Committee
Minutes

MEETING DETAILS		
Time and Date	2:00pm, Wednesday, 18 May 2011	
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom	
1	**KARAKIA**	
	The Chair declared the meeting open at 2:00 pm. Taima Campbell led the meeting with the karakia.	
2	**ATTENDANCE AND APOLOGIES**	
	Committee Members Dr Lee Mathias (Chair) Peter Aitken Susan Buckland Gwen Tepania-Palmer	Jo Agnew Judith Bassett Robyn Northey Ian Ward
	Management in Attendance Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Taima Campbell – Executive Director Nursing Hilda Fa'asalele – General Manager Pacific Health Naida Glavish – Chief Advisor Tikanga, General Manager Maori Health Aroha Haggie – Maori Health Gain Manager Janice Mueller – Director Allied Health Ian Bell – Board Administrator	
	Apologies Rob Cooper was on leave of absence and apologies had been received from Dr Lester Levy and Dr Chris Chambers. An apology for lateness was recorded for Susan Buckland.	
3	**CONFLICTS OF INTEREST**	
	There were no declarations of conflicts of interest with any item on the agenda.	
4	**CONFIRMATION OF MINUTES 20 APRIL 2011**	
	Moved Jo Agnew; seconded Ian Ward *That the minutes of the Community and Public Health Advisory Committee meeting held on 20 April 2011 be confirmed as a true and correct record.* Carried	

5	ACTION POINTS 20 APRIL 2010
	Smoking Cessation Funding Funding for the Pacific Smoking Cessation service was confirmed for one year and funding related to the national target was confirmed for 3 years at the present level. **Contracting** A paper on contracting models had been presented to the Finance Committee. The Finance Committee had requested that all contracting options be considered when contracting in the future and not just those which had become practice in recent years.
6.1	**Planning and Funding Summary Report**
	From 1 May 2011 the Primary Care Funding teams of ADHB and WDHB had merged into one. The target for minor surgery - skin lesions, will not be met by 30 June and while the primary care contracting and credentialing had progressed well volumes were not being diverted from the DHB. All those that had responded to the project were contracted. A remedial plan was being developed to ensure a change in behaviour within the DHB. Susan Buckland joined the meeting at 2:10pm. ADHB had met the target for access to diagnostic radiology but this had not been reached regionally. The Balmoral Dental Clinic would be open the next Tuesday by the Deputy Chair, Lee Mathias. The work on the Mental Health Secure Rehabilitation Unit was noted with people presently being inappropriately placed. GAIHN has been refocused to a single goal, moving from 3 goals, to where they could make a difference, including for children. Concern was expressed at the level of investment in GAIHN and the lack of progress which may be due to it not being an entity but rather a collaboration of PHOs. The investment was 50 cents per enrolled patient, or approximately $280k, plus significant staff time. GAIHN had arisen out of different relationships between DHBs, the amalgamation and reduction of PHOs from 18 - 6 with now contracts with DHB to PHO rather than multiple contracting. The Community should see better services and locality in the future with the suggestion that if results are not visible within 12 months that the funding should be reconsidered. It was noted that GAIHN had a new Chair, Ray Naden, and six months should be given to refocus on outcomes. The discussion would be communicated to GAIHN noting that ALT was meeting at the end of the month and there would be a paper on what was going to be done, with measures, for the next meeting. GAIHN had been informed that there would be no more resources provided. A paper on diabetes management would be provided to the next meeting.
9.1	**Child and Youth Health in ADHB**
	Dr Richard Aitken, Director of Child Health, Carol Stott, Strategy and Planning Manager, Child Youth and Women, and Ruth Bijl, Associate Strategy and Planning Manager, Child Youth and Women were in attendance. The Children's HSG was developing a 5 year plan and sought involvement of the Board and Committee early to have input into its direction. The paper outlined how the plan was being developed and the direction it wanted to take, noting the environment of delivering more in the community through Better Sooner More Convenient and working more regionally with neighbouring DHBs. The strategy for the HSG was to cover a very large scope from community i.e. immunisation to quaternary services i.e. paediatric cardiac with the challenge being balancing between these. It was noted that Starship was an aging facility and was over crowded with plans to try and refurbish, although this did not have high visibility in the planning a national services from Wellington. While the building could be made to last another 10 - 15 years the region needed to consider the future as well as strengthen secondary care at the other regional DHBs.

	While the numbers of children were increasing they were a decreasing percentage of the population and there needed to be discussion on allocation of resources with it argued that there must be investment in children rather than the last year of life. Disparities related to economic disadvantage and access to health services with some diseases affecting children for their life time particularly in Maori and Pacific. Other factors were crowded housing, smoking, inadequate nutrition and how to influence these working across sectors. Maternal health also influenced child health outcomes. It was noted that Starship had become more tertiary and while it got a tertiary adjuster this was being reduced. The Plan was for ADHB's population and national services needed to be separated with this work being done by the National Health Board. There needed to be a debate on the priorities in health with support into young people being lower than other countries. There was discussion on how maternity services integrate to well child services. B4 School Checks were being transitioned to another provider in primary care. The Northern Region Health Plan focused on adults although it was noted that this was only what was being done in the next year, was not a regional service plan, but in future plans needed to be adjusted for children in particular. The Minister's targets focused on other groups with the exception being immunisation and it was hoped to get more measures for children in the future i.e. mortality rates. The Chair thanked the team for a very informative paper. A range of methods would be employed for consultation with the draft plan being brought back to the Committee. <u>Moved Lee Mathias; seconded Susan Buckland</u> *That the CPHAC:* *1. Notes the contextual and health status information for children and youth in ADHB;* *2. Endorse and shape the proposed approach for development of a new Child Health Plan 2012-2017 for the Child (and Youth) Healthcare Service Group.* *3. Endorses the proposed approach for implementation for the ADHB Child (and Youth) Health Improvement Plan.* <u>Carried</u>
6.2	**Planning and Funding Indicators Exception Report**
	The diabetes targets were not the same across the country or the region. ADHB had set their target based on clinical need and while ADHB was doing better than other DHBs it was still not at an acceptable level. The regional and national targets should be the same. Practice systems for counting were being reviewed. There is discussion on changing the diabetes target.
7.1	**DAP Projects Report**
	There were no changes from the previous month.
8	**Feedback from Committees**
	Maori Health Advisory Committee There had been full discussion on the Maori Health Plan and the Chair endorsed the style of that plan. **Pacific Health Advisory Committee** There had been robust discussion on child health and the future of the Committee with a resolution to support a Pacific appointment to CPHAC and expand PHAC to focus across Waitemata as well as meeting quarterly.

9.2	**Tender for Assisted Reproduction Services – Fertility Services**
	In seeking value for money this was inclusive of value for clients and the community. Letters had been issued to providers and a specific proposal will come back to the Boards. There will be a consultation obligation to fulfil which will affect the timetable with a verbal update to the next meeting. The stakeholders had been informed and the contracts rolled over for the intervening period. Moved Lee Mathias; seconded Robyn Northey *That the CPHAC notes that Waitemata DHB as the lead DHB for the regional contract process has put the tender for fertility services process on hold, is clarifying expectations from ADHB and is revising the proposed style of contracting with fertility service providers.* Carried
10.1	**Phobic Trust: Update on Discussions**
	The current contract with the Phobic Trust was to provide telephone support services and while they proposed clinical services this will be a decision and prioritisation at the regional level with the regional services being key. The paper was noted. The paper is to be provided to WDHB. Garry Smith left the meeting at 3:30pm. The service is primarily for adults although the Phobic Trust will support young people. Young people and children go to the Kari Centre.
11.1	**Action Points for next CPHAC meeting**
	Action points for the next CPHAC meeting would be the assisted reproduction report, update on GAIHN and diabetes.
12	**GENERAL BUSINESS**
	There were no items of general business.
	NEXT MEETING
	The meeting closed at 3:31 pm The next scheduled meeting is for 2:00pm, Wednesday, 15 June 2011 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Epsom
CONFIRMED **CHAIR:**	**DATE:**

5

ACTION POINTS

- WEDNESDAY 18 MAY 2011

Community and Public Health Advisory Committee
Action Points from the meeting on Wednesday 18 May 2011

Item	Detail	Designated	Action
6.1	The discussion would be communicated to GAIHN and there would be a paper on what was going to be done, with measures, for the next meeting.	Denis Jury	July
8.1	A paper on diabetes management would be provided to the next meeting.	Denis Jury	Section 9.1
9.2	Verbal update on Assisted Reproduction Services	Denis Jury	July
10.1	Paper on Phobic Trust to be provided to WDHB	Denis Jury	Actioned

6

PLANNING AND FUNDING PERFORMANCE

6.1 Planning and Funding Summary Report

6.2 Planning and Funding Indicators List and Exception Report

6.3 National Targets

*** "% D`Ubb]b[ `UbX`: i bX]b[ `Gi a a Ufm`F Ydcfh**

Planning and Funding Functional Group

Summary Report

1. Lifting the Health of people in Auckland City

Planning

The Board-approved Annual Plan for 2011-12 was submitted to the National Health Board as our final on 20 May. Since that time we have been in communication with the NHB, resolving what were a few outstanding issues. Work on resolving elective targets still continues. The NHB expects to receive a signed copy of our Annual Plan before 3rd June and this will be done electronically. The Annual Plan goes to the Minister on 27 June for his consideration.

The Statement of Intent is now being constructed from the relevant modules of the Annual Plan. There are now two documents: an Annual Plan and a Statement of Intent. Work is now focused on resolving issues related to the Crown Entities Act as raised by Audit NZ and NHB. The NHB will receive a final copy of our SOI on 20 June and this will also go to the Minister on 27 June.

Child, Youth and Women's Health

Immunisation

Provisional data as at 30 May shows 89% coverage of 2 year olds fully immunised for all ethnicities (Maori 85%, Pacific 90%, NZE 88%, Asian 93% and Other 84%).

As reported previously a number of initiatives are currently being undertaken to improve coverage. It is still expected that these initiatives will together result in ADHB achieving at least the 90% national coverage target 30 June 2011.

Health Services for Children and Young People in Care

Funding for the national rollout of a programme to address the health and education needs of children and young people who come to the attention of CYF was confirmed in Budget 2011. This included:

- **Gateway Assessments Programme (a.k.a. Health Assessments for Children in Care)**

  ADHB has been a pilot site for this programme for the last 2 years. DHBs will be funded $3.8 million p.a. by CYF to provide health assessments for an expanded group of children and young people including children and young people entering care (est. 2,200 p.a. nationally), those considered by CYF to be 'high risk' regardless of whether they are in or out of home care (est. 1,500 p.a. nationally), and complex young people in care (est. 500 p.a. nationally). It is estimated that ADHB will receive 257referrals p.a. This is significantly more assessments than ADHB is currently undertaking.

- **Primary mental health services for children and young people.**

  Building to $2.5 million p.a. over 3 years. Little detail is yet available about this programme.

- **Intensive Clinical Support services for children and young people**

  Building to $2.5 million over 4 years. Little detail is yet available about this programme.

B4 School Check programme

This programme was transitioned to a primary care service delivery model from 1 January 2011 managed through a Service Alliance Agreement. Although it had been expected that performance would drop in the initial period following the transition, performance data so far indicate a poorer performance than expected. As at 8 May the Alliance had achieved 42% against target for high needs children and 51% against target for all eligible children. The expected year to date level of achievement was 83%.

Key reasons for the poor performance were reported on last month and the Service Alliance Leadership Team is now considering a number of model and system redesign options to improve future performance.

Health of Older People

Enhanced Home Based Support Services Project

Work continues in preparation for the implementation of the case mix funding model from 1 July. Several work streams are now in place working concurrently to bring each facet of the project together, and overall we look to be on track.

The Adult HSG has agreed to devolve significant resource tagged for Respite care to the 4 community provider agencies, which is a significant step in the devolution pathway and sets the platform for further services to be devolved from 11/12.

Residential Care

The Edmund Hillary facility was audited on the 1st and 2nd of June.

Interim Funding Pool (IFP)

Agreement has now been reached on a complete 100% risk share for these clients. DHB's will each receive both the service and the management revenue directly and a quarterly wash up will take place via NDSA.

Primary Care

Implementation of Governments BSMC Primary Care Strategy:

Regional Progress to Date:

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

Business Cases

Active involvement continues to support the three Business Cases. Alliance Health + and the National Hauora Coalition have both raised the issues of resources and DHB support which is being worked through by the BFG. Issues around the GAIHN governance to five DAP projects still needs to be clarified and worked through to be appropriately reflected in new contracts and governance models.

Progress with PHO Consolidation

When BSMC was released during October 2009 there were 19 PHOs across Metro Auckland. With the final PHO merger of Te Hononga into the National Hauora Coalition coming into effect on 1 July 2011 the Metro Auckland region will have reduced its PHOs by over two thirds to seven PHOs. There has been a slight delay in North Waikato in joining NHC and this is expected to be completed by October 2011.

PHO	Merge Date	Previous PHO	Host DHB	Partner DHB
Te Hononga	01.10.10	•Te Kupenga o Hoturoa •Tamaki PHO	ADHB	CMDHB
Alliance Health+ (AH+)	01.01.11	•Ta Pasefika •AuckPac •Tongan Health Society	CMDHB	ADHB
ProCare Networks	01.01.11	•ProCare Network Manukau •ProCare Network Auckland •ProCare Network North	ADHB	CMDHB WDHB
Te Hononga	01.04.11	•Total Healthcare Otara	ADHB	CMDHB
Waitemata PHO	01.07.11	•Coast to Coast •Harbour Health •Waiora Healthcare	WDHB	N/a
ProCare Networks	01.07.11	•*Health*West •Te Puna •Mangere Community Health Trust	ADHB	CMDHB WDHB
National Hauora Coalition	01.07.11	•Te Hononga	CMDHB	ADHB WDHB
National Hauora Coalition	01.10.11	•North Waikato	CMDHB	ADHB WDHB

ADHB Specific Progress to Date

In addition to active involvement in the above regional work programmes ADHB PHO & Primary Care team work plan progress includes:

Progress with the ADHB PHO Alliance

The fourth of the ‘fast five’ workshops was held on 31 May. This workshop considered alliancing options for immunisation and diabetes. A project looking at the moderate to severe mental health needs of patients who are currently accessing the primary mental health service is being scoped.

Progress with the Locality Planning

Model development continues and discussions are taking place with Waitamata DHB regarding the adoption of a joint approach to Localities Management. It is planned to bring a positions paper to the first combined ADHB and WDHB CPHAC.

Health Needs Assessment for Maungakiekie Tamaki is underway. Guided interviews with health and other professionals working in the locality are being undertaken.

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

Access to Diagnostics-Radiology

Overall the Access to Diagnostics-Radiology Project has been very successful and more than 53,000 direct GP referrals for diagnostic radiology have been delivered across the region YTD to the end of April; 52,382 tests have been provided by DHBs and 1,304 tests have been outsourced and provided by private providers. Less outsourced private tests have been completed than planned (target 4,500 and actual YTD 1,304), as the focus has been on achieving acceptance of the clinical triage criteria and embedding new processes across all DHBs.

YTD at least 951 First Specialist Appointments (FSAs) have been avoided as a direct result of this project. The Project Clinical Governance Group consider that the only accurate measure of released or avoided FSAs is GP direct referred CT and MRI procedures, as previously patients requiring CT or MRI were required to see a specialist prior to having a diagnostic CT or MRI.

GP utilisation of the ProExtra tool continues to increase for ADHB. Pre-implementation testing began at three pilot CMDHB practices on the 24th May, and the rollout to 100 CMDHB practices, between June and October 2011, will follow. WDHB continues to manually triage all referrals using the ATD-Radiology Clinical Triage Criteria whilst awaiting e-Referrals implementation.

A meeting between the Clinical Governance Group and e-Referrals team is planned for early June to facilitate the inclusion of Radiology in the e-Referrals team Phase 2 work plan.

Minor Surgery - Skin Lesions

The number of minor surgery referrals sent to accredited GPs is steadily increasing across the region. The key focus for May was to review the dermatology wait lists to identify any suitable referrals for the GP scheme. This was completed and all appropriate referrals were forwarded to the central triage point. A second communication was also sent out to all GPs across the region. The memo provided answers to frequently asked questions arising from the advertising of the new clinical pathway. The project is unlikely to meet the 1200 volumes for the 2010/11 financial year. As of April 2011, 654 volumes have been achieved, leaving a variance of -347. The new clinical pathway has been widely advertised across the region so we expect to see an increased number of referrals. In addition, a central triage point has been established at each DHB to triage all skin cancer referrals and forward appropriate referrals to the accredited GPs.

Regional Clinical Pathways

Further work has suggested that it may not be possible to hit 30% reduction but aiming for 20% with the overall reductions in FSAs to be made up from other pathways being developed.

The Dyspepsia and Iron Deficiency Anaemia (IDA) pathways are now being utilised and are accessible to primary and secondary care via Health Point. Progress is being made on other clinical pathways and the Annual Plan target of having five pathways fully developed and implementable by the end of June is on track to be achieved.

Acute Demand / POAC

POAC is on track to meet target for the 2010/2011 year. With recent activity in hospitals there has been an increase in early discharge referrals; in particular with Auckland hospital who have not previously been large users of POAC.

After Hours

The feedback to the draft RFP has been considered and it has been agreed by the DHBs to progress with the Auckland Regional After Hours Network (ARAHN) through an Alliancing approach. A Primary Care-led consortium, which represents Primary Health Organisations and Accident & Medical Centres across Auckland will co-ordinate the establishment of a low-cost, easily available after-hours service across Auckland.

The new service plans are due to be finalised by June 30th, (and Board papers in July) and implementation over the following three months expected, in collaboration with the existing providers.

All contracts with existing providers will be extended for 3 months.

Pharmaceuticals CMDHB & ADHB Project

Work continues reviewing the prescribing patterns for a number of medicines and overall the initiative is progressing well. It is apparent the prescribing is being optimised, but the financial impact is still to be agreed.

Maori Service Development

The original project intention was to devolve $600k of services (largely health promotion and public health) from metro-Auckland DHBs and the Ministry of Health (MoH) to Iwi and Maori providers by 30 December 2010. This target date was too ambitious and was revised to 28 February 2011 for the identification of services across the DHBs to be devolved and construct a devolution framework. A number of services from CMDHB and WDHB were tagged for devolution and these are so far;

- CMDHB: Smokefree RFP has been awarded to Raukura Hauora o Tainui. Total contract price is $240k PA
- WDHB: CAYAD contract has been let, value $176PA. Well Child contract awaiting MoH decision, therefore RFP process on hold

A draft devolution framework (the second deliverable) developed for CMDHB by the National Hauora Coalition has been presented to the regional DHBs. There are a number of concerns with the proposal and further work has been suggested.

Regional Health Targets

Targets for diabetes detection & CVD risk assessment are on track to be met by end of the year. The immunisation target and satisfactory Diabetes management are unlikely to be met by year end.

Initiative		Regional Volumes		Target to end June 2011
		Month (April)	YTD	
Acute Demand / POAC		1,326	14,478	15,000 cases POAC is on track to meet target for the 2010/2011 year. With recent activity in hospitals we have seen an increase in early discharge referrals to POAC; in particular some movement with Auckland Hospital who have not been using the POAC service to date.
Access to Diagnostics	**DAP Target 1** *Measures elective plain x-ray and ultrasound referrals by GPs for diagnostic radiology to Non DHB Providers (N.B. GP's cannot refer CT Scans and MRI to Private Radiology Providers)*	98	1,304	4,500 Discussions will be had with all DHBs in early June to determine whether further outsourcing to private radiology providers is appropriate.
	DAP Target 2 *Measures elective referrals by GPs to DHB Radiology Services for diagnostic radiology*	2,273 (referred via Clinical Triage Criteria) 2,387 (referred via "old" forms)	22,250 30,132 **Total= 52,382**	16,000+ Target Exceeded
Skin Lesions		104	654	1,200 community based skin lesion procedures during 2010/11.
Regional Clinical Pathways		On track with the noted variance in the target for FSA reduction in Dyspepsia		
After Hours		Not tracking to plan, and a new timeframe has been agreed (risks noted above)		
Pharmaceuticals CMDHB & ADHB Project		Tracking to plan (issues noted above)		

Pharmaceuticals WDHB Project	Tracking to plan
Maori Service Development	Not tracking to plan (issues noted above)
Health Targets	Data for the month of April 2011 •89% Immunisation – target 90% •66% Diabetes Detection (Get Checked) – target 55% •69% Diabetes Management – target 70% •81% CVD Risk Assessment – target 80%

Business Cases

Active DHB involvement continues to support the three Business Cases in the development and the rollout of their respective Implementation Plans.

GAIHN

As reported previously, the GAIHN ALT has taken the decision to refocus GAIHN on a single goal to acute reduce demand and unplanned hospital admissions across Auckland. This moves the focus of GAIHN from the original business case intent somewhat to position the group as a change agent in the primary care sector for acute demand management and prevention. A work programme has been developed at a high level and there is work underway currently to add to this the necessary project and initiative detail, timeframes and resource requirements.

It is intended to present a paper to PHO and DHB Boards in July 2011 to seek endorsement of the direction and approval of funding and DHB staff resources. The paper is likely to include information about achievements to date, the change of direction and intentions from the agreed business case, an overview of projects and initiatives planned over the next 1-3 years to address acute demand with specific detail for the 2011/12 year, and the detail of funding and resource requirements.

National Hauora Coalition

The National Maori PHO Agreement is now in place with an initial PHO register in May of 244,000 enrolled patients across 5 DHBs. Ngati Porou in Tairawhiti DHB and North Waikato in CMDHB/Waikato DHBs did not meet the deadline (due to Iwi accord) and will join from 1 October. A further 8 practices from Waitemata DHB known as the West Auckland Practice Network are also part of NHC but currently sit with Procare following an agreement between NHC and Procare.

The NHC has also been working on a proposed framework for the devolution of Maori service agreements, focused on integrated whanau ora services. Discussions are underway between DHBs and NHC to develop the initial concept into a workable model and proposal for formal consideration of DHBs. It is likely that an alliancing model will underpin the development of whanau ora integrated service specifications and template agreements by NHC on behalf of/for DHBs.

Alliance Health +

DHBs and the MOH are providing support to AH+ to establish effective management and governance processes to implement their business case and be a successful single regional Pacific PHO.

The ALT have recently reconfirmed their role, organisational arrangements, and resource requirements and a transition plan has been developed to focus on key requirements going forward.

2. Performance Improvement

Community Pharmacy

The major issue still facing community pharmacy at present is the expiration of the national contract on 1 September 2011. Formal feedback from PHARMAC and the 20 DHBs was released on 11 May stating 108 written responses were received and 14 DHB consultation meetings were held with 350 attendees. Two work groups have been set up to explore in more detail the proposed long term conditions and ARC options and work is still progressing although the original timeframes of the 20 May have passed and no new deadlines set.

SIG is currently considering the options available to them and has asked for further information to be provided to the three options tabled in May which were broadly;

(1) Rollover of the current fee for service arrangement (status quo)

(2) Bulk funded transition & transitional service specifications

(3) Three year phased transition

Suspension of pharmacist

As reported previously, a pharmacist operating in ADHB and WDHB has been under threat of suspension. Medicines Control have now taken the decision to not suspend the pharmacist in question although they have put restrictions on his license to operate and continue to monitor closely. He still has a number of audit issues to resolve or face further action by the end of the month. ADHB has cancelled the pharmacist's monitored therapies contract for fears of patient safety and a number of other contracts which are not being executed according to protocol. All the patients being delivered medication under the monitored therapies contract have been transferred to an alternate provider. We will continue to monitor this pharmacy closely with Medicines Control.

Oral Health

The fourth mobile unit was delivered during the last month and the Balmoral fixed clinic was formally opened on 24th May.

3. Live Within Our Means

Month's Funding Issues

A verbal update on any developing funding issues will be given.

*.2 D`Ubb]b[⁄ ˙: i bX]b[˙=bX]WUhcfg˙@]gh⁄ ˙9l WYdh]cb˙FYdcfh

"

"

"

"

"

"

Vj gtg"ctg"pq"gzegr vkqpu"vj ku"o qpvj "

*** " BUh]cbU`HUf[Yhg**

Project: Diabetes

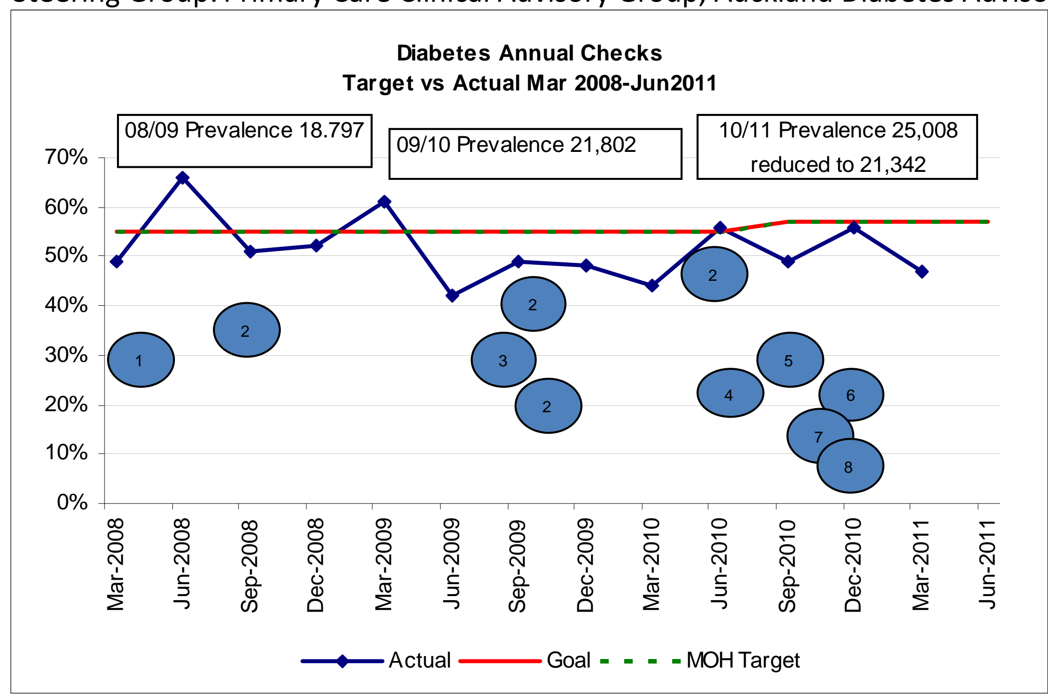
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

Date of Delivery: 55% June 2011

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team



Recent and Current activities:

1) Increase awareness project with PHOs driving information share

2) Practise based data (results) feedback

2a) Increase other feedback options

3) Improved understanding of IT linkages in Practice systems

4) Paper from the Auckland Diabetes Advisory Team to CPHAC requesting funding to implement improvements in diabetes care and management that will impact on National Health Targets.

5) Routine reports to clinical advisory leadership meetings

6) CPHAC initiatives for long term conditions quality improvement coordinators and population audit tool beginning to be implemented.

7) Regional shared care pathway work

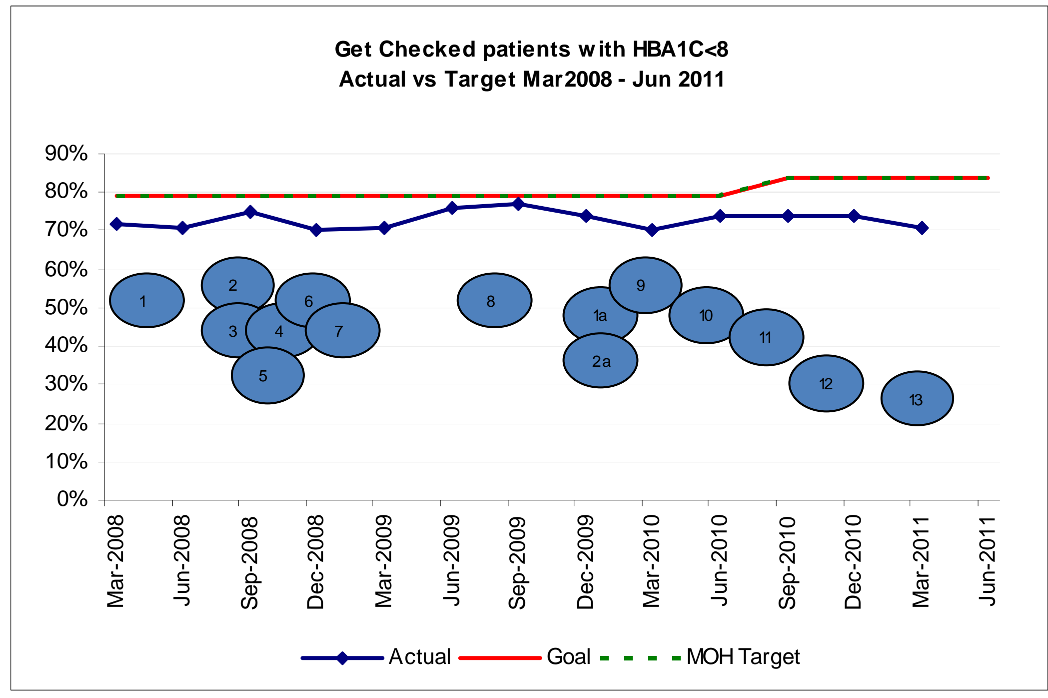
8) Regional shared target setting and service outcomes

Project Risks / Comments:

Q3 activity shows we have dipped significantly below target to 47% for the quarter, which was due to the low number of diabetes annual reviews during the holiday period (January). The number of reviews for Pacific and Indian populations continues to perform above target but activity for “Other” is significantly underperforming this quarter (35%). In order to improve performance, the DHB is working with primary care to implement a comprehensive range of activities to improve DGC numbers and initiate an overall quality improvement framework. The contract for the long term condition quality improvement coordinators is underway with the coordinators starting work with priority practices to improve Diabetes Annual Check numbers. Performance against this target is also being raised with the PHO CEO’s and Primary Care Clinical Advisory Group this month, and we are working with our largest PHO (where most of the underperformance lies) to devise and implement strategies, in addition to those we have put in place, to improve performance for the remaining quarter of this year.

[Note: Q2 data has been updated to reflect actual activity from Tongan Health Society – this was estimated in last quarter’s report, changing Q2 performance from 57% to 56%]

Project: Diabetes
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management
Date of Delivery: 79% of people with diabetes will have a HbA1c ≤8%
Clinical Lead: Gayl Humphrey
Project Sponsor: Dr Denis Jury
Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team



Recent and Current activities:
1) Increase awareness project with PHOs driving information share
1a) reinforce awareness
2) Practise based data (results) feedback via various mediums including Health point
2a) increase feedback processes
3) Direct Secondary Service phone support for GPs
4) Increased community shared clinics with secondary care
5) Increased SEAsian Nurse Specialist access
6) Widened opportunity for self management to include greater than 2 year or less diagnosed people with diabetes
7) Improved culturally appropriate self management courses
8) Improved understanding of IT linkages in Practice systems (linking PPP)
9) Auckland Diabetes Advisory Team – structured agreed district plan of action
10) Redesign the supported self management to meet needs of population
11) Developing shared care pathway for Diabetes
12) Regional shared care pathway work including clinical workshop
13)Implementation plan being developed for diabetes coordinators (quality improvement roles) and population audit tools for each practice.

Project Risks / Comments:

Q3 performance shows a decrease in management from the previous two quarters, achieving 71% against a target of 84% of people having an HbA1C <8. The target for Other has been achieved (83%) however the target for both Maori and Pacific has not been meet (60% and 55% respectively). The long term condition quality improvement coordinators will be working with practices to improve this target as part of their overall approach. The contract for Diabetes Self Management Education services has started, with four courses (of 4 sessions each) being run in February and March. This contract delivers to all of ADHB and aims to ensure accessibility (in terms of access and cultural competency) to our high needs populations. Additionally a generic self management course for long term conditions (based on the Stanford model) is being implemented for our Pacific populations through the HVAZ framework, with the first courses due to start this month.
[Note: Q2 data has been updated to reflect actual activity from Tongan Health Society – this was estimated in last quarter's report, changing Q2 performance from 73% to 74%]

Project: Cardiovascular Risk Assessment

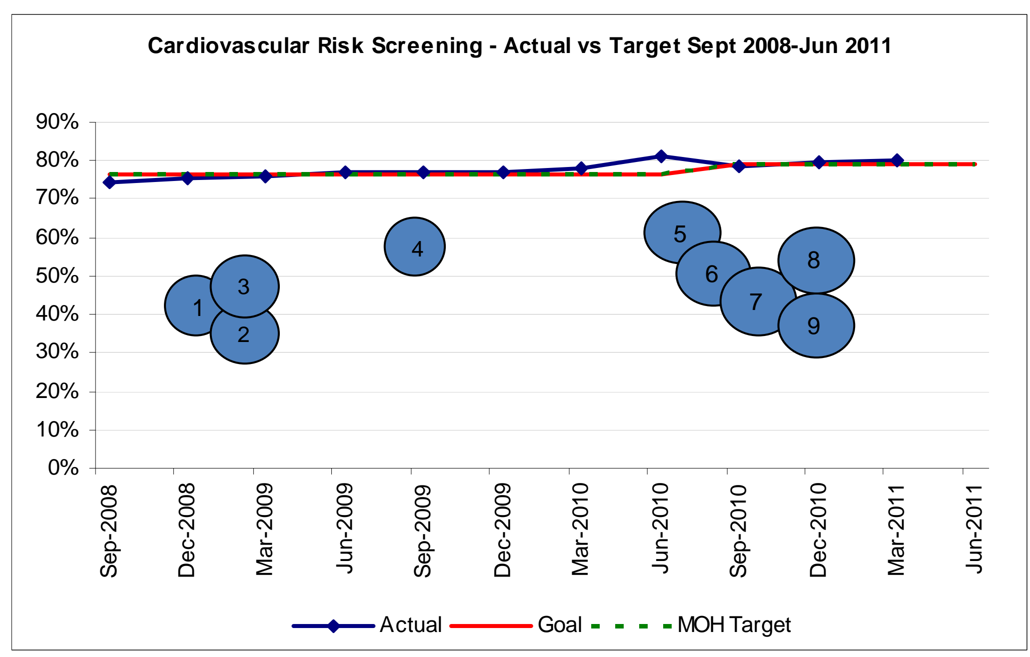
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

Date of Delivery: Overall goal is to have 80% of eligible population CVD risk assessed every five years.

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team



Recent and Current activities:

1) Support the uptake of an electronic CVD tool

2) Training and information system support for electronic tool

3) IT help line for GPs for risk assessment tool

4) Increase the cumulative incentive payments for achieving both good assessment and good management together

5) Review and reshape incentives to link with PPP targets

6) Enhance links to Green Rx and maximise primary care uptake

7) Continue to work in various workplaces to enhance CVD risk assessment for men

8) Link in with research looking at ways to optimise Pacific males participation in health self management

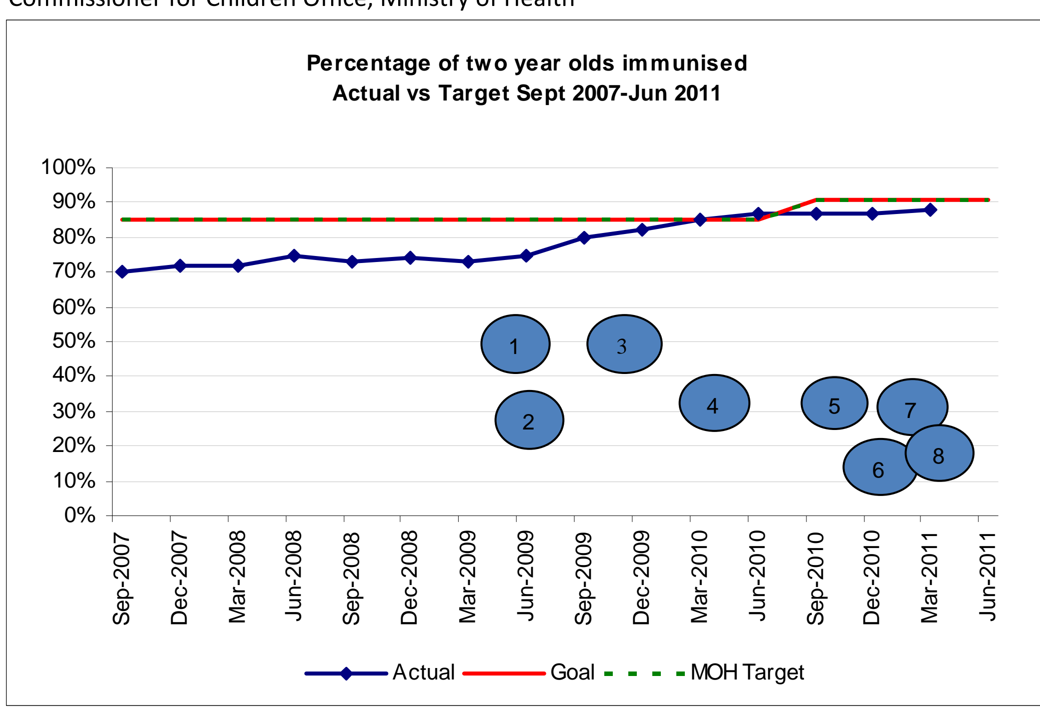
9) Work regionally to have similar focus on incentive goals

Project Risks / Comments:

The Q3 CVD data from the MOH shows a small but steady improvement on this target with an increase of 0.5% from the last quarter, giving us a 79.9% performance against a target of 79%. Individual targets for each ethnicity have also been meet.

We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract, which we will be reviewing in the coming months to ensure that incentives are properly aligned.

Project: Increased Immunisation
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012
Date of Delivery: 1 July 2010, 1 July 2011 and 1 July 2012
Clinical Lead: Richard Aickin
Project Sponsor: Richard Aickin
Steering Group: Richard Aickin, Carol Stott, Aroha Haggie, Hilda Faasalele, Ruth Bijl, Alison Leversha, IMAC, Auckland PHO, Public Health, Plunket, Commissioner for Children Office, Ministry of Health



Current activities

1. Practice level reporting available
2. Primary care Immunisation Co-ordinators funded - ongoing
3. ADHB Immunisation Strategy approved
4. Funding application made to Starship Foundation to fund social marketing programme
5. Data cleansing project in primary care approved and funded
6. Scoping project for multi-agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices begins with final results expected by June 2011.
8. Letters sent to all parents who are noted on the NIR as having declined immunisation for their child to check that this is correct.

Project Risks / Comments:
Coverage for Quarter 3, 2010/11 (2 years olds full immunised all ethnicities) is 88% (regional target 90%, ADHB target 91%). Maori coverage at 18 months increased by 4% in February. The data quality and practice nurse education project targeting systems issues is well underway with so far 2426 missing doses entered manually on the NIR including 214 children who will turn 2 in the next 3 months. In addition, all children turning 2 in the next 3 months who are currently overdue for a scheduled immunisation are being automatically referred to the Outreach Service for follow up and as of 1 April 63 children had been referred. ‘Courtesy’ letters to check ‘decline’ status on the NIR have been sent 554 parents to check that they had intended to decline immunisation. Of 95 responses received so far 31% did not intend to decline immunisation and these children will be followed up. Together, it is expected that these initiatives will result in at least a 2-3% increase in coverage by 30 June 2011.

7

IMPROVEMENT ACTIVITIES

7.1 DAP Projects Report

Group Pack Report

Group/Committee: Community and Public Health Advisory Committees

Goal Level Summary

DAP Projects - total projects: 25

			Current Phase						On Time			On Budget			Expected Outcome				Post Implementation Benefits		
			Plan			Do/ Check	Act														
Goal	Number	Started	Define	Measure	Analyse	Improve	Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
1 Lift the Health of the people in Auckland City	18	18	3	3	1	8	2	0	14	2	1	17	0	0	17	0	0	1	1	0	0
2 Performance improvement	7	7	0	1	0	6	0	0	5	2	0	7	0	0	4	3	0	0	0	0	0
3 Live within our means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	**25**	**25**	**3**	**4**	**1**	**14**	**2**	**0**	**19**	**4**	**1**	**24**	**0**	**0**	**21**	**3**	**0**	**1**	**1**	**0**	**0**
Total %	**100%**	**100%**	**12%**	**16%**	**4%**	**56%**	**8%**	**0%**	**76%**	**16%**	**4%**	**96%**	**0%**	**0%**	**84%**	**12%**	**0%**	**4%**	**4%**	**0%**	**0%**

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

High Level Summary - total projects: 18

High Level Strategy	Number	Started	Current Phase					Cancelled	On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/ Check	Act														
			Define	Measure	Analyse	Improve	Control		Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red
1.1 Reduce inequalities in health status	7	7	2	1	1	3	0	0	6	1	0	7	0	0	7	0	0	0	0	0	0
1.2a Improve outcomes for children and young people	2	2	0	1	0	0	1	0	2	0	0	2	0	0	2	0	0	0	0	0	0
1.2b Improve outcomes for older people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2c Improve outcomes for mental health and addictions	3	3	0	0	0	2	0	0	2	0	0	2	0	0	2	0	0	1	1	0	0
1.2d Improve outcomes for long term conditions	5	5	1	1	0	3	0	0	4	0	1	5	0	0	5	0	0	0	0	0	0
1.2e Improve outcomes for Palliative care	1	1	0	0	0	0	1	0	0	1	0	1	0	0	1	0	0	0	0	0	0
Total #	**18**	**18**	**3**	**3**	**1**	**8**	**2**	**0**	**14**	**2**	**1**	**17**	**0**	**0**	**17**	**0**	**0**	**1**	**1**	**0**	**0**
Total %	**100%**	**100%**	**17%**	**17%**	**6%**	**44%**	**11%**	**0%**	**78%**	**11%**	**6%**	**94%**	**0%**	**0%**	**94%**	**0%**	**0%**	**6%**	**6%**	**0%**	**0%**

Objectives

Objective	Objective Owner	Comment
1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	Aroha Haggie (ADHB)	Projects under this objective are progressing as expected. Significant support is being provided to these activities especially in the BSMC space to support the implementation of whanau ora and activities focused on reducing inequalities. Whanau Ora Outcomes Framework - We are experiencing some delays in the development of outcomes for the framework however we are seeking to align DHB:MAPO outcomes with those recently development in the primary care and BSMC business case space.
1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	Hilda Faasalele (ADHB)	A busy month of multiple HVAZ (Zone) HEHA and primary care/health screening activities and events. Many of the activities are collaborative events by Procare & Alliance Health+ HVAZ staff - supported by the ADHB Pacific team. The HVAZ Self Management Education (SME) was rolled out by jointly appointed (ADHB/CMDHB) Pacific SME Nurse. Two churches have begun the SME 6 week Course - successful engagement was shown by all participants (mostly elderly) returning every week and participating fully in the programme. Training of ADHB Pacific Best Practice Education Programme has had approx 85 staff participating this month with more sessions planned. Secondment of Pacific team member providing secretariat support to the newly established AH+ Clinical governance Group. Provider Arm Pacific Events included a Pacific Celebration of International Nurses Day with a Pacific Nursing Grand Round "Talanoa Session' attended by over 60 people. This was organised and facilitated by the ADHB Pacific Nurse Leadership Group.
1.1.3 Increase access to services for culturally and linguistically diverse populations	Denis Jury (ADHB)	Increased utilisation of online cultural competency training modules and interpreters by both primary and secondary care has continued over the last month.
1.1.4 Support disabled	Denis Jury (ADHB)	Disability Responsiveness Audit recommendations currently being reviewed and prioritised and paper to SLT planned for June / July. Regional work

people and improve their access to health care and support services		underway to manage devolement of the IFP by July 2011, and issues of regional processes and risk sharing to be considered by RFF in May.
1.2a.1 Achieve immunisation targets	Denis Jury (ADHB)	Immunisation rates are now 88% and focus continues on the data improvement project and the follow up training for practice nurses. The rate for Maori is now 81%, an increase of 6% over the last two months.
1.2a.2 Improve the oral health of children	Denis Jury (ADHB)	Construction of clinics and service development continues according to plan -the Otahuhu clinic was opened in mid-April.
1.2b.1 Home-based support services and restorative homecare initiatives	Denis Jury (ADHB)	Casemix work, and particularly that related to high and complex needs client on tract to meet dealine of 31 May.
1.2b.2 Quality improvement in residential care	Denis Jury (ADHB)	Development of the process for introduction of the EDEN programme continues with support of the relevant providers. Number of complaints decreased compared to last financial year.
1.2c.1 Increase effectiveness across primary, secondary, tertiary services for mental health and addictions	Denis Jury (ADHB)	Satisfactory progress with all projects.
1.2d.1 Strengthen community participation and action for long term conditions	Denis Jury (ADHB)	280 clients now enrolled with the commuity breast feeding service over the last quarter. Coordinator employed and Plunket and Ngati Whatua working in partnership.
1.2d.2 Integration of services across primary and secondary care for long term conditions	Andrew Coe (ADHB)	BSMC DAP targets for for clinical pathways are progressing satisfactorly. Regional work continues on the establishment of an Auckland Region diabetes network.
1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	Andrew Coe (ADHB)	The interim retinal screening community provider continues to work throuh patients on the wait list, and all new referrals are now seen within the screening guideline requirements.
1.2d.4 Support whanau and self resilience for long term conditions	Aroha Haggie (ADHB)	The Diabetes Self Management Education service is establish. Te Hononga O Tamaki Me Hoturoa was awarded the contract at competitive tender. Two training courses are underway with more planned over the six months. The wider communication and raising awareness about the service has commenced. The diabetes self management project progressing as expected.
1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	Andrew Coe (ADHB)	All projects progressing well, with clients in the primary care programme now at the planned levels and implementation of Liverpool pathway ahead of schedule.

Exceptions

			On	On	Expected	

Project	Coverage	Phase	Time	Budget	Outcome	Sponsor Review
Increase access and capacity to community diabetic eye screening	National	Improve	Red	Green	Green	The work to enable the wider community screening programme to be operationalised is continuing with clinical and project teams working closely together to ensure that the system meets the work flow, data requirements and new structure. Customisation discussions with the vendor for the software component of the project is in progress as is the regional alignment for the solution to ensure that a regional system is developed and meets the regional needs. The support from the community provider to enable the volumes to continue to be screened is operating well and the additional capacity offered is helpful.
Māori Service Development	Regional	Define	Orange	Green	Green	The original project intention was to devolve $600k of services (largely health promotion and public health) from metro-Auckland DHBs and the Ministry of Health (MoH) to Iwi and Maori providers by 30.12.10. This target date was too ambitious and was revised to 28/02/2011 for the identification of services across the DHBs to be devolved and construct a devolution framework. A number of services from CMDHB and WDHB were tagged for devolution and these are so far; • CMDHB: Smokefree RFP has been awarded to Raukura Hauora o Tainui. Total contract price is $240k PA • WDHB: CAYAD contract has been let, value $176PA. Well Child contract awaiting MoH decision, therefore RFP process on hold The draft devolution framework was due to CMDHB by 06/05/11. The original timeframes have already passed but the tools for future devolution work are in place and $416K worth of services should be devolved before the financial year end.

Legend: Red - ◆, Orange - ▲, Green - ●

Goal: 2 Performance improvement

High Level Summary - total projects: 7

			Current Phase						On Time			On Budget			Expected Outcome				Post Implementation Benefits		
			Plan			Do/ Check	Act														
High Level Strategy	Number	Started	Define	Measure	Analyse	Improve	Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
2.1a Efficient and effective Primary health care	2	2	0	0	0	2	0	0	2	0	0	2	0	0	1	1	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	4	4	0	1	0	3	0	0	2	2	0	4	0	0	2	2	0	0	0	0	0
2.1c Improve quality of hospital care while improving productivity	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
2.2 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.3 Improve Clinical Quality and Professional Governance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.4 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.5 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.6 Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	**7**	**7**	**0**	**1**	**0**	**6**	**0**	**0**	**5**	**2**	**0**	**7**	**0**	**0**	**4**	**3**	**0**	**0**	**0**	**0**	**0**
Total %	**100%**	**100%**	**0%**	**14%**	**0%**	**86%**	**0%**	**0%**	**71%**	**29%**	**0%**	**100%**	**0%**	**0%**	**57%**	**43%**	**0%**	**0%**	**0%**	**0%**	**0%**

Objectives

Objective	Objective Owner	Comment
2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	Andrew Coe (ADHB)	ADHB continues participation at national, regional and local level regading primary care planning and implementation. The PHOs in GAIHN responded to the consultation process regarding the proposed RFP for after hours services questioned various aspects of the proposaln and particularly the need for an RFP. Alternative approaches to deliver this project to the timeline are currently being considered.
2.1b.1 Improve access and efficiency of service delivery for primary–secondary system	Andrew Coe (ADHB)	Overall projects are progressing well and while there have been time delys most of the targets will be met; this does require constant attention though to ensure delivery. As noted previously there are issues regarding the RFP for after hours and calculation of the savings form the pharmaceutical utilisation project.
2.1b.2 Reduce acute demand	Andrew Coe (ADHB)	Development of the extented POAC services continue, but the RFP approache will be designed following completion of the after hours project.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Pharmaceuticals	Regional	Measure	⚠	●	⚠	Optimal prescribing – to improve medicines safety for patients and to improve prescribing quality of providers through a multi-faceted approach

						which utilises bulletins, analysis and prescriber level data through GP cell groups to encourage peer review and pressure to inform 'best practice' prescribing. By adopting 'best practice' prescribing efficiencies can be made through the quantity and type of medications prescribed and the reduction in polypharmacy in the elderly. The project was originally envisioned to save at least $1.5million of pharmaceutical expenditure in the 2010 / 2011 financial year which would be divided equally with the project. This was a joint project with CMDHB and involves Procare and East Health Trust. The project's programme of interventions is progressing well and is gaining traction with GPs. There has been difficulty in agreeing on a methodology for calculating savings as it is a complex process which involves pharmaceutical rebates which are unknown and there are so many external factors that can impact on pharmaceutical spend. The project is on budget, ADHB has contributed $300K to the project which is expected to be covered by the pharmaceutical savings made (once a methodology is agreed). However the target of $1.5 million in savings may have been too ambitious as highlighted above external factors can impact and plans for reduced costs or additions to the schedule which have fallen through will have impacted on the original savings estimated. Regardless of the savings the project is improving the quality of prescribing and so is improving clinical practice and optimising community pharmacy budget.

Legend: Red - , Orange - , Green -

8

FEEDBACK FROM MAORI HEALTH ADVISORYCOMMITTEE AND PACIFIC HEALTH ADVISORY COMMITTEE

9

PAPERS

9.1 Diabetes Annual Review & Management & Health Target

Community and Public Health Advisory Committee

Briefing Paper

Date	Wednesday 15 June 2011
To	Community & Public Health Advisory Committee
From	Denis Jury Chief Planning and Funding Officer Auckland District Health Board Level 8, Building 13, Greenlane Clinical Centre E-mail: denisj@adhb.govt.nz Phone: 09 630 9943 Ext 8071 Mobile: 021 306044
Author	Gayl Humphrey, Manager Strategy Implementation and Louise Dickinson, Project Manager Long Term Conditions
Functional Group	Planning and Funding Management Group
Subject	Diabetes Annual Review and Management and National Health Target

1 Purpose

To update CPHAC on ADHB activities and strategies in place to improve performance against the diabetes annual review and management national health target

2 Recommendations

1) For CPHAC to note activities being undertaken to improve diabetes health outcomes for our population and as a consequence achieve our diabetes annual review and management targets.

2) For CPHAC to note our Diabetes performance is equal or greater than our neighbouring DHBs despite not achieving targets

3) For CPHAC to note our 2011/2012 targets remain as stretch targets with the goal to improve health outcomes for people with diabetes

4) For CPHAC to approve the scoping of a community diabetologist position with a paper to come back to CPHAC with recommendations

5) For CPHAC to agree that a Diabetes Update be on Board Agenda six monthly

<table>
<tr>
<td>3</td>
<td>
Setting the Scene

Our Performance

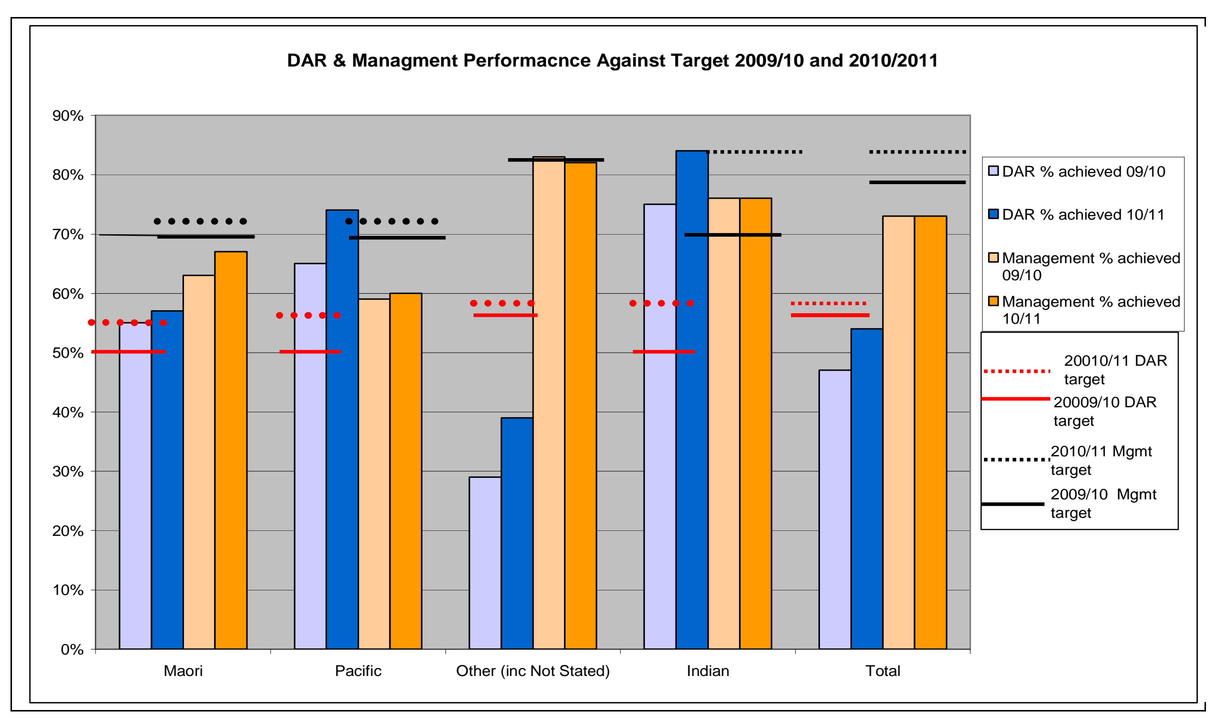
Diabetes is a core Ministry of Health focus for health outcomes. Diabetes annual reviews also known as Diabetes Get Checked, is the mechanism for which reporting is obtained. This measure includes both number being reviewed and HbA1c as the best proxy for the health outcome for that review.

Targets for both annual reviews and management are determined by DHB’s, and as such are different across the country. This impacts on our position nationally as we are compared with DHB’s whom have significantly different targets (mostly lower).

The following chart illustrates our performance for 2009/10 and 2010/11 year (to date). The blue columns are the annual review and the orange columns show the management. The lines illustrate the targets we wish to achieve, with the block line being 2009/10 and the dotted line 2010/11.

For annual review, there has been an overall improvement from 2009/10 to 2010/2011, with Maori, Pacific and Indian achieving their target goal. However, Other is significantly under achieving. As Other represent the majority of the volumes, this poor outcome significantly influences our target performance.

For management of diabetes based on HbA1c ≤ 8%, we have had minimal improvement in the overall performance over the two years with neither year achieving overall target. Other and Indian are the only groups to achieve their target but when reflecting on the numbers represented, this is not for a large volume of our population. Maori and Pacific are significantly below their targets.
</td>
</tr>
</table>



	Good diabetes management is essential, as poor blood glucose control is a significant contributor to micro and macro vascular harm such as cardiovascular and renal disease. These are significant contributors to morbidity and disability in people and have significant impacts on health care resources. For example a person with diabetes progressing to renal disease could cost $80K per year for dialysis rather than $400 per year with good management. Nevertheless, it is important to note that a single HbA1c target point of ≤8% does not reflect continued improvements in HbA1c management that are being made. Research suggests that improvements in HbA1c take time and depending on the start point, it is not realistic to see a change for example from 11% to ≤ 8% within a single annual review time frame however, a reduction from 11% to 10% contributes to a reduction in risk for complications. We are currently attempting to examine the distribution curve for HbA1c results to enable a better understanding of the population at greatest risk for harm. **Performance by PHO** It is clear that performance is different by PHO, with ProCare being the significant contributor to overall failure to meet annual review targets albeit 78% are well managed (HbA1c ≤8%). The table below shows the actual performance in numbers that have been achieved. It is clear that ProCare have the most population with diabetes yet to date are seeing significantly lower numbers. Overall, to meet our 2010/2011 annual review target, a further 2548 reviews need to be undertaken.
Performance 2010/2011 by PHO as at April 2011.	

Actual performance per PHO (ADHB practices only)						Prevalence	#of DAR needed to meet annual target (57%)	Difference between target and actual YTD	
PHO	Q1 Jul - Sep	Q2 Oct-Dec	Q3 Jan-Mar	April	Total				
Auckland PHO	329	450	333	128	1240	2153	1227	13	*greater than target*
Auckpac + THS (Alliance Health +)	755	576	629	159	2119	3074	1752	367	*greater than target*
Procare	1558	1515	1086	630	4789	13846	7892	-3103	*number needed*
Tamaki / Te Hononga	439	452	452	126	1469	2269	1293	176	*greater than target*
Total	3081	2993	2500	1043	9617	21342		-2548	number needed to reach target

Discussions with ProCare have highlighted that there are some clear business rule inaccuracies and these are currently being resolved. As such it is anticipated that for the May to June months significant improvement should emerge.

In addition, despite the three other PHO's achieving their target for their PHO, the target is low and the PHOs have been encouraged to achieve greater outcomes for their population. There is no funding cap to diabetes annual reviews and as such, no disincentive to reduce activity despite achieving target.

ADHB compared with WDHB and CMDHB for Diabetes Management

Although ADHB is not achieving our stretch targets, we are performing better than both WDHB and CMDHB for all ethnicity groups (see table below for 2010/2011 year to date). Our targets, particularly for Maori and Pacific are significantly higher than out counterparts.

2010 / 2011	Maori		Pacific		Other		Total	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual
WDHB	65%	63%	62%	56%	83%	77%	79%	74%
CMDHB	53%	53%	48%	46%	70%	70%	59%	58%
ADHB	72%	67%	72%	60%	83%	82%	84%	73%

Note: WDHB reporting period April –Dec 2010 while ADHB and CMDHB reporting period July 2010-March 2011

It is acknowledged that management figures are drawn from the number of annual reviews undertaken and CMDHB have achieved 79% for Maori and 68% for Pacific. It is recognised that Maori and Pacific have notably higher HbA1c results than their non Maori and non Pacific counterparts and it is expected that given CMDHB annual review results, they will have a more difficult task to achieve higher management targets. WDHB and ADHB annual reviews are similar in volumes.

Targets for 2011/2012

	After discussions with our primary care partners, it was acknowledged that a management target of 84% was too high and not achievable. Currently this has not been achieved elsewhere in New Zealand. As such, the proposal to decrease our target to 77% seemed an acceptable compromise to setting achievable targets but also having an element of aspiration. Despite this decrease, our target is still greater than CMDHB and WDHB targets for the 2011/2012 year. Of note, the regional health plan is aiming to have no difference in targets by ethnicity. The ADAT team agree with this concept but acknowledge that targets also need to be achievable and therefore this is likely to be a goal for 2112.

	ADHB Proposed annual target 2011/12	**WDHB Proposed annual target 2011/12**	**CMDHB Proposed annual target 2011/12**
Ethnicity	**HBA1c < 8.0**	**HBA1c < 8.0**	**HBA1c < 8.0**
Maori	72%	67%	54%
PI	72%	60%	49%
Other	80%	78%	71%
Total	77%	75%	60%

4 **Current Strategies to Improve Performance**

ADHB and our PHO partners acknowledge there is a considerable amount of work required to improve both annual review and diabetes management health outcomes and achieve our targets. There is a wide range of activities happening that are aimed at achieving this outcome.

1) Creation of three quality improvement (QI) coordinators situated in primary care (PHO agnostic). Their first priority is a focus on improving diabetes health outcomes for which annual review and management data collection is part. To achieve this they are :

   - working with practices across the ADHB to utilise information systems that enable and support the environment, resulting in increased Diabetes Annual Review (DAR). This includes establishing and maintaining diabetes registers and recall systems.
   - supporting and enabling practices to improve diabetes management by linking them in with other services, such Self Management Education, Green Prescription or the Auckland Diabetes Centre.
   - encouraging practices to look at roles within practices to create a dynamic workforce and supporting the role of nurses in diabetes care.
   - developing a patient centred diabetes clinical pathway that is adopted and consistently used across the district, preferably with an electronic flow chart format.
   - reviewing existing services and practices across the district and sharing good ideas to improve patient access and health outcomes. This may include trying to establish a diabetes clinical champion in each locality.

	These three positions commenced work between February and April 2011. 2) Funding support for all primary care practices to have a population audit tool. The tool enables practices to interrogate their practice management system to identify people with long term conditions, their risk factors and key clinical information such as those who have received preventative services (e.g. smoking cessation, CVD risk screening). Contracts for this tool were in place from January 2011, with all PHO's signed up by May 2011. 3) Technology support for smaller PHO's to enable a single seamless pathway for both clinical review and data entry for CVD and diabetes. This support was contracted in December 2010 and work is in progress 4) A significant review of the self management support for people with diabetes was undertaken in 2010. The outcome of which was a competitive tender process and the appointment of a new provider in January 2011. The provider, Te Hononga, has operationalised courses and there are culturally and linguistically appropriate ones being delivered to meet the population needs. In addition to providing for all people, they have a particular brief to focus on ensuring access and cultural appropriateness for our high needs population with diabetes as this is where the greatest health gain can be achieved. 5) A Self Management Group is also being established to support the development of self-management competencies, planned strategic direction, identification of outcome tools etc. This group is planned to be a metro Auckland group to ensure cross learning and resource maximisation. This group is expected to be operational by June 2011 The development and support of a Pacific self management facilitator has been established. The role of facilitator includes training HVAZ parish nurses, community health workers and lay people to increase the numbers of people connected to our Pacific populations delivering self management. A specific course delivered fully in Samoan is being implemented, with two courses currently being held. Further workforce development to support the roll-out and sustainability of the programme through the establishment of a network of Master Trainers will start in June. 6) A self management tool kit is being developed to provide health care professionals the resources needed to support their patients with changing behaviour and improving health outcomes. This will be a robust evidence based tool accessible online and in hard copy. This will work in conjunction with the self-management training and workforce development mentioned above and is expected to be available by July 2011

	7) Continued support for the Cardiovascular Risk Assessment and Diabetes Management decision support tool, which links to meeting our cardiovascular risk assessment targets. Additional information on improving HbA1c e.g. clinical pathway could be tagged on to this. 8) The enhancement of diabetes retinal screening to include community provision, particularly in our high needs locations. This will also increase the number of retinal screens in ADHB by a further 3000 by June 2012 9) Proactive interactions with our PHOs to identify barriers to good diabetes management. Some of these activities are promoting the linkages with specialist services, work force development, and data analyses support. A particular project has been to support practices to identify all their patients with diabetes and review their care i.e. the emergence of creating an accurate diabetes registry. In collaboration with the improvement coordinators, those practices with high numbers are being actively supported to examine ways for a systematic and sustainable approach to care including supporting nurse led clinics. 10) ADHB is also participating in the National Diabetes Nurse prescribing pilot sponsored by the MoH. This pilot will provide enhanced resources for primary care to capitalise on for improving the health outcomes of our diabetic population. 11) Adjuvant activities include the support of an evidenced based nutritional assessment decision support tool (Food Habits) for all primary care practices. Its value is that it provides systematic assessment and outcome advice to support people with diabetes to change their nutritional habits. A nutritional resource guide for weight management has also been developed and supplied to all primary care in hard copy and will be available on line. 12) The Auckland Diabetes Advisory Group is being reoriented to have a more strategic and clinical focus under the label of a Long Term Conditions Diabetes steering group. This group will be directly linked with the diabetes network group established under the regional health plan . The new group, which will receive direct reports from two operational groups being established for both DSME and the QI Coordinators, will be established by July 2011 These are all long term initiatives aimed at improving performance by embedding good systems in practices to ensure that people with diabetes receive timely, coordinated diabetic care. Given the long term nature of these initiatives, it is likely that the 2011/12 year will show a moderate amount of improvement only but that once the foundation has been created, the gains should be significantly more noticeable. However, the work currently being undertaken with ProCare to improve the immediate diabetes reviews should be apparent in the April-June quarter (Q4 2010/11).
5	**Other Linked Activities** The North Region's Health Plan has identified diabetes as one of four areas

	to improve quality of life and life expectancy. Under the plan a diabetes network has been established, the purpose of which is to ensure a regionally consistent response and methodology to issues relating to prevention, care and treatment of people with, or at risk of developing, diabetes. Immediate initiatives of the network include: 1) Establishing a register of patients with diabetes or at high risk of developing diabetes. 2) Bridging information gaps to support and improve quality of care for patients with diabetes and CVD. 3) Taking a leadership role to increase diabetes prevention, screening and assessment, through increasing the number of patients who have their Diabetes Get Checked and retinal screening. 4) Minimising the impacts from diabetes and promoting good diabetes management through developing and implementing a diabetes pathway and improving HbA1c to <8% in an increased number of patients. 5) Mentoring system for diabetes teams. 6) Workforce growth in diabetes nurse specialists. The network will support and enable practices to better manage their populations with, or at risk of, diabetes and through this support the achievement of the national health targets.
6	**Additional Activity** The planning team are working with primary care partners to examine new mechanisms for funding of diabetes annual reviews. It is intended that these discussions will lead to an agreed new funding method for supporting practices to improve diabetes health outcomes. The planning team is also actively working with the Localities team to identify approaches for improved local diabetes service provision. The synergy with integrated family health centre activity and devolution of care is evident. We would like to investigate the feasibility of creating a community diabetologist role to promote greater support at individual practice and locality settings in the community according to need. The role could include seeing patients with diabetes at their local practice or Integrated Family Health Centre, thereby removing the barriers of transport and cost in being seen at the ADC; providing education and training to practice staff either at individual practices or in a locality, to support their ability to better manage patients with diabetes in the community. Evidence from the UK suggests that a community focused role resulted in a reduction in hospital admissions, reduced visits to secondary service out-patients, as well as improved patient satisfaction. This would also reflect similar roles, such as ADHB's community pediatrician and Waikato community multidisciplinary diabetes team. The funding for this role could be part of the examination of existing funding mechanisms for diabetes annual review.

7	**Barriers**
	Some of the feedback from primary care practices around barriers that still exist to improved diabetes care include the following: 1) **Other Data Monitoring Systems Not Aligned:** The target setting within PPP has two components: detection and detection and follow-up. Unlike the national health target, the PPP target is volume oriented (i.e it has no diabetes management target such as the percentage of people managed with an HbA1c ≤ 8%), and collects is the number of people that have had their annual review completed. To enable improved performance a clinical indicator target would play a stronger driver for change. 2) **Diabetes Get Checked Limitations:** It is still the opinion of some practitioners that the DGC system is a data gathering exercise and does little to support good management of patients. However, the support of the QI Coordinators can help mitigate this through ensuring good systems are in place to capture and submit data for the DGC to the PHO and DHB, as well as providing a mechanism for feeding back on performance at a practice level to illustrate . 3) **Workforce Limitations**: Primary care practitioners currently receive diabetes education through Continuing Medical Education sessions run through their PHO, workshops held by the ADC, conferences and even drug company workshops. Despite this it is still felt that there is insufficient training to support GP's and nurses, for example, to initiate insulin in their practice. 4) **Funding Model**: The current primary care funding model is not conducive for supporting increasing complex care in the community. For example, funding for the time taken to assist patients initiating insulin is perceived to be inadequate for those patients not on Careplus. A practice nurse will spend a considerable amount of time providing the patient with appropriate information, assisting them with injecting the insulin and titrating the insulin dose over the first few months. The initiatives discussed in this paper are intended to intervene, address and develop new mechanism with which these barriers can be addressed.

10

CONFIRM

10.1 Action Points for next CPHAC Meeting

10.2 CPHAC Feedback to Board

Use Forms at beginning of Meeting Pack

11

GENERAL BUSINESS

12

BOARD

12.1 Update on Planning Documents: Annual Plan and Statement of of Intent

Board Briefing Paper

Date	Wednesday 15 June 2011
To	Special meeting of the Board
From	Denis Jury Chief Planning and Funding Officer Auckland District Health Board Level 8, Building 13, Greenlane Clinical Centre E-mail: denisj@adhb.govt.nz Phone: 09 630 9943 Ext 8071 Mobile: 021 306044
Author	Tony O'Connor, Engagement and Planning Manager Ext 26765 tonyO@adhb.govt.nz Julie Helean, Manager Planning and Service Development' Ext 4390 jhelean@adhb.govt.nz
Functional Group	Planning and Funding Management Group
Subject	**Update on planning documents: Annual Plan and Statement of Intent**

1 Purpose

To ensure that Auckland DHB fulfils its accountability responsibilities associated with the Annual Plan and Statement of Intent for the forthcoming financial year.

2 Recommendations

It is recommended that the Board:

1. **Approve** the final Statement of Intent for submission to the National Health Board on 20 June
2. **Note** the feedback to date from the National Health Board and Audit NZ on our Annual Plan and the various Statement of Intent components

3 National Health Board Feedback on the Auckland DHB Annual Plan

The National Health Board and Audit NZ have been in contact with us since we submitted our final Annual Plan on 20 May. The Annual Plan is largely complete with the exception of the final elective target for the 2011-12 year. Work to resolve this is progressing with our full cooperation.

	Most of the feedback subsequent to 20 May has concentrated on the sections of the Annual Plan designed to fulfil the requirements of the Crown Entities Act. This Statement of Intent has now been developed into a separate document, created from modules 1,2,4,5 and 8 of the Annual Plan. It is presented to this meeting of Board under a special cover. The Statement of Intent will be submitted to the National Health Board on 20 June as our final work. While the Annual Plan and Statement of Intent are virtually identical in content, the Statement of Intent does focus more on our Intervention Logic, and on Module 4: the Forecast of Service Performance. This module sets out the measures of output and health impact that we need to cover in detail in our Annual Report at year end.
4	**The sign off process** **For the Annual Plan** The final Annual Plan has been approved by the Board. Two Board members and the CEO, along with the Chair of Te Runanga o Ngati Whatua are being asked to sign a hard copy of this document. Two scanned pages of electronic signatures will be inserted into our master document and this will be re-submitted to the National Health Board on June 20. At such time as we are assured that the Minister of Health plans to approve the Annual Plan, we will ensure that he receives a signed, hard copy of the document for his signature. **For the Statement of Intent 2011-2014** Because we have created a separate document for the Statement of Intent, Board members are now asked to approve this final document for submission to the National Health Board on 20 June. This document will be circulated under separate cover prior to the meeting. Once approved, the Statement of Intent requires signing by the Chair and one other Board member. As with the Annual Plan, we will use scanned signatures in an electronic master copy for the 20 June submission. The National Health Board will then submit our Statement of Intent to the Minister for his consideration. The Minister of Health’s signature is not required on the Statement of Intent. Hard copies of the signed Statement of Intent are due in the Minister’s Office and in the Bill’s Office (for tabling in Parliament) before 30 June. Once it has been tabled in Parliament it will be placed on our website.

5	**Timeline and process**	
	Date	**Required**
	15 June	Board approves the Statement of Intent
	By 17 June	Board members sign 2 hard copies of the document
	20 June	Deadline for submission of the Annual Plan or Statement of Intent to the National Health Board. All outstanding issues resolved including any raised by the Minister of Health
	27 June	The National Health Board present the Minister of Health with copies of our Annual Plan and Statement of Intent, along with their assessment of the documents
	30 June	Statement of Intent sent to House of Representatives (45 hard copies) and to the Minister's Office (2 hard copies)
	No later than 11 July	By law, the Statement of Intent must be made available to the media and public via the Auckland DHB internet site

13

APPENDICES

13.1 Statement of Intent 2011-2014 fl bXYf˙gYdUfUhY˙Wcj YfŁ

Community and Public Health Advisory Committee

Agenda

MEETING DETAILS		
Time and Date	2:00 p.m. – 5:00 p.m. Wednesday, 15 June 2011	
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre	
Members	Dr Lee Mathias (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Lester Levy, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.	
Apologies		
On Leave	Rob Cooper	
In Attendance	Garry Smith, Dr Denis Jury, Taima Campbell, Hilda Fa'asalele, Naida Glavish, Janice Mueller, Ian Bell.	
	Item	**Page No**
1 5m to 2:05 pm	**Karakia**	**001**
2 5m to 2:10 pm	**Attendance and Apologies**	**005**
3 5m to 2:15 pm	**Conflicts of Interest**	**007**
4 10m to 2:25 pm	**Confirmation of Minutes** - Wednesday 18 May 2011	**015**
5 10m to 2:35 pm	**Action Points** - Wednesday 18 May 2011	**021**
6 25m to 3.00 pm	**Planning and Funding Performance** 6.1 Planning and Funding Summary Report	**025**

	6.2 Planning and Funding Indicators List and Exception Report 6.3 National Targets	
7 15m to 3:15 pm	**Improvement Activities** 7.1 DAP Projects Report	**045**
8 15m to 3:30 pm	**Feedback from Maori Health Advisory Committee and Pacific Health Advisory Committee**	**053**
9 30m to 4:00 pm	**Papers** 9.1 Diabetes Annual Review and Management and National Health Target	**055**
10 10m to 4:10 pm	**Confirm** 10.1 Actions Points for next CPHAC Meeting 10.2 CPHAC Feedback to Board	**067**
11 10m to 4:20 pm	**General Business**	**069**
RECONSTITUTE BOARD		
12 30m to 4:50 pm	12.1 Update on Planning Documents: Annual Plan and Statement of Intent Note: This will be as a duly convened meeting of the ADHB Board	**071**
13 5:00 pm	**Appendices** 13.1 Statement of Intent 2011-2014 (under separate cover)	**077**
NEXT MEETING		
Date and Time: 2:00 p.m. – 5:00 p.m. Wednesday 20 July 2011 **Venue:** Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre		

Hei Oranga Tika Mo Te Iti Me Te Rahi

Healthy Communities, Quality Healthcare