Community and Public Health Advisory Committee
Minutes

MEETING DETAILS	
Time and Date	2:00pm, Wednesday, 20 July 2011
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom

1	**KARAKIA**
	The Chair declared the meeting open at 2:01 pm. Kerry Hiini led the meeting with the karakia.
2	**ATTENDANCE AND APOLOGIES**

Committee Members

Dr Lee Mathias (Chair)
Judith Bassett
Dr Chris Chambers
Peter Aitken
Susan Buckland
Ian Ward

Management in Attendance

Dr Denis Jury – Acting Chief Executive
Hilda Fa'asalele – General Manager Pacific Health
Aroha Haggie – Maori Health Gain Manager
Kerry Hiini – Planning and Funding Manager
Janice Mueller – Director Allied Health
Andrew Old – Public Health Physician
Ian Bell – Board Administrator

Apologies

Apologies had been received from Dr Lester Levy, Jo Agnew, Rob Cooper, Robyn Northey, Gwen Tepania-Palmer, Garry Smith and Taima Campbell. Judith Bassett advised that she would be leaving at 3:30pm.

Moved Peter Aitken; seconded Susan Buckland

That the apologies be sustained.

Carried

9.2	**GAIHN Proposed Work Plan 2011 – 2013**

Dr Ray Naden, Chair of GAIHN and David Tucker were in attendance. Since the last meeting, where there had been an update, a paper on the direction and approach had been developed. There was still work to be done on timelines and implementation. The first quarter of the work programme is to be funded through current available funds noting that the indicative budget requirement in 2011 - 2012 for ADHB is $450k.

GAIHN was looking at an integrated approach across the sector focused on patients who have acute events. The purpose of the project is to maximise benefit for the patients and their families and reduce the flow of acutes admissions. Auckland, as a region, has a higher rate of hospital admissions. The approach is to identify the patients in order to prevent acute events. Secondly, if there is an event, to initiate the response at primary care level and if hospitalisation is required to shorten that as much as possible through such programmes as "making time to care".

	The project also includes identifying the vulnerable frail elderly in residential care more clearly.. An example of care change was chest pain rather than heart attack which could be handled in primary care. When identified by name they can be linked to a carer "navigator" to see that their needs are met. The aim was to provide better and effective triage in the community. Work would begin 1 September with first patients 1 December targeting "frequent flyers" and groups. There would be an After Hours proposal later in the meeting. GAIHN represented the bulk of patients in the region and it was important to get consistency of services across the region. The Committee discussion included that stage gates should not be used to hold up the process and most do not involve the DHB but the Alliance Leadership Team. Public funds were being used so they had to be spent wisely and so, rather than spending a lot on a detailed plan and delaying the proposal, the strategy was to undertake work in the stages. While identifying individuals in the population risk groups is difficult it was needed to ensure that they are looked after taking a whanau ora approach. The governance model of seven Alliance partners had been challenging, but was working reasonably well now, with more effective decision making with a clear focus that was achievable. Reporting would be through the Planning & Funding Summary Report monthly as well as quarterly reports or at major milestones in projects.
3	**CONFLICTS OF INTEREST**
	There were no declarations of conflicts of interest with any item on the agenda.
4	**CONFIRMATION OF MINUTES 15 JUNE 2011**
	Moved Lee Mathias; seconded Susan Buckland *That the minutes of the Community and Public Health Advisory Committee meeting held on 15 June 2011, with the amendment to a reference to cellulitis, be confirmed as a true and correct record.* Carried
5	**ACTION POINTS 15 JUNE 2011**
	Diabetes This had been covered in the meeting on 15 June 2011. **Assisted Reproduction Services** This project was being led by Waitemata who were looking at the differences in performances of providers with a service review commenced with CMOs involved and Margaret Wilsher the CMO sponsor. The review included looking at the weighting of public services as well as prices of the relative services.
6.1	**PLANNING AND FUNDING SUMMARY REPORT**
	The Annual Plan and Statement of Intent had been sent on the due dates with a few subsequent questions and changes done and now the Annual Plan had been signed. Immunisation rates were 92% against the target of 90%. B4 School Checks continued to be a problem, with performance less than hoped for, but collaborative PHOs were working with the approach being to use Well Child providers, including Plunket and Pacific, but with accountability still remaining with the service Alliance Leadership Team. Some national services would be responsible to the National Health Board with national provision and funding i.e. clinical genetics. There may be some flow on to ADHB and impact on providers. Aroha Haggie left the meeting at 2:55pm. A number of changes have been made to minor skin surgery - skin lesions to increase volumes.

Issues were communication with primary care, difficulties in joining the network and determining what lesions were sensible to be done.

After Hours Proposal for Auckland Metro Region

Andrew Coe, Manager PHOs and Primary Care and Dr Stewart Jenkins, Clinical Director Primary Care were in attendance.

The Auckland After Hours Network proposal had been distributed noting that the indicative funding was $10m with approximately $5m already committed by DHBs with the remaining funding proposed to be shared between DHBs and PHOs with the DHB contribution on a population based funding equivalent basis rather than the historically contributions.

Target groups would be defined as high need, rather than Maori and Pacific and deprivation, identified by NHI. After Hours should not be cheaper than day visits to GPs. Funding for over night of $2.8m would be removed as this may be undertaken in the hospital EDs. There were links with St Johns to get the right place for right care. While the proposed model was not ideal, and will need to be managed carefully so as not to move patients from their medical home for longer term management, there was a need to work with primary care on what is proposed. There was a need to model the effect on individual practices.

The committee asked that contractual obligations be limited to a maximum of one year. An indication was given that the proposal was for 10 months in the first instance.

Judith Bassett left the meeting at 3:30pm.

Specifications would be waiting times less than one hour and other quality and performance measures.

PBF allocation was important, involvement of primary care and ED clinicians as well as an evaluation of what would change from 1 September although it may not be in final form, the stages and dollars. It was essential that the bundle of services were only paid for once and it needed to link to the GAIHN projects to change acute demand. There was concern at the short timeframe with issues to be resolved such as the definition of high needs and noting that A&M clinical governance did not sit under PHOs or DHBs. There was also concern to ensure medical home retention.

<u>Moved Chris Chambers; seconded Peter Aitken</u>

That the CPHAC recommends that the Auckland DHB Board:

1. ***Receives** the Auckland Region After Hours Proposal to Metro Auckland DHBs June 2011 prepared by the After-Hours Alliance, noting that the Proposal is currently being updated to include further operational detail and specificity*
2. ***Endorses** the redesign of after-hours services in the Auckland region over the next year in line with the After-Hours Alliance Proposal, subject to sufficient funding being approved by Metro Auckland DHBs and PHOs*
3. ***Notes** that indicative funding for the total Proposal is $10M; approximately $5M of which is already committed by DHBs in existing services and the remaining funding of $5M is proposed to be shared by DHBs and PHOs*
4. ***Endorses** that the DHB contribution across the region is on a population based funding equivalent basis*
5. ***Approves** that management proceed to work through the required implementation detail with the After-Hours Alliance, and provide a report by the end of August 2011 that includes specific funding recommendations*
6. ***Notes** that a phased implementation approach is proposed, and a review of overnight service options will be completed in phase two and prior to 31 December 2011, in order to inform service arrangements and funding from 1 April 2012*
7. ***Notes** the current rural after hours services will continue as now and be unaffected by the changes proposed in Phase 1and 2 (to March 2012)*

<u>Carried</u>

6.2	**Planning and Funding Indicators Exception Reports**
	There were changes to the B4 School Checks taking a Well Child approach. Other indicators were procedural.
7.	**DAP PROJECTS REPORTS**
	The work on primary care had meant more time at Waitemata, with staff working unacceptable hours at present, on aligning the locality approach and providers. The two DHBs were not too different although different language was used.
8	**PACIFIC HEALTH ADVISORY COMMITTEE FEEDBACK**
	The Committee wanted more information on the Rangitahi programme so that awareness could be raised of this programme in their communities. The Committee also sought regular update on the new graduate nurses project, express concern at the need for Pacific requirements not to be lost i.e. in the After Hours project and the Committee had received a presentation on the HVAZ evaluation and sought the CPHAC's support for that project.
9.1	**Migrant Health**
	Sarah Marshall, Planning and Funding Manager was in attendance. This was part of ADHB's population which was not well understood however over the years ADHB had built credibility with those communities. Some funding was provided through the Resettlement Programme and there was a powerful GP collaborative with a strong network of practices that were prepared to work with the populations, interpreters and other services etc. Refugee Health Services were recognised internationally and were looking at what drove hospital admissions i.e. oral health, CVD. New Zealand does take refugees with medical needs unlike some countries.
9.3	**Community Pharmacy Contract Renewal**
	It was proposed to have Pharmac revise the rules for close control to move from weekly to monthly and then to long term conditions management to effectively cap close control. There were definition difficulties for both close control and long term conditions. There was concern that the Pharmac Board would not make the changes in time. <u>Moved Lee Mathias; seconded Peter Aitken</u> *That the Community and Public Health Advisory Committee recommends that the Auckland DHB Board:* 1. *endorses the general direction of the Pharmacy agreement proposal.* 2. *endorses the proposal's aims to cap close control which should equate to $500k of savings for ADHB, against the 2011-12 budget.* 3. *notes the risks of a 1 September 2011 implementation date.* 4. *endorses the approach of a contract roll over and a later implementation start.* 5. *endorses a 1 September 2011 start date should the majority of DHBs vote in its favour to align ADHB with the national process; and* 6. *endorses the need for well defined long term conditions criteria.* <u>Carried</u>
10	**ACTIONS**
	The After Hours and Pharmacy proposals were to be put to the Board. The dates and venue of the next meeting needed to be confirmed. There would be a briefing paper on the Community Laboratory contract to the CPHAC.

	NEXT MEETING
	The meeting closed at 4:32pm The next scheduled meeting is for combined ADHB and WDHB meeting 2:00pm, Wednesday, 10 August 2011 Waitemata District Health Board Boardroom 15 Shea Terrace Takapuna Auckland
	CONFIRMED **CHAIR:** **DATE:**