AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

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COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE

Minutes of the Community and Public Health Advisory Committee meeting held on Thursday 5 July 2007 in the Marion Davis Library, Building 43, Auckland City Hospital, Grafton commencing at 9:00 am

1. ATTENDANCE AND APOLOGIES

Committee Members

Wayne Brown (Chair)
Dr Chris Chambers
Dr Virginia Hope
John Retimana
Rev Alfred Ngaro
Paul Stephenson
Winston Timaloa
Dr Daniel Wu
Harry Burkhardt
Barry de Geest
Dr Di Nash
Dr Ian Scott
Paul Roseman
Teriki Stewart
Professor Alistair Woodward

Management in Attendance

Garry Smith – Chief Executive
Dr Denis Jury – Chief Planning & Funding Officer
Dr David Sage – Chief Medical Officer
Taima Campbell – Executive Director Nursing
Naida Glavish – Acting GM Maori Health
Janice Mueller – Director Allied Health
Dr Celia Palmer – Clinical Leader Planning and Funding
Aseta Redican – GM Pacific Health
Ian Bell - Board Administrator

Apologies

The Chair declared the meeting open at 9.07am.
John Retimana opened the meeting with the karakia.

Apologies had been received from Ross Keenan and Mark Vinall.

2. CONFIRMATION OF MINUTES 7 JUNE 2007

Moved John Retimana, seconded Virginia Hope

That the minutes of the Community and Public Health Advisory Committee meeting held on Thursday 7 June 2007 be confirmed as a true and correct record.

Carried

3. ACTION TABLE – 7 JUNE 2007

Removal of Residential Care Managed Bed Policy
Changes to the Social Security Act meant that if persons were eligible for rest home care the Funder was required to fund. The emphasis was now on assessment for eligibility for rest home care and the strengthening of support services for ageing in the home as a means of managing numbers in rest homes. While a number of years ago Auckland's residential care population was 6% compared with a population based average of 4% any disparity was now addressed through the IDF mechanism.

4. PRIMARY HEALTH CARE STRATEGY 2007 SUBSIDY ROLL OUT (25 – 44 AGE GROUP)

This had been well advertised and ADHB had participated in a media campaign for several months encouraging people to enrol with a PHO and have a GP with quite a successful uptake. There was a question of measurement of outcomes in primary care and while there was international evidence that investment in primary care did produce better health outcomes it was noted that New Zealand was usually in the top group of countries relating to that evidence anyway. The intention of lowering the cost of people going to a GP was to encourage participation from those that had not previously gone and to improve service utilisation. The Committee asked that primary care indicators and measures of improved health outcomes be developed over time. This is to assess the effectiveness of the large increase in investment and funds being applied to the sector through the Primary Healthcare Strategy.

Dr Di Nash declared a conflict of interest being the Chair and Convenor of the NZ Labour Party Health Policy Committee noting that GPs saw PHOs as extra administration now that the initiatives which had been initially funded from savings had ended. Dr Daniel Wu declared a conflict of interest being a GP and noted that how GPs were paid did not change how they made clinical decisions.

Concern was expressed at the political statements in the releases and whether it was a reasonable investment or rather a tax redistribution which did not contribute to improved health outcomes. Planning and Funding would monitor development of primary care measures and report back to the Committee periodically.

5. PACIFIC HEALTH

Rev Alfred Ngaro declared a conflict of interest in providing the leadership training for the Healthy Village Action Zone (HVAZ) churches and Paul Stephenson declared a conflict of interest in assisting in development of the Healthy Village Action Zone Strategy.

Aseta Redican presented to the Committee giving an overview of the Pacific population in New Zealand and the percentages between the three regional DHBs with an apparent shift in Pacific population to Counties Manukau. The ethnicity of the Pacific population also showed variations between censuses with decreased percentages for Samoan and Cook Island and increases in Tongan and Niuean. The span of the ADHB Pacific Health Group across the sector was shown covering the community primary care and NGO sectors, Planning and Funding and Provider arm. There was involvement through

regional collaboration and involvement at a national level through national forums and national projects.

Rev Alfred Ngaro outlined building the Healthy Village Action Zone project using churches which operate in the Pacific community in a comparable manner to marae as a centre of activity and social gathering. The key concepts were self determination, empowerment, building capacity and leadership based on the premise that "a healthy village is a happy village".

Hilda Faasalele outlined the work of the Pacific Family Support Unit providing cultural/advocacy and social support services for Pacific in-patients and their families working as part of the multi disaplinary health teams. Key outcomes for the unit were decreased avoidable admissions and readmission rates for Pacific children, improved utilisation of available child health services especially primary care services, improved understanding between the care giver, child and their family and decreased DNA rates. Mazin Gahfel, Epidemiologist, Public Health Medicine demonstrated population data relating to discharges, deprivation deciles and distribution of churches used to establish the village zones.

The Committee thanked the presenters for an excellent presentation and expressed their support for the project going forward. John Retimana pledged the support of the manawhenua and offered his congratulations to the Pacific team and Rev Alfred Ngaro.

6. PUBLIC HEALTH – ALCOHOL UPDATE

Frank Booth, Manager Public Health Intelligence and Infrastructure and Dr Virginia Endres were in attendance. Public Health's involvement was a focus on enforcement as they were not funded for prevention activities. There is a scarcity of data concerning alcohol and links to crime, number of premises etc. although there were intuitive links. Collaborative Liquor Enforcement Groups (CLEGs) were an important link for Public Health and while Counties Manukau worked better with their CLEG a new appointment at Auckland may enhance the Auckland relationship. Public Health were aware of the Canterbury Public Health onsite host responsibility programme. Public health questions related to licensing included licensees knowledge of public health, host responsibility, food availability, transport options etc. The implication of banning party pills was unknown. It was noted that Public Health funding is not allocated on PBF with a higher proportion of funding going to the South Island.

7. AFTER HOURS SERVICE PLAN – CONSULTATION DOCUMENT

Wendy Hoskin, Planning & Funding Manager, Primary, Community and Ambulatory Services was in attendance. This was a consultative document being issued on an After Hours Primary Healthcare plan and funding strategy. Presently there were no incentives for GPs to direct patients to Accident and Medical Clinics (A&M) rather than ED with the disincentives for A&M being co-payments requested from patients. It was noted that A&M centres refer more people to ED that GPs. During strike action advertising suggesting people go to other centres rather than ED had been successful and there may be a need for further investment in this communication.

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8. PLANNING AND FUNDING MONTHLY REPORT

Main points noted were the negotiations with the pharmacists progressing well with both parties positive about the progress, and aged residential care and home base support service contracts being sent to providers to be signed by 27 July in order to back pay the increases for the month of July. Included in the report was a summary of new initiatives funding for 2006/2008 with $7.8m for 2007/2008 and $7m for 2008/2009. Additional funding of $13m has been used to bring ADHB's population intervention rates up to national intervention rates however this funding was at risk if the MoH base elective volumes are not achieved.

The Committee acknowledge the progress on meeting elective volumes noting the funding risk.

$120k were being allocated for interpreter services for primary care. Means of accessing those services are to be advised.

Morning Tea
The Committee broke for morning tea at 11:00am.

The Committee reconvened as a combined Community and Public Health Advisory Committee and Hospital Advisory Committee at 11:20am.

10. CARDIO VASCULAR DISEASE (CVD) AND DIABETES

Tom Schaefer, Manager, Our Health 2020 introduced the presentation with CVD–Diabetes being one of 5 priority areas in Our Health 2020. The plan covered prevention, management of disease, health system design and integration and addressing inequalities with, under management of the disease detection, evidence based management, managing care in the community and secondary care enhancements. Mapping CVD discharges, use of lipid lowering drugs and medication usage across the Auckland population showed an even spread by geographical and social indicator distribution across the population.

Peter Ruygrok, Clinical Director, Cardiology presented on the cardiology department, having 16 SMOs, 16 RMOs, 100 nursing staff and total staff of 196. Local, regional and national services were outlined as were the volumes of patients seen through 2005 – 2006 including 32 outpatient clinics per week and 10,143 out-patients seen. 3,695 angiograms, 1,307 coronary angioplasty/stents, 479 pacemaker implants and 92 implantable defibrillators procedures were performed. The budget was $40m per annum.

Robert Doughty, Clinical Leader, Heart Failure Programme outlined the common themes of approach being patient centred not hospital centred with primary-secondary-community linkages and evidence based and data driven quality improvement through a Funder/Provider partnership. Heart failure is due to many different cardiac diseases with 8,000 people in ADHB affected resulting in 860 admissions per annum with a heavy burden of a 20% readmission rate within 30 days and a 50% readmission rate within 6 months. He outlined the current patient admission process and issues being management, primary and secondary care being inconsistent, patients treated by several services, less than ideal discharge and long term planning, existing services not coordinated, no central focus on heart failure and variation from best practice care. Key

areas of improvement were diagnosis with the causes of heart failure established and then heart failure guidelines implemented.

Liz Shaw, Nurse Advisor, Cardiology,outlined the integrated programme being patient centred planning, coordination of in-patient care, consistent best practice care regardless of setting, out-patient services to follow up patients with support for GPs in diagnosis and/or management and better access to secondary care and advice. Additional staff were a 0.5 SMO and 3 heart failure clinical nurse specialists. Initiatives were education/training for all primary care providers through PHOs, additional payments to primary care for care planning and patient management, and direct access for primary care to specialist services for diagnostics and virtual consults etc. The programme timeline was outlined with finalisation of project details through June to August 2007 and implementation through August to November 2007. Results expected from the programme were a 25% reduction in readmission rates, improved patient compliance and improvement in nationally and internationally benchmarked quality indicators

She also outlined the cardiac rehabilitation programme with Phase 1 being in-patient, Phase 2 out-patient rehabilitation and Phase 3 long term maintenance and support. 720 patients were referred for Phase 2 rehabilitation per year. Issues were that it was estimated that 25% of eligible patients were not referred, 40% of those referred attend at least one session and 20% of those referred completed the programme, however there was no specific approach for Maori, Pacific or high needs groups and there was no specific link to community or primary care. The programme would look at improved linkages between primary and secondary care, have a focus on self management, be evidenced based and seek reduced barriers to access. The aim was to enhance community based programmes including HVAZ based programmes, home based programmes using Heart Guide Aotearoa and a Kaupapa Maori Cardiac Rehab Programme including additional staffing. The Heart Guide Aotearoa was a modernised programme modelled on the British Heart Manual designed to increase access to cardiac rehabilitation and complement existing programmes and provide rehabilitation focused on the needs of the individual and their family/whanau. In August to September the programmes details would be finalised with training in October and implementation from October 2007 to January 2008. Goals of the programme were that all patients discharged who are eligible would be seen and assessed with a goal of 80% acceptance rates to Phase 2 rehabilitation and 80% completion rate, a reduction in readmission rates and mortality rates, improved quality applied and increased patient compliance with lifestyle modification issues.

While it was acknowledged that heart failure was a terminal disease, life expectancy could be improved and quality of life was a key component. While there were increased numbers at a lower age there were also greater numbers at an older age as the population profile aged. With lifestyle issues there was partnering with Sports Auckland to enhance their programmes and access.

The Committee thanked the presenters for an interesting and informative presentation.

11. NEXT MEETING

The next meeting is scheduled for
9:00 am, Thursday 2 August 2007
Marion Davis Library
Building 43
Auckland City Hospital
Grafton

CONFIRMED

CHAIR: …………………………………………DATE: …………………….