Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 1 May 2013

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna,
commencing at 2.02 p.m.

COMMITTEE MEMBERS PRESENT:

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

ALSO PRESENT: Debbie Holdsworth (WDHB, Chief Planning and Funding Officer)
Denis Jury (ADHB, Chief Planning and Funding Officer)
Andrew Coe (ADHB & WDHB, Group Manager Primary Care)
Ann Davis (ADHB & WDHB, Programme Manager, Primary Care)
Rachel Mattison (ADHB & WDHB, Associate Planning and Funding Manager, Primary Care)
Janine Pratt (WDHB, Group Planning Manager)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Tim Wood (WDHB, Group Manager, Funder NGOs)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Lynda Williams, Auckland Womens Health Council
Tanja Binzegger, Health Link North
Anne Curtis, Health Link North
Tracy McIntyre, Waitakere Health Link
Lorelle George, Waitemata PHO
Charlotte Harris, Auckland PHO
Brian O’Shea, ProCare
Ian Scott, Auckland PHO
Ian Snow, Auckland PHO
Barbara Stevens, Auckland PHO
Alastair Sullivan, White Cross Healthcare
Adrian Collier, Pfizer
Samuel Cho, The Asian Network Inc.
APOLOGIES: Apologies were received and accepted from Gwen Tepania-Palmer, Tim Jelleyman, Ailsa Claire and Andrew Old

WELCOME Lee Mathias welcomed those present.

KARAKIA Rob Cooper led the meeting in a karakia.

DISCLOSURE OF INTERESTS

With regard to the Interests Register, Eru Lyndon advised that he had been appointed Regional Commissioner, Social Development, Northland, Ministry of Social Development and a Director, Tamaki Development Company. He advised that the following items should be deleted from the Register:Ngati Whatua o Orakei Corporate Ltd and Te Mata a Maui Law.

With regard to the agenda for this meeting, Warren Flaunty declared an interest as a Trustee of West Auckland Hospice in Item 4.1 – Palliative Care Services in the Waitemata District – Model of Care Update. It was noted that this was an information only item and the Committee considered that there was no reason for him not to participate in consideration of the item.

PRESENTATION: CVD RISK ASSESSMENT TARGET FOR PRIMARY CARE

Andrew Coe (Group Manager Primary Care, Waitemata and Auckland DHBs) introduced the two presenters: Barbara Stevens (CEO, Auckland PHO) and Dr Charlotte Harris (Clinical Director, Auckland PHO) who would be providing the presentation on behalf of all of the PHOs in the Auckland and Waitemata DHB Districts.

Barbara Stevens and Dr Charlotte Harris provided a presentation which included the following:

- The targets of 75% of the enrolled population having CVD Risk Assessments by June 2013 and 90% by June 2014.
- The importance of the programme, with coronary and stroke deaths being by far the leading cause of death in New Zealand.
- The much higher rates of CVD deaths for Maori (27%), Pacific Islanders (29%) and South Asian (29%) than for the rest of the population.
- A year ago there had been 60,000 people needing to be screened to meet the target for Auckland DHB and 47,000 for Waitemata DHB.
- PHO performance result charts as at December 2012 and for the last two months. Currently they are reaching close to 70% and there is a level of confidence that there is a good chance of achieving the June 2013 target of 75%. The PHOs are submitting weekly data to the DHBs on performance. Barriers to be overcome and PHO strategies to achieve the target were outlined.
- A detailed explanation was provided of how risk assessments are carried out, the tools for assessing risk and the strategies used for patients who fall into the different risk categories (referring to case studies as examples).
- The PHOs’ strategy to achieve the 90% goal in 13 months includes a whole of system approach (the aim being to have every eligible person who sees a health professional/service anywhere to have a CVD risk assessment completed); evaluating what worked well in achieving the 75% target; community and work place screening; systemising “doing the right thing”; and concentrating on good CVD management. The numbers to achieve the 90% target are equivalent to one assessment per practice per day.
- The ultimate goal is to manage CVD risk, however there is a need to measure that risk first.

Copies of the full presentation were circulated at the meeting and can be provided on request.
Matters covered in discussion and response to questions included:

- The PHO representatives present at the meeting were reasonably confident of meeting the 75% target. Andrew Coe noted the importance in this process of getting information quickly enough to make changes if necessary – achieving that had been one of the positive features of the process.
- General practices do their best to follow up with those patients who are identified as having a high CVD risk but don’t arrive for appointments. After numerous calls, sometimes saying “this is your last chance” produces results.
- Nurses can be trained to do CVD Risk Assessments; it does not need to be a general practitioner.
- Incentive payments for CVD Risk Assessments are used in different ways. Some PHOs pay on number of assessments; others to fund particular measures, for example additional nurses to carry out assessments. The Committee requested a breakdown on the amount of money paid in incentive payments for the CVD Risk Assessment Programme at its next meeting.
- The Board Chair noted that from a report he had seen the previous day, achieving the 75% target remained a significant challenge, however definitely the trajectory towards that had changed and it was also pleasing to see a lot of good will and commitment.
- In response to a question about achieving consistent application in the approach taken to those patients identified as having high CVD risk, Dr Charlotte Harris advised that she visited peer groups, making sure that those involved are thinking clinically about how to help the people identified. It was important to look at the needs of the whole person and to ensure follow up occurs.
- In answer to a question about the possible impact of prescription charges, Barbara Stevens advised that it is of concern that the prescribing dispensing data being received from NDSA indicates that only 50 to 60% of those prescribed triple medication for CVD risk are picking up their medicines. At the moment follow up lies at practice level (normally starting with phone contact to the pharmacy) but the PHOs are now working on investigating and auditing this problem.
- The CVD Risk Assessment tool in use is highly regarded as a well based, smart tool, very successful at a number of levels. It had originated from the work of Professor Rod Jackson at the University of Auckland.
- In answer to a question about advice on lifestyle intervention, Charlotte Harris advised that the gold standard involves discussing physical activity, diet modification etc. It is very difficult to be specific about how well this is achieved and whether it always takes place.

Barbara Stevens and Charlotte Harris were thanked for their presentation.

1. AGENDA ORDER AND TIMING

Items were taken in the order listed on the agenda.

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 20 March 2013 (agenda pages 1-9)

Resolution (Moved Judith Bassett/Seconded Jo Agnew)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 20 March 2013 be approved.

Carried

Matters Arising:

No issues were raised.
3 DECISION ITEMS

3.1 Orientation of NGO Contracts to Support Health Targets and Better Public Health Services Targets (agenda pages 10-12)

Leanne Catchpole (Team Leader Health of Older People and Healthy Lifestyles, Waitemata DHB) was present for this item. Denis Jury summarised the report.

Leanne Catchpole advised that for Waitemata DHB they had written to all of the NGO providers advising of the proposed changes and had now received the feedback from them. Some are in support, others not.

The Committee Chair noted that there is nothing exceptional in what is being proposed: as part of the Boards’ smokefree and nutrition projects they would be asking for sign up from other organisations.

Denis Jury confirmed that the clauses will be non negotiable, but both DHBs will be offering support to the NGOs in these areas.

In answer to a question, Denis Jury advised that the Aged Related Residential Care Contract is a national contract which the Ministry of Health negotiates. He thought that probably more progress could be made locally with Aged Related Residential Care providers on smokefree and nutrition objectives outside the contract, rather than trying to achieve a change to the national contract.

Resolution (Moved Chris Chambers/Seconded Jo Agnew)

That it be recommended to the Auckland DHB and Waitemata DHB Boards:

That the Board approves that smokefree and nutrition clauses are inserted into all NGO contracts to support the implementation of Smokefree Aotearoa and improved nutrition environments.

Carried

4. INFORMATION ITEMS

4.1 Palliative Care Services in the Waitemata District – Model of Care Update (agenda pages 13-18)

Tim Wood (Group Manager Funder NGOs, Waitemata DHB) summarised the paper. He confirmed that John Robertson, the Chair of the Steering Group, is still in the process of working through who the membership of the group should be.

Matters covered in discussion and response to questions included:

- Irrespective of ethnicity, those people needing palliative care need the same type of service, primarily involving helping people in their own homes. In doing so it is important to respond appropriately to cultural needs. At present however different workforces are carrying out this work in different parts of the District. The development of the model of care is intended to make sure availability and type of support is consistent across the District.
- Part of this initiative is trying to work out how to use the skilled workforce more effectively. That will be a key to success.
- It is hoped to get the steering group formed and to have its first meeting soon. The first draft of the discussion document for that meeting is being finalised.
The Committee Chair asked that the Committee be kept updated on progress and Tim Wood advised that it will be possible to have a short update for the next meeting in June.

The report was received.

4.2 The International Residential Assessment Instrument – InterRAI Long Term Care Facility Tool Update (agenda pages 14-21)

Tim Wood introduced this paper, noting that there will be a more detailed report to the Auckland and Waitemata DHB Board meetings on 15 and 22 May respectively. He noted that the paper predominantly focuses on the roll-out of InterRai to Age Related Residential Care facilities and the challenging target of achieving that for 100% of those facilities in a short space of time. There is not a lot of leverage to achieve this under ARRC agreements and there are particularly difficult issues in achieving it for smaller providers.

Matters covered in discussion and response to questions included:
- The IS issues partly relate to InterRai being run from two hubs nationally, with the northern DHBs being served from Canterbury DHB. Reliance on wireless connections meant that if they go down while an assessment is taking place, all the data gathered to that point is lost. An issue with the tool itself is that data cannot be saved until the assessment is completed. Assessments are reported as taking as long as three or four hours each. Another issue is non-integration with the systems that ARRC providers have.
- The Board Chair commented that InterRai is quite a good tool, but the problem is that it is difficult to use. In view of the strong national commitment to it, he suggested that some thought be given to whether there is some way of getting more utility out of it. He also noted that there is an issue that when the larger ARRC facilities do train people in InterRai, they become targets for recruitment from other organisations.
- The Committee Chair noted that the report identified the problems well, but did not provide much in the way of solutions. Members hoped that the report to the Boards would develop on that.

The report was received.

5. STANDARD MONTHLY REPORTS

5.1 Planning and Funding Update (agenda pages 22-25)

Janine Pratt (Group Planning Manager, Waitemata DHB) updated the Committee on progress with the Annual Plans for 2013-14. She advised that the National Health Board has granted one week’s extension to the deadline for submitting the Annual Plans, which is now 25 May. The revised Annual Plans will be considered at the DHB Board meetings on 15 and 22 May.

The Committee discussed the increased complexity of the templates and instructions for completing Annual Plans, which led to them essentially being accountability documents, with little real use as planning documents. The Board Chair advised that the DHB Chairs are highlighting this as a key issue to be addressed in advance of the 2014/15 Annual Plan process and that he had also asked the CEOs to bring it up in their forum and in the discussions that the CEOs’ Forum has with the Ministry of Health. He would also see if the CEO of the National Health Board and the Director General of Health would be willing to attend a CPHAC meeting to explain their approach and discuss the Boards’ concerns.

Other matters discussed included:
- With regard to cervical cancer screening (pages 23-24 of the agenda), it was noted that removal of the ethnic data disparities would not in itself increase screening participation
and, as affirmed at the 20 March CPHAC meeting, there are a whole range of other measures to be pursued to improve participation.

- It was noted that the section in the report on Maori Health Gain is to recognise a gap in reporting for those members of CPHAC not members of Manawa Ora, the Maori Health Gain Advisory Committee. It is a summary of some items only and in no way a substitution for the full paper on Whanau Ora which, in addition to consideration by Manawa Ora, has or will be considered by both DHB Boards.
- With regard to the comment on this subject in the Auckland DHB section of the report, it was agreed that information on how the different agencies are working together to provide better Mental Health wraparound services for vulnerable children and youth be provided at the next meeting.

The report was received.

6. General Business

Chris Chambers raised the issue of potential changes to the legislation concerning fencing of swimming pools, on which the Clinical Director of the Emergency Department at Starship Hospital had recently commented. The Committee supported the view that this legislation has had a significant impact on reducing child deaths by drowning (and damage to children from part drowning) and that any relaxation of requirements should be firmly opposed. It was agreed that the Auckland Regional Public Health Service be requested to make a submission on this. Denis Jury advised that he would follow this up.

There was also a discussion of whether a response should be made to the Auckland Council’s Draft Unitary Plan, currently out for feedback. Issues mentioned included population health, disability access, home insulation, the differing standards proposed for large and small developments and the need for more playgrounds (particularly for 8-12 year olds) in intensive developments. Janine Pratt advised the meeting that the Auckland Intersectoral Health Group, with DHB representation, is looking at the public health issues raised by the Unitary Plan with a view to making a submission. It was agreed that a copy of the proposed submission from the Auckland Intersectoral Health Group should be referred to the DHB Boards before it is submitted. The Board Chair noted the wider point of the need to engage more in the overall determinants of health.

7. Resolution to Exclude the Public (agenda page 26)

Resolution (Moved Jo Agnew/Seconded Christine Rankin)

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

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

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
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<tbody>
<tr>
<td>1. Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting with Public Excluded</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would</td>
<td>Confirmation of Minutes</td>
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As per resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
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<td><strong>20/03/13</strong></td>
<td>exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Commercial Activities  The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]</td>
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<tr>
<td><strong>2. Presentation – Future Development</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
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<td><strong>3. Capitation Funding</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
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**Carried**

3.30p.m – 4.40p.m – public excluded session.

The Committee Chair thanked those present for their participation in the meeting.

The meeting concluded at 4.41 p.m.