Community and Public Health Advisory Committees Meeting

Wednesday, 10th October 2012
2.00pm

Venue
Waitemata District Health Board Boardroom
Level 1, 15 Shea Tce
Takapuna
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 inoa 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.
AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
10th October 2012

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

COMMITTEE MEMBERS
Lee Mathias - Committee Chair (ADHB Deputy Chair)
Warren Flaunty - Committee Deputy Chair (WDHB Board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Deputy Chair
Jo Agnew - ADHB Board member
Peter Aitken - ADHB Board member
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
Gwen Tepania-Palmer – WDHB Board member
Tim Jelleyman - Co-opted member
Eru Lyndon - Co-opted member

MANAGEMENT
Dale Bramley - WDHB, Chief Executive
Margaret Wilsher - ADHB, Interim Joint Chief Executive
Ngaire Buchanan – ADHB, Interim Joint Chief Executive
Debbie Holdsworth - WDHB, Acting Chief Planning and Funding Officer
Denis Jury - ADHB, Chief Planning and Funding Officer
Naida Glavish – ADHB and WDHB Chief Advisor, Tikanga
Paul Garbett - WDHB, Board Secretary

Apologies: Susan Buckland, Debbie Holdsworth

AGENDA

KARAKIA

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

Items to be considered in public meeting
All recommendations/resolutions are subject to approval of the ADHB and WDHB Boards.

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

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES
2.05pm  2.1 Confirmation of Minutes of the Auckland and Waitemata DHBS’ Community and Public Health Advisory Committees Meeting held on 29/08/12

3 DECISION ITEMS
2.10pm  3.1 2013/14 Annual Plan Approach

3 STANDARD MONTHLY REPORTS
2.40pm  5.1 Primary Care Update
3.10pm  5.2 Planning and Funding Update

3.30pm  6 GENERAL BUSINESS
## REGISTER OF INTERESTS

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<thead>
<tr>
<th>Committee Member</th>
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| Lester Levy      | Professor of Leadership – University of Auckland Business School  
Co-Director – New Zealand Leadership Institute  
Deputy Chair – Health Benefits Limited  
Independent Chairman – Tonkin & Taylor  
Chair – Auckland District Health Board  
Chair – Waitemata District Health Board  
Chairman – Auckland Transport (commencing 1st November 2012) | 28/08/12     |
| Max Abbott       | Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology  
Patron – Raeburn House  
Board Member – Health Workforce New Zealand  
Board Member, AUT Millennium Ownership Trust  
Chair – Social Services Online Trust  
Board Member – The Rotary National Science and Technology Trust | 28/09/11     |
| Jo Agnew         | Professional Teaching Fellow – University of Auckland  
Casual Staff Nurse – Auckland District Health Board | 12/10/11     |
| Peter Aitken     | Pharmacist  
Shareholder/Director, Consultant - Pharmacy Care Systems Ltd  
Owner – Pharmacy New Lynn Medical Centre | 18/09/12     |
| Judith Bassett   | Nil | 09/12/10 |
| Pat Booth        | Consulting Editor – Fairfax Suburban Papers in Auckland | 24/06/09     |
| Susan Buckland   | Self employed – Writing, editing and public relations services  
Professional Conduct Committee member – Medical Council of New Zealand  
Professional Conduct Committee member – Occupational Therapy Board  
Member – Northern Regional Ethics Committee | 12/10/11     |
| Chris Chambers   | Employee – Auckland District Health Board (wife employed by Starship Trauma Service)  
Clinical Senior Lecturer – Anaesthesia Auckland Clinical School  
Associate – Epsom Anaesthetic Group  
Member – ASMS  
Shareholder – Ormiston Surgical | 20/04/11     |
| Sandra Coney     | Elected Member – Chair, Parks Committee, Auckland Council | 02/05/11     |
| Rob Cooper       | Board Member – Auckland District Health Board  
Board Member – Waitemata District Health Board  
Chief Executive – Ngati Hine Health Trust  
Advisory Board Member – James Henare Research Centre, University of Auckland | 19/09/12     |
| Warren Flaunty   | Member of Henderson – Massey, Rodney and Upper Harbour Local Boards, Auckland Council  
Trustee - West Auckland Hospice  
Trustee - Waitakere Licensing Trust  
Shareholder - Metlifecare  
Shareholder - EBOS Group  
Shareholder – Pharmacy Brands Ltd  
Shareholder – Westgate Pharmacy Ltd  
Chair – Three Harbours Health Foundation  
Trustee – Trusts Community Foundation Ltd | 18/07/12     |
| Lee Mathias      | Managing Director – Lee Mathias Ltd  
Director – Midwifery and Maternity Providers Organisation Ltd  
Shareholder/Director – Pictor Ltd  
Director – John Seabrook Holdings Ltd  
Governance Advisor – AuPairlink Ltd  
Council member – NZ Council of Midwives  
Chair – Tamaki Transformation Transitional Board  
Chair – Health Promotion Agency Board  
Governance Advisor – Health Vision Ltd | 18/09/12     |
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| Robyn Northey               | Project management, service review, planning etc. – Self employed Contractor  
  Board member – Hope Foundation Northern Region  
  Trustee, A+ Charitable Trust                                                                                                                                       | 18/07/12   |
| Christine Rankin           | Member - Upper Harbour Local Board, Auckland Council  
  Member – The Families Commission  
  Director – The Transformational Leadership Company                                                                                                                  | 02/02/11   |
| Allison Roe                 | Shareholder – Optimisewellbeing.com  
  Founding member – Breast Health Foundation  
  Director – Spiritus NZ  
  Trustee – Allison Roe Trust  
  Founder – Takapuna 2020 Community Group  
  Board member – North Shore Hospital Foundation                                                                                                                       | 28/03/11   |
| Gwen Tepania-Palmer         | Chairperson – Ngatihine Health Trust, Bay of Islands  
  Committee Member – ACC’s ERMG Committee  
  Life Member-National Council Maori Nurses  
  Alumni – Massey University MBA  
  Director – Manaia Health PHO, Whangarei  
  Board Member – Auckland District Health Board                                                                                                                         | 06/12/10   |
| Co-opted Members           |                                                                                                                                                                                                        |            |
| Dr Tim Jelleyman            | Clinical Director, Paediatrics (Child Health Service)  
  Member, Active Clinical Network (ACN) for the Greater Auckland Integrated Health Network (GAIHN) Project                                                                                     | 08/09/10   |
| Eru Lyndon                  | Ngati Whatua o Orakei Corporate Ltd  
  Honorary Research Fellow – Auckland University  
  Member – AUT Business School Industry Advisory Committee  
  Te Mata a Maui Law                                                                                                                                                | 12/08/11   |
### Auckland and Waitemata District Health Boards
### Community and Public Health Committees
### Member Attendance Schedule 2012

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* absent
^ leave of absence
* attended part of the meeting only
# absent on Board business
2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 29th August 2012

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 29th August 2012 be approved.

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

Lee Mathias (Committee Chair) (ADHB Deputy Chair)
Lester Levy (WDHB and ADHB Board Chair) (until 3.46p.m.)
Max Abbott (WDHB Deputy Chair) (until 4.00p.m.)
Jo Agnew (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Susan Buckland (ADHB Board member)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member) (until 4.36p.m.)
Allison Roe (WDHB Board member) (until 4.43p.m.)
Gwen Tepania-Palmer (WDHB Board member)
Tim Jelleyman (Co-opted member)
Eru Lyndon (Co-opted member)

ALSO PRESENT: Dale Bramley (WDHB, Chief Executive)
Debbie Holdsworth (WDHB, Acting Chief Planning and Funding Officer)
Denis Jury (ADHB, Chief Planning and Funding Officer)
Andrew Coe (ADHB and WDHB, Group Manager Primary Care)
Peta Molloy (WDHB, Acting Board Secretary)
Naida Glavish (ADHB and WDHB Chief Advisor, Tikanga)
Janine Pratt (WDHB, Group Planning Manager)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Tim Wood (WDHB Group Funding Manager)

(Public 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
Mark Vella, Total Healthcare
Adrian Collier, Pfizer
Margaret Willoughby, Health Link North
Lorelle George, Waitemata PHO
Dr Nicole Coupe, Hapai te Hauora Tapui
Tracy McIntyre, Waitakere Health Link
Katie Mariner, NZ Doctor
Matt Wright, Clinical Consultant A & M Consortium
Saera Chun

WELCOME Lee Mathias welcomed those present.

PRESENTATION - The Refugee Health Collaborative: Improving the Quality and Experience of Primary Health Care for Refugees.
Denis Jury introduced Laura Patterson (Localities Manager, Auckland DHB) and Mahad Warsame (Refugee Community Health Worker, Auckland DHB) to the Committee and noted that Laura has undertaken a high level ‘Refugee Health Collaborative’ involving nine general practices in the Auckland central area. The collaborative has demonstrated what can be achieved in improving health outcomes for refugee populations.

Laura began her presentation with an interactive journey to understand what a new New Zealander may experience when entering the primary care setting. Laura’s presentation highlighted:

- Issues - practices unable to identify the refugee population; is funding for refugee health making any difference? Low utilisation of CALD training by primary care.
- The Collaborative Methodology – working together and sharing knowledge works well; it works with a coaching approach; changes are tested in small cycles so they are manageable (PDSAs: Plan-Do-Study-Act).
- The model was initially for a 12 month period which has been extended a further six months to ensure it is working well.
- Working with general practice receptionists is the ‘gateway’ to primary care.
- The importance of interpreting services – many families continue to use other family members (often school-aged children) to interpret, this can often limit discussion between the patient and doctor. General practice staff have indicated that they are willing to use formal interpreter services.
- That culturally appropriate care is given to all clients – fact sheets have been developed and translated into five different languages.
- Clinical target areas – an improvement is showing in a number of indicators including: immunisation rates, before school checks, mental health, sexual health for youth, antenatal care, breast and cervical screening, CVD, diabetes care and oral health.
- Establish closer working relationships between practice staff and social services - such as WINZ and Housing NZ. To initiate this, nine forums/training sessions were held with an average total attendance of 32 people.
- Key enablers of the project include a dedicated person to facilitate the project, an active expert advisory group, funding support, a dedicated forum and website for information sharing, CALD training, access to primary health interpreting service.
- It is recommended that the project should continue in some form. It should continue to promote the collection of ethnic data and share the information gained and tools developed with other DHBs.

Mahad noted that general practice nurses and receptionists are now more understanding of health care for refugees.

Matters covered in response to questions included:

- That the model is sustainable, but does require time to maintain the practices. Tools and techniques are being instilled into practices.
- The collaborative defines a refugee as someone who is a quota refugee, an asylum seeker or within the refugee family support category.
- Ethnic patients often require more time with their doctor to ensure adequate discussion and understanding of health issues occurs.
- The Whanau Ora model was highlighted as a great concept and it was noted that a lot of Whanau Ora practices had a high number of refugees as patients.

Laura and Mahad were thanked for the presentation.

KARAKIA  
Pat Booth read to the meeting the English translation of the karakia.
APOLOGIES: Apologies were received and accepted from Warren Flaunty, Chris Chambers, Rob Cooper, Peter Aitken, Paul Garbett, Margaret Wilsher, together with an apology for early departure from Lester Levy.

DISCLOSURE OF INTERESTS
There were no additions or amendments to the Interests Register.
There were no declarations of interest with regard to the open agenda.

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 18 July 2012 (agenda pages 1-11)

Resolution (Moved Judith Bassett /Seconded Gwen Tepania-Palmer)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 18 July 2012 be approved.

Carried

Matters Arising:

Population Nutrition: Following an article in the NZ Herald it was decided that a policy on health nutrition be developed and presented in an environment that will have influence, such as a partnership with a University or the Auckland Council. The policy is not a replacement for HEHA, but is a ‘push’ for better nutrition and exercise by the District Health Boards with a focus on our population as a whole rather than individuals.

ADHB Locality Atlas: this matter was actioned and a link sent to the CPHAC members via e-mail.

3 DECISION ITEMS

3.1 Rheumatic Fever Prevention in Auckland and Waitemata DHBs (agenda pages 12 - 18)

Dr Alison Leversha (Community Paediatrician, Auckland DHB), Carol Stott (Strategy and Planning Manager, Auckland DHB) and Tim Wood (Group Manager Funder, Waitemata DHB) were present for this item.

The paper was introduced and matters covered in discussion and response to questions included:

- That the reduction in the incidence of Rheumatic Fever is a government priority; DHBs will be notified of their targets in October 2012. The financial implication for the Auckland District Health Board will be for the 2013/14 financial year.
- Whilst refocusing the work of public health nurses across all schools will be looked at, closer attention will be given to working with high deprivation schools (it was noted that there are some schools in West Auckland with higher rates of rheumatic fever).
• It was noted that the additional cost of $850,000 excludes consumables and laboratory costs – clarification is required on the impact for the funder if the recommendation is agreed.
• The Ministry of Health will continue to hold the contract direct with the provider and will not be contracting with District Health Boards directly - the existing contract is with the National Haoura Coalition.
• It was noted that the Waitemata DHB does not have a caveat around the provider to be used.
• It was suggested that the Auckland DHB and Waitemata DHB could work together on this programme.
• It was noted that higher rates of rheumatic fever can be connected to crowding in the home. The Auckland Council’s fund for ‘healthy homes’ (insulation) and other government funded insulation programmes was noted and it was suggested that if the programme does go ahead the DHBs could liaise with programme managers and the Council.
• There is a high impact on the Maori and Pacific population and discussion needs to occur within these areas in order to address these issues.

Resolution (Moved Lee Mathias / Seconded Gwen Tepania-Palmer)

That the Auckland DHB and Waitemata DHB Community and Public Health Advisory Committees support the throat swabbing programme in principle. A revised decision paper is to be submitted direct to the Auckland DHB Board which includes:

i) A more defined budget.

ii) A better defined service specification of what the programme will look like and the evidence base for the intervention.

iii) Clarification on why there is a limitation of non-DHB providers.

iv) Advice on what relationship there may be with the Waitemata DHB.

v) Clearly defined engagement with both Maori and Pacific groups.

Carried

3.2 Recommendations Following the Combined Community and Public Health Advisory Committees Meeting Review (agenda pages 19 -23)

Denis Jury introduced the paper and the Committee Chair noted that the CPHAC Committee is an advisory committee of the Boards. Matters covered in discussion and response to questions included:

• It was noted that the combined CPHAC Committees are dealing with a varied community, local need and diverse services such as schools, dental and primary care.

• Concern was expressed at the reduction in Committee members to four from both Auckland DHB and four from Waitemata DHB, noting that this may disenfranchise those who have views on special areas of interest. A reduction in Committee members may also reduce the ability for members to have a say.

• In response to a comment, it was noted that the basis for the combined Auckland DHB and Waitemata DHB Committee is that of collaboration. It is an opportunity for the Boards (via the Committee) to set an example of collaboration at a governance level, noting that collaboration is occurring between both DHBs in many services (for example: interventional radiology, child health and planning and funding).
• It was noted that the Minister of Health has indicated in his correspondence that there is a real emphasis on working towards collaboration.
• It was noted that public health ‘does not know the boundaries of a DHB’ and that this is an opportunity to provide better services/programmes (for example the previous item on rheumatic fever prevention).
• It was noted that it is an important committee for elected members to be a part of as it is community based.
• The CPHAC Committee is an advisory committee that gives advice to the Boards – it was noted that prior to the combined CPHAC committee meetings being implemented very few recommendations were made and that recommendations since 1 January 2012 have greatly increased.

It was agreed that this matter would be revisited.

4 INFORMATION ITEMS

4.1 Asian Health Planning and Funding Update (agenda pages 24 - 38)

Sue Lim (Asian Health Services Manager, Waitemata DHB), Lifeng Zhou (Epidemiologist, Waitemata DHB) and Jean-Marie Bush (Programme Manager, Mental Health and Asian Health, Waitemata DHB) were present for this item.

The paper was introduced noting that the deliverables for both Auckland DHB and Waitemata DHB are on track.

Matters covered in discussion and responses to questions included:
• It was noted that there has been a significant update of CALD training across the region. An independent evaluation shows that there has been a significant increase in cultural competence.
• It was noted that Asian parents are very particular about immunisation of their children with 97% of children fully immunised by the age of two years (as at 30 June 2012).
• Work was being undertaken to increase Asian patient enrolment – it was noted that most Asian patients were not aware of the enrolment process as there is no such process in their home countries.
• It was noted that a survey of the Waitemata DHB Asian mental health and CADS workforce team indicated that improvements could be made with the current screening tool for Asian patients. A working group is now developing a process to assist clinicians which will be rolled out late September 2012. A global review is also being undertaken of valuable tools and clinicians will be made aware of these. It is also intended to provide additional training for interpreters.

The work being undertaken by the team was acknowledged; the developments occurring are very positive and are ‘hitting the heart of the community’.

Resolution (Moved Lee Mathias / Seconded Gwen Tepania-Palmer)

That the Committee notes the activity and end of year report against targets of the Asian Health Action Plan.

Carried
4.2 Pacific Health Update (agenda pages 39 - 55)

Hilda Fa’asalele (General Manager, Pacific Health Auckland DHB), Leani O’Connor (Pacific Planning and Funding Manager, Auckland DHB) and Fili Tupu (Pacific Planning and Funding Manager, Auckland DHB) were present for this item.

Hilda introduced the report and noted that she works alongside both Denis Jury (Chief Planning and Funding Officer, Auckland DHB) and the Auckland DHB hospital team. She acknowledged that being part of the senior leadership team (at Auckland DHB) has had a very positive influence on work being undertaken for the Pacific population. Positive work was also occurring in collaboration with Waitemata DHB.

Matters covered in discussion and response to questions included:

- It was noted that it is important to engage with the Pacific population and roll out programmes in liaison with Pacific church groups.
- The Pacific Best Practice programme is available to all Auckland DHB staff and has been a positive step in developing awareness of the Pacific culture across the organisation.
- It was noted that the Pacific youth suicide rate was still disappointingly high and that the high rate affects all the DHBs in the Auckland region. NDSA has taken a lead in coordinating with key stakeholders to address this issue.
- The low breast-feeding rates for both DHBs were noted – the community breastfeeding service ceased on 31 July 2012.
- An update on ‘Well Child’ and its target achievement is to be provided to CPHAC.
- It was noted that the rate of cervical screening is higher at Auckland DHB than Waitemata DHB – the reason for this is clear, work is being undertaken to engage with people within primary care.
- A report on the Auckland PHO’s offer to provide a ‘Health Women’s Check’ is to be provided to CPHAC.

It was noted that co-opted Pacific representative would be appointed to the CPHAC Committee following a decision on the CPHAC Committee review.

The report was received.

5. STANDARD MONTHLY REPORTS

5.1 Primary Care Update (agenda pages 56 – 81)

Andrew Coe (Group Manager Primary Care, Waitemata and Auckland DHBs) and Stuart Jenkins (Clinical Director Primary Care, Waitemata and Auckland DHBs) were present for this item.

The revised report layout was acknowledged. In response to a question, Stuart noted that to connect primary care and communities, multi-disciplinary and inter-sectorial links were being looked at and will include not only general practice staff, but also housing and education. With regard to the issue of ‘unstable PHO practice affiliation’, Andrew noted that a meeting with the Regional Working Group (set up under the Better Sooner, More Convenient Primary Care Funding Group) was to meet today – progress is being made on this matter.

The report was received.
5.2 Planning and Funding Update (agenda pages 82 - 86)

Denis Jury (Chief Planning and Funding Officer ADHB), Debbie Holdsworth (Chief Planning and Funding Officer WDHB) and Peter Sandiford (Public Health Physician, Waitemata DHB) were present for this item.

Matters covered in discussion and response to questions included:

- With regard to Meals on Wheels, Spotless Services have given three months’ notice and will not renew their contract with Auckland DHB. It was noted that Auckland DHB are about to sign a contract with an interim provider for a term of one year. A national RFP for food service is to be undertaken next year.

- With regard to cervical screening, it was noted that the identification of the screening coverage rate for Maori women is a nationwide issue. The area of where a mismatch occurs in identifying Maori women screening rates has been identified and whilst it will be a significant job to amend this, it will show a substantial difference in the coverage rate.

The work being undertaken on the cervical screening coverage rate was acknowledged as it is a critical piece of work. It was also noted that Peter Sandiford is the lead author of an academic paper on this issue.

The report was received.

6. GENERAL BUSINESS - RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved Lee Mathias/Seconded Gwen Tepania-Palmer)

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>
</tr>
</thead>
<tbody>
<tr>
<td>1. After Hours</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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Negotiations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Official Information Act 1982 S.9 (2) (j)]</td>
</tr>
</tbody>
</table>

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

The meeting concluded at 4.49 p.m.
# Actions Arising and Carried Forward from Meetings of the Community & Public Health Advisory Committees as at 1 October 2012

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPHAC</td>
<td>18/07/12</td>
<td><strong>3.2 Improving Population Nutrition</strong> – ADHB to seek publicity in the media for its insistence on nutrition standards in the leases it has recently granted for food premises.</td>
<td>Mark Fenwick</td>
<td></td>
<td>An interview with Dr Toomath on healthy food initiatives ran in the NZ Herald of 6 August 2012</td>
</tr>
<tr>
<td>CPHAC</td>
<td>29/08/12</td>
<td><strong>3.1 Rheumatic Fever Prevention in Auckland and Waitemata DHBs</strong></td>
<td>Carol Stott, Alison Leversha and Tim Wood.</td>
<td>ADHB Board 24/10/12</td>
<td>A revised paper to be submitted direct to the Auckland DHB Board.</td>
</tr>
<tr>
<td>CPHAC</td>
<td>29/08/12</td>
<td><strong>4.2 ‘Well Child’</strong> – An update report on the ‘Well Child’ programme and its target achievements</td>
<td>Denis Jury</td>
<td>CPHAC Nov or Feb 2012</td>
<td>A short briefing was taken to the last ADHB Board meeting based on MoH summary data for ADHB Well Child Tamariki Ora services. The MoH is unable to produce full reports for another 2-3 months and it is anticipated having a full Well Child report at the November or February CPHAC meeting.</td>
</tr>
</tbody>
</table>
3.1 2013/14 Annual Plan Approach

Recommendation:

That the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees recommend to the Auckland and Waitemata DHB Boards:

1. That Auckland and Waitemata Boards support the proposal to have joint planning and accountability documents across Auckland and Waitemata DHBs for 2013/14, specifically one Annual Plan and one Statement of Intent.
2. That the Boards support the proposed approach for developing future planning and accountability documents.
3. That the Boards note the challenges and opportunities in combining planning and accountability documents across the two board districts.

Prepared by: Dr Denis Jury (Chief Planning and Funding Officer ADHB), Dr Debbie Holdsworth (Chief Planning and Funding Officer WDHB), Julie Helean (Manager Planning and Service Development ADHB), Janine Pratt (Group Planning Manager WDHB)

Glossary:

DHB  - District Health Board  
HSGs - Healthcare Service Groups  
NHB  - National Health Board

1. Summary

This paper proposes that Auckland and Waitemata DHBs have one joint Annual Plan and one joint Statement of Intent for the 2013-14 financial year. Although the two DHBs tried to align planning and accountability documents in the 2012-13 year, both Boards were clear that more progress in this regard was required. There is potential, leading up to the 2013-14 financial year, to develop an Annual Plan for Auckland and Waitemata that covers both health board districts while retaining the necessary accountability link between each DHB and the Ministry of Health. This may also be possible for the Statement of Intent. This paper examines the logistics, challenges and opportunities associated with joining our planning and accountability documents, while also ensuring that our Annual Plan functions as a useful management tool for staff.

2. Requirements of an Annual Plan

Annual Plan requirements are covered in the NZ Public Health and Disability Act 2000. Section 39 of the Act expects an Annual Plan to include the intended outputs of the DHB for that year and the funding proposed for those outputs. This includes the expected performance of the DHB’s hospital and related services. While this may not preclude having one Annual Plan across two DHBs, it is clear that the Plan must be a robust accountability document i.e. is sufficiently detailed to allow the Minister to assess the performance of an individual DHB.
DHB planners are currently seeking legal, National Health Board, Office of the Auditor General, and Audit NZ opinions on how a joined Annual Plan and Statement of Intent could be constructed to fulfil all the necessary legal and policy requirements. This approach would be a first in New Zealand. Southern DHB develops a plan to cover both Otago and Southland geographies (previously separate DHBs). However, the merger of the two DHBs occurred in May 2010, creating one DHB, which now furnishes one set of accountability documents. Canterbury DHB similarly, works closely with the West Coast on their ‘transalpine collaboration’ but these DHBs submit separate Annual Plans.

The key concern in a joined approach remains the compliance with statutory requirements. It is likely that this may need to be resolved by having two almost identical plans with different cover pages. The majority of the content would be consistent, with only minor and appropriate differences for each DHB.

Other relevant legislation covering Annual Plans and Statement of Intent is contained in the Crown Entities Act, 2004 and the Public Finance Act, 1989. The Ministry of Health Planning Package is also important in considering this change to a joined approach.

At this stage, the proposal relates to non-financial aspects of the Plan. The financial component of the Plan would be specified for each DHB within the joined Annual Plan, making clear how each DHB’s finances map to objectives in the Plan. Some shared financial content may be possible, such as the financial assumptions for the financial year in question and any high level expectations from the Minister of Health and the Government such as savings targets or efficiency gains.

3. Agreeing Content for one Plan

While the 2012-13 Annual Plans were not successfully aligned, the collaborative work undertaken as part of the process was positive and confirms that a joined plan is possible. Planners have worked together for over ten years with great collaboration across the four DHBs in the region. These are long standing relationships underpinned by a history of support and sharing information.

In 2012-13, Waitemata DHB took the lead in developing a set of measures for both Auckland and Waitemata DHBs, resulting in one Statement of Forecast Service Performance (with only minor and appropriate differences) for Auckland and Waitemata DHBs. Similarly, both DHBs contributed to the development of the primary care and service integration section of the Annual Plan. These approaches set the scene for 2013-14. A joint Annual Plan can be developed in a way that does not submerge the unique aspects or intentions of the collaborating DHBs. The intention is to streamline where this is appropriate, while retaining the sovereign responsibilities of each DHB along with their distinct health needs, characteristics, and priorities.

Strategic Framework

In recent years, DHBs have not had the same focus on organisational strategy and business planning as they have had on meeting national and regional priorities and performance expectations. Similarly, each year the DHBs have responded to new Board priorities. As a result, Auckland and Waitemata DHBs have lacked a clear strategic framework from which to drive goals and objectives. There is an opportunity, via the collaboration, to develop one logic intervention framework for both DHBs and to use that for all business and operational planning.

At Waitemata DHB effort has been put into organisational purpose. The results of this work were discussed at a special Board meeting on 26 September. The promise statement of Best
Care for Everyone and Values (Everyone Matters, With Compassion, Connected, and Better, Best, Brilliant) were confirmed. The following purpose of healthcare delivery in Waitemata DHB was proposed:

- Relieve suffering of those in our care
- Prevent, cure or ameliorate ill health
- Promote health.

The organisational purpose will inform organisational strategy and the care management model implemented within Waitemata DHB.

**Input from stakeholders**

DHB accountability documents need to align with regional service plans (The Northern Region Health Plan). We also need to involve primary care stakeholders in the development of Annual Plans in particular. Furthermore, the development of the joint health services plan, associated asset management plan and the link to financial planning, creates a complex and complicated set of linkages that need to be captured in the annual accountability documents.

The development of a joint Annual Plan reduces one level of complexity in this process. However, the roles and expectations regarding the development of our accountability documents for 2013-14 will need to be clearly identified early in the process. For example, key stakeholders and contributors will be provided clear information on timeframes, expectations and the schedule of work as soon as possible. It will be imperative that linkages are maintained and or established with primary care planners, health service planners, financial planners and regional services planners.

### 4. Sign Off Process and Timelines

It is proposed that the approval process for the accountability documents remains as in prior years. This is via the joined CPHACs, with final sign-off for the review document (mid-March) and the final Annual Plan (mid May) going before our respective Boards. The Annual Plan will also be approved at these critical stages by our MoU and other partners: Te Runanga o Ngati Whatua, and designated primary care partners.

The final Annual Plan will require the signatures of the following:

- Board Chair
- One other Board member from each Board (for the Statement of Intent only)
- The two CEOs
- The Chair of Te Runanga o Ngati Whatua
- Primary care partners (to be determined).

As in past years, it is proposed that any amendment or last minute changes to the Annual Plan and Statement of Intent be delegated to the Board Chair and the respective CEOs. This provision allows flexibility to accommodate late information. The other option is to re-schedule Board meetings or have additional Special Meetings for the approval process.

Regular oversight of the Annual Plan and the Statement of Intent while under development is the responsibility of the two Chief Planning and Funding Officers.

**Provisional Timeframe**

*Note this timetable focuses on the non-financial elements of the planning process and does not include the budgeting process deadlines and milestones.*
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| 10 October 2012 | • Confirm the Boards’ expectations regarding one plan or two separate Annual Plans, the strategic direction and framework, the narrative approach and format to be utilised etc.  
• Confirm with MoH/NHB the proposed approach re one plan (legislative requirements etc)  
• Provide input to National Health Board pre-planning round activity  
• Identify areas where there is minimal collaboration underway and undertake pre-planning service development sessions  
• Release of draft Planning Package by NHB | Chief Planning & Funding Officers  
DHB Planners |
| November 2012 | • Possible workshops with key stakeholders and contributors i.e. Boards, Executive Teams, primary care, planning & funding, provider arms etc  
• Planning Package and Funding Envelope released late November  
• CPHACs meet: Annual Plan update with specific timeframes and activities | DHB Planners |
| 21 November   |                                                                                                                                            | Executive Team  
DHB Planners |
| December 2013 | • Staff provided with clear instructions about the expectations and process for 2013-14 planning. Objective templates available to staff (key contributors)  
• Prioritisation work, consideration of asset development and capital works and service changes  
• Organisational priorities and high-level drivers clear to staff  
• Minister’s Letter of Expectations released  
• ADHB Board meeting: Approach approved  
• WDHB Board meeting: Approach approved | DHB Planners |
| 5 December 12 December |                                                                                                                                            | DHB Planners |
| January 2013  | • Contributors prepare planning content                                                                                                      | Contributors |
| February 2013 | • Planners develop annual plans to meet requirements in the planning package  
• First draft provided to CPHACs / Boards for approval to submit | DHB Planners |
| 13 February   |                                                                                                                                            | DHB Planners |
| March 2013    | • First draft of the Annual Plan due with the NHB for review (date TBA)  
• First draft of the Statement of Intent due with the NHB (and ideally with Audit NZ) for review  
• CPHACs meeting: update on Annual Plan progress | DHB Planners  
Chief Financial Officers |
| 20 March      |                                                                                                                                            | DHB Planners  
Chief Financial Officers |
| April 2013    | • Feedback received from NHB  
• Boards notified of feedback  
• Amendments made to the plan and SOI as required | DHB Planners  
Chief Financial Officers |
| 1 May 2013    | • Final Plan to CPHACs for consideration  
• Final Plan to Boards for respective approval | DHB Planners  
Chief Financial Officers |
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Final board-approved Annual Plan due with the NHB (date TBA)</td>
<td>Officers</td>
</tr>
<tr>
<td>June 2013</td>
<td>• Final SOI to Boards for respective DHB approval</td>
<td>DHB Planners</td>
</tr>
<tr>
<td></td>
<td>• Final Statement of Intent due with the NHB</td>
<td>Chief Financial Officers</td>
</tr>
<tr>
<td>July 2013</td>
<td>• Statement of Intent submitted to House of Representatives and posted on our respective websites</td>
<td>DHB Planners</td>
</tr>
<tr>
<td></td>
<td>• Documents made widely available to staff and others</td>
<td></td>
</tr>
</tbody>
</table>

### 5. Risks and Mitigations

<table>
<thead>
<tr>
<th>Risk area</th>
<th>Specifically</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unclear boundaries of responsibility</td>
<td>The Annual Plan and Statement of Intent must both act as primary vehicles for monitoring DHB performance. We have had informal discussions with NHB about the proposal to merge the Annual Plans, and have made the Office of the Auditor General aware of the intention. This area requires more investigation. The legislation is clear that each DHB must submit its own Annual Plan. It is not clear to what extent the Annual Plans for ADHB and WDHB can be merged into one.</td>
<td>We will continue to discuss this with NHB. There are a few options that may satisfy the legal requirement here, including submitting two virtually identical Annual Plans. Further legal advice is being sought.</td>
</tr>
<tr>
<td>Agreeing the right narrative</td>
<td>In 2012-13 Annual Plans had similar content but not the exact same look and feel, or approach to the narrative. Plans must accurately represent each separate entity and their constituent population and financial situation. There are several ways of approaching this and further consideration of the right look, feel and narrative is required to arrive at the best approach for each module.</td>
<td>The planners have several mock-ups of suitable text and format. Once the narrative form is clear, we can write in line with it. We need to be sure that NHB will approve a joined approach to planning.</td>
</tr>
<tr>
<td>Linking high level plans with DHB business (implementation) plans</td>
<td>The Annual Plan may be viewed foremost as a compliance document and written to achieve approval with as much streamlining as possible. Our Annual Plans of recent years have not been particularly useful as business planning tools for our managers. For this reason, it will be important to also produce separate business plans for Waitemata and Auckland. While the joining and streamlining of the Annual Plan is possible across two DHBs, the approach moves us away from business planning. Developing a useful management tool requires considerable involvement/engagement and workshopping with senior staff. Staff will need more help to see how the Annual Plan content relates to them at the point of service delivery.</td>
<td>Early workshops with staff. Clear priorities and messages communicated to staff throughout the planning process. Templates and systems that help the staff construct objectives that are aligned to high-level regional (specifically bi-lateral) goals.</td>
</tr>
<tr>
<td>Delays in sign off</td>
<td>Collaboration between the two DHBs requires more steps in the sign-off process. This cannot</td>
<td>Early workshops with staff. Clear priorities</td>
</tr>
<tr>
<td>Risk area</td>
<td>Specifically</td>
<td>Mitigation</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Too many stakeholders</td>
<td>Each DHB Annual Plan involves between 55 and 70 contributing authors. In turn, each author must liaise with a great many staff within and across teams in order to arrive at a sensible and tested suite of objectives. This workload will increase as we work across the two DHBs.</td>
<td>Responsible authors identified at the start of the process and their role clear in December. Clear roles and responsibilities identified early in the process.</td>
</tr>
<tr>
<td>Impact of the timing of the planning &amp; funding merger</td>
<td>The key milestones of the planning timetable coincide with the planned merger of the planning and funding functions. It is likely that only a partial merger (i.e. primary care, Māori and Pacific teams) will have occurred when annual planning activity begins in October / November 2012. Staff will be distracted with the merger and / or will be in new roles at the time key planning activity occurs.</td>
<td>Develop the timetable by early October 2012 so staff are aware of what is required. Identify areas where there is minimal collaboration underway and undertake pre-planning sessions. Commit to regular communication that keeps everyone up to date with planning expectations for 2013/14 throughout a time of great transition</td>
</tr>
</tbody>
</table>

6. **Conclusion**

Developing joint Annual Plans and Statements of Intent for both DHBs is achievable however, there are some challenges. Key to our success is gaining a clear direction from both DHB Boards regarding their expectations of joint planning and agreeing a clear plan regarding service and priority areas. We will also need to make sure that all key stakeholders are informed about the collaborative approach and have an opportunity to provide input into the planning process. The work proposed will move us towards positive collaboration across the two DHBs, recognising that 2013-14 will be a transition year.
5.1 Primary Care Update

Recommendation:

That the report be received.

Prepared by: Andrew Coe (Group Manager Primary Care, Waitemata and Auckland DHBs) and Stuart Jenkins (Clinical Director Primary Care, Waitemata and Auckland DHBs)

Glossary

A&M - Accident and Medical Centre
ACE - Advanced Choice of Employment
AH+ - Alliance Health Plus
ALT - Alliance Leadership Team
BFG - Better, Sooner, More Convenient Primary Care Funding Group
CAP - Competence Assessment Programme
COPD - Chronic Obstructive Pulmonary Disease
DHB - District Health Board
DVT - Deep Vein Thrombosis
IFHC - Integrated Family Health Centre
NeTP - Nurse Entry to Practice
NHC - National Hauora Coalition
PHO - Primary Health Organisation
POAC - Primary Options for Acute Care
RFP - Request for Proposals

Note: Initiative not yet started

1. Summary

This report provides an update on matters relating to Primary Care to the end of August 2012. It covers progress in our four main activity areas:

1. National health targets relevant to primary healthcare
2. Objectives set in our Annual Plan for this financial year
3. Locality development in Auckland North, Central and West
4. Key Performance Measures – Primary Care.
### 2. National Targets

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Metro Targets Q1 2012/13</th>
<th>August 2012</th>
<th>On track</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ADHB</td>
<td>WDHB</td>
<td>Metro</td>
</tr>
<tr>
<td>Immunisation</td>
<td>85%</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td>More Heart &amp; Diabetes Checks</td>
<td>75%</td>
<td>48%*</td>
<td>56%*</td>
</tr>
<tr>
<td>Smoking – Brief advice</td>
<td>90%</td>
<td>27%*</td>
<td>31%*</td>
</tr>
<tr>
<td>Smoking- Brief advice for Maternal smokers</td>
<td>90%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Note: June Quarter data as only available quarterly
<table>
<thead>
<tr>
<th>Target area</th>
<th>On track</th>
<th>Comment</th>
<th>Actions</th>
<th>Risks &amp; future management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td><strong>ADHB Diabetes Care Improvement Package (DCIP)</strong></td>
<td>• The DCIP in ADHB has now been agreed in all PHOs. Following a series of meetings that were facilitated by the MOH, agreement on the DCIP has now been agreed with ProCare.</td>
<td>• Contracts for Auckland PHO, Alliance Health + and National Hauora Coalition are being processed. The contract and service specification for ProCare is in development.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>WDHB</strong></td>
<td>• Diabetes Care Improvement Package service has been confirmed with ProCare Networks Limited. This service will commence from 1 October 2012. Transitional to Diabetes Care Improvement Packages service is underway with Waitemata PHO. The new service will be fully operational from December 2012.</td>
<td>• Contracting process to be completed for ProCare Networks Limited Agreement. The baseline services are consistent with Auckland DHB. Waitemata DHB will offer additional services due to funding variances. PHOs are working with their practices to inform them of the changes to service. First quarter report on service delivery to the Ministry of Health will be via teleconference. This will provide the DHB with the opportunity to update the Ministry on the Diabetes Care Improvement Package services that will be available within the DHB. Low use of diabetes annual reviews in general practice. PHOs are including this function as a core part of the service change information provided to general practice. ProCare Networks Limited will delay the change to the Diabetes Care Improvement Package until the agreement is signed. This would delay the transition of the service.</td>
</tr>
<tr>
<td>More Heart &amp; Diabetes Checks</td>
<td></td>
<td><strong>ADHB</strong></td>
<td>• As at June 2012, Q4 performance was 47.8%. This is a small improvement from Q3 at 46% but we acknowledge there is considerable work that needs to be done to reach the target of 75% by June 2013. The Ministry are also</td>
<td>• We are currently exploring opportunities to link secondary care Acute Predict with primary care to enable those people post CV event to be captured in the data. A working group has been established to realign the small discretionary funding ADHB has to</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• It is currently estimated that ADHB will need to screen an additional 70,000 people to reach the 75% target by June 2013. PHOs have agreed to provide ADHB monthly reporting on CVDRA.</td>
<td></td>
</tr>
<tr>
<td>Target area</td>
<td>On track</td>
<td>Comment</td>
<td>Actions</td>
<td>Risks &amp; future management</td>
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<tr>
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</table>
| **Supporting the delivery of this health target in ADHB by meeting with ProCare and through setting up a workshop in September to support this target.**  
  - There remain some data issues with this target. | | support this target. | | |
| **WDHB CVD**  
  - Each PHO is reporting an increase in coverage.  
  Waitemata PHO has been showing a 0.5% growth in coverage each week. They expect this will ensure they achieve the 75% coverage rate for their population.  
  - This has increased coverage from 55.9% 30 June 2012 to 58% 17 October 2012.  
  - Waitemata DHB is awaiting service plans from the PHOs that will demonstrate the actions that will be taken to achieve the targets. | ![Yellow diamond] | Both PHOs have been reminded of the requirement of service plan.  
  - The PHO and DHB discuss process to achieving target at our two weekly meeting. These meetings will be used as the foundation for discussing performance against target achievement.  
  - Secondary service risk assessment process has continued with the commencement of recruitment for staff and the finalisation of information hardware needs. We are awaiting confirmation that the software will be tested for launch on 15 October 2012. | • There will be a transfer of general practice between Waitemata PHO and ProCare Networks Limited. The low performing practices will be under contract to ProCare Networks Limited through a ‘letterbox’ agreement. Waitemata DHB will have to manage service expectation with ProCare Networks Limited to ensure that coverage increases in these practices. Failure to achieve this may impact on our ability to reach the target |
| **Smoking**  
  - 90% of patients who smoke and are seen by a health practitioner are offered brief advice and support to quit smoking  
  - Progress towards 90% of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with an LMC are offered advice and support to quit. | ![Yellow diamond] | The Primary Care results are published quarterly, the (unverified) Auckland DHB result for Q4 2011-12 was 31.9% and Waitemata DHB was 33.4%. Most DHBs around the country have results between 30-40%.  
  - Auckland DHB and Waitemata DHB have reviewed service plans submitted by ProCare and The National Hauora Coalition in order to | • The target for primary care was new in 2011/12 and systems are being put in place to facilitate advice being routinely given in primary care.  
  - We await MOH confirmation on how the Pregnancy Target will be measured. Therefore, it is anticipated that the ability to report on performance will not be possible in the short term. |
<table>
<thead>
<tr>
<th>Target area</th>
<th>On track</th>
<th>Comment</th>
<th>Actions</th>
<th>Risks &amp; future management</th>
</tr>
</thead>
</table>
|             |          |         | meet both sections of the Health Target.  
• ProCare are making further changes to their plan.  
• Waitemata DHB has approved Waitemata PHO’s plan.  
• The National Hauora Coalition has redrafted their plan which is currently being reviewed.  
• Waitemata DHB has developed a plan in collaboration with primary care and maternity services to meet the pregnancy sub-target. | In the meantime, the DHBs and PHOs will look at current systems and processes and how we can improve on these to identify pregnant women who smoke and are offered advice and support to quit. |

There are three business cases operating in Metro Auckland; GAIHN, Alliance Health Plus and National Hauora Coalition. The DHBs are partners within these business cases and their progress against their business case deliverables is available on request. The business case reports are discussed at BFG monthly and any risks identified. The table below is a DHB summary of business case progress to date.

Summary
Overall progress to date with the business cases has been disappointing; current work plans whilst agreed are very different from the original cases agreed and signed off by the DHB Boards. Although we now have in place more focused activity and robust infrastructure we are collectively struggling to drive a change programme of sufficient size and scale required to meet the challenges ahead. Current operational churn within primary care is also having a negative impact upon planned integration activity.

<table>
<thead>
<tr>
<th>Business Case</th>
<th>Monthly report received</th>
<th>On track</th>
<th>Risks &amp; future management</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAIHN</td>
<td>YES</td>
<td></td>
<td>A reworked plan, revised governance and project management structure is now in place. This new structure will drive the achievement of agreed business case deliverables across member PHOs and DHBs.</td>
</tr>
<tr>
<td>NHC</td>
<td>YES</td>
<td></td>
<td>A more robust reporting structure is being put in place to ensure all stakeholders are aware of progress against agreed deliverables.</td>
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<tr>
<td>AH+</td>
<td>YES</td>
<td></td>
<td>A robust operational management structure is now in place to drive the delivery of the health targets, business case deliverables and Whanau Ora activity. ADHB continues to support service integration activity.</td>
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### Annual Plan Objectives

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<tr>
<th>Business Case</th>
<th>On track</th>
<th>DHB Annual Plan deliverables</th>
<th>Progress</th>
<th>Risks &amp; future management</th>
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<td>GAIHN</td>
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<td>Work with GAIHN in the first instance, to develop and implement clinical guidelines for management of asthma and skin sepsis in primary care, building on existing Starship Clinical Guidelines.</td>
<td>• Project on track to deliver to targets GAIHN continues to liaise with PHOs around the implementation of this strategy. This is also being considered within the DHB’s approach to locality work. ALT have advised the clinical pathways workstream that the priority is to develop project plans and business cases for 13/14 for implementation of clinical pathways.</td>
<td>• Monitor progress through ALT.</td>
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<td>10% reduction in number of residents from aged care facilities presenting to Adult Emergency Department through GAIHN’s project to improve primary care support within facilities by June 2013 (determine baseline in Q1 and set trajectory for Q2, Q3 and Q4).</td>
<td>• Project on track to deliver to targets.</td>
<td>• Monitor progress through ALT.</td>
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<td></td>
<td></td>
<td>Implement GAIHN shared care planning for high risk individuals using the GAIHN predictive risk planning tool.</td>
<td>• Project on track to deliver to targets.</td>
<td>Monitor progress through ALT.</td>
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<td>Implementation of GAIHN’s regional pathway for Chronic Obstructive Pulmonary Disease (COPD) by March 2013 (engagement and planning in Q2, Implementation in Q3) –Auckland DHB only.</td>
<td>• Project on track to deliver to targets Work is progressing through collaboration between ADHB and ProCare to make GPs aware of the COPD pathway through CME sessions in both West and Central Auckland, which were well attended. A patient attended to share his story which saw him admitted 13 times last year with</td>
<td>• Diagnostic spirometry is a key component of the new pathway which has no funding allocated currently and there is a significant waiting list (approx. 6 months) to access this within the hospital.</td>
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<tr>
<td>Business Case</td>
<td>On track</td>
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<td>Risks &amp; future management</td>
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<td>COPD and no admissions this year after attending pulmonary rehab.</td>
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<td>• Support GAIHN Primary Care Transporting Options for Auckland Ambulance for select patients to be treated at community Accident and Medical facilities or their ‘medical home’/GP (20% of all status 3 and 4 patients transferred by St John to a primary care setting instead of Emergency Departments) – Auckland DHB specific.</td>
<td>• Project on track to deliver to targets.</td>
<td>• Monitor progress through ALT.</td>
</tr>
</tbody>
</table>
| NHC (Auckland DHB only) | ![Green](image) | • Support the National Health Coalition’s Mama, Pepi, Tamariki programme to deliver on improved breastfeeding rates, oral health, B4SCs, immunisation coverage and ASH rates for under 2 year olds (respiratory conditions in particular) and rheumatic fever.  
• Agree service integration implementation processes for all agreed contracts within the scope of Oranga Ki Tua and Mama, Pepi, Tamariki with the National Hauora Coalition. | • He Kamaka Oranga and the primary care team have had several discussions about this shared priority but have yet to agree a process on how to bundle up relevant contracts to fit within the NHC’s programmes. | • Agreement on a process on how to bundle up relevant contracts to fit within the NHC’s programmes. |
| AH+ (Auckland DHB only) | ![Yellow](image) | • Auckland DHB, in partnership with Counties Manukau DHB, provide nursing leadership to support Alliance Health + to develop nurse led clinics by March 2013 - Auckland DHB specific.  
• Implementation of new models of care in collaboratively agreed priority areas within Alliance Health + Integrated Family Health Centres. | • Discussions have begun with nurse leaders from DHB’s and Alliance Health+ to identify specific clinics within Alliance Health+.  
• Discusisons have begun to identify potential service delivery within IFHCs. | • Practices movement between PHOs has disrupted discussions. |
### Integration Activities

<table>
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<tr>
<th>Objective</th>
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<th>Actions</th>
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</table>
| Community dialysis |          | Renal Services to           | • Negotiating contract with Maori provider for Glen Innes site delivery of adult haemodialysis and community home haemodialysis.  
• Pacific Provider negotiating with local board re leasing period, prior to development of concept plan and cost estimate for delivery of adult haemodialysis and community home haemodialysis at an Onehunga site.  
• Balancing costs and quality of service delivery against delays in project, especially around  
  - Pacific and Maori needs  
  - Patient expectations/ resistance to change |
|                    |          |                             | • Work with a Maori primary care provider to design, devolve and deliver Adult Haemodialysis services in a community setting  
• Work with a Pacific primary care provider to design, devolve and deliver Adult Haemodialysis services in a community setting  
• Work with primary care providers to design, devolve and deliver Adult Haemodialysis for patients who are unable to home dialyse (Community Home Haemodialysis)  
• Implement a new model of care which will integrate kidney disease prevention, early intervention, and chronic kidney disease management services |                                                                                             |
| POAC               |          |                             | • Continue education, development of pathways, including for access to radiology services.  
• Investigate and work with into other potential referral sources.  
• DVT pathway implementation strategy has changed, with point of care testing being removed. Data is being collected and will be analysed once all sample cases received to allow a decision on future use of pathway.  
• Close monitoring of WDHB volumes.  
• Govern the appropriate use of IV Antibiotics for Cellulitis treatment and continue work on revision of pathway and education within general practice. |                                                                                             |
|                    |          |                             | • Deliver regionally 23,500 Primary Options (POAC) episodes of care across metro-Auckland, resulting in at least 19,975 avoided attendances at hospital emergency departments by June 2013. Agreed volumes are;  
  - CMDHB 11,623  
  - ADHB 5,700  
  - WDHB 6,150 |                                                                                             |

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<thead>
<tr>
<th>DHB</th>
<th>Month Target</th>
<th>Month Volume</th>
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<tbody>
<tr>
<td>ADHB</td>
<td>475</td>
<td>381</td>
</tr>
<tr>
<td>WDHB</td>
<td>512</td>
<td>665</td>
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<td>CMDHB</td>
<td>969</td>
<td>1005</td>
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<tr>
<td>TOTAL AUGUST</td>
<td>1956</td>
<td>2051</td>
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<td>TOTAL YTD</td>
<td>3912</td>
<td>4033</td>
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<tr>
<td>Objective</td>
<td>On track</td>
<td>DHB Annual Plan deliverables</td>
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<td>Regional after hours project</td>
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<td>• Reporting: A report on A&amp;M volumes through to 31/03/12 has been produced. A set of indicator conditions are still being tested and refined by the clinical sub-group. Synergia are developing a collective PHO pivot spreadsheet with per capita values, anonymised at the practice level.</td>
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<td>• Evaluation: The Evaluation of the After Hours Network will be completed in two phases with the Auckland University School of Population Health being the lead investigator for both phases:</td>
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<td>• Phase 1 is to be a modified version of the original Synergia proposal designed to provide information that will inform DHBs about future funding for the afterhours initiative past June 2013</td>
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<td>o Funding for phase 1 will be shared between the afterhours consortia and the DHBs</td>
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<td>• Phase 2 is a more robust evaluation that will look in much more detail at aspects of the initiative (including the St John Transport initiative) and will include modeling, cost benefit analysis, unintended consequences etc</td>
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<td>o Funding for phase 2 will be sought from the HRC/MoH through their current partnership RFP process.</td>
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<td>• New Entrants: An application has been received from Coast Care Red Beach to be part of the After Hours Network. The Chair of the After Hours Network has spoken with Coast Care Red Beach and explained the cost associated with being free for under 6s.</td>
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<tr>
<td>Objective</td>
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<td>part of the Network. Coast Care Red Beach have put a hold on the application while they consider the associated cost.</td>
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<td><strong>Free After Hours For Under 6s</strong>: The MoH has confirmed that the requirement is that there will be 60% coverage by 1 July 2012 and rising to 95% over a period. This means that 60% of under 6s will have access to free after hours services within a 60-minute drive. The Auckland Metro DHBs have implemented this initiative through the After Hours Network. Synergia has confirmed that the three Auckland Metro DHBs already have 97.65% coverage.</td>
</tr>
</tbody>
</table>
| COPD-Pulmonary Rehabilitation | ![Green Circle] | • Deliver 120 completed pulmonary rehabilitation programmes in the community by June 2013: (30 in Q1, 30 in Q2, 30 in Q3 and 30 in Q4) current baseline is approx. 100 patients - Auckland DHB specific. | • The community programmes are on target for >80 patients completed PR by December.  
• The Physiotherapy Specialist is engaging Primary Care via CME evening sessions to GPs, via GAIHN; Pro Care and through targeting interested GP practices around the PR centres in Glen Innes and Mt Albert.  
• A Physiotherapy Specialist led wait list initiative has significantly reduced the waitlist for PR.  
• An opportunity is being investigated to engage a possible third site for community PR at no cost to the DHB, PHO or the patient.  
• Evaluation of the current PR services due to commence. | A recent NZ study states that GPs refer less than 1% of patients with COPD that would benefit from Pulmonary Rehabilitation. The team are finding that GPs are under referring patients to the programme. Referral rates will impact the ability of Community Pulmonary Rehabilitation services to deliver target numbers. |
### Primary health interpreting

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>On track</td>
<td></td>
<td>• Increased uptake of CALD Cultural Competency training (online and face to face), averaging 40 enrolments a month.</td>
<td>• Face to face courses offered for ADHB and PHO/primary care staff. Online courses promoted.</td>
<td>• Trained interpreters are not available in required languages. Training support being considered.</td>
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<tr>
<td></td>
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<td>• Primary health interpreting services use is increased by 20%.</td>
<td>• Trained interpreters required and being sought in Pacific, Burmese, and Somali languages.</td>
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### Primary Care Nursing

#### Wound care

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<td></td>
<td>• Waitemata DHB is working with Counties Manukau DHB to pilot an integrated model of care for complex lower leg wounds.</td>
<td>• Pilot practices and District Nurses have commenced enrolment of suitable patients into pilot programme.  • Good progress to date.</td>
<td>• Patients refuse to be on the programme. To manage this, patients will be screened for eligibility before offering to be on the pilot.</td>
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#### Workforce development

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<td>• Seven nurses continue to be supported on the February 2012 Nurse Entry to Practice (NeTP) Expansion Programme in Primary Health Care. Eight PHC new graduates are ready to start in the September intake following state examination results. Five nurses are undertaking the Competence Assessment Programme (CAP) in the Primary Care setting.  • Professional Development and Recognition Programme (PDRP) workshops for 1)Aged residential Care nurses and 2)school nurses.  • Peer review / appraisal workshops for PHC nurses held in the West and North.</td>
<td>• PHC placements are being confirmed and interview times booked for the February 2013 intake ready for the new national recruitment process, Advanced Choice of Employment (ACE) for new graduate nurses.</td>
<td>• That the ACE process will not work for Primary Care where the new graduate is employed by a private organisation and not the DHB and are unable to commit as unable to predict if they will have a vacancy in February.</td>
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<td>Project</td>
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<tr>
<td>WDHB Primary Care Nursing Workforce Survey</td>
<td>✔️</td>
<td>• Primary Care Nursing Workforce Survey developed with Waitemata PHO and ProCare has been completed in the Waitemata District and has been reported on by Awhina Health Campus. This report will inform future nursing workforce planning.</td>
<td>• Report available from [<a href="http://www.awhinahealthcampus.co.nz/Portals/0/Documents/Education/PrimaryCare/Surveys/WDistrictPHC">http://www.awhinahealthcampus.co.nz/Portals/0/Documents/Education/PrimaryCare/Surveys/WDistrictPHC</a> NursingSurveyReportFINALJuly2012.pdf](<a href="http://www.awhinahealthcampus.co.nz/Portals/0/Documents/Education/PrimaryCare/Surveys/WDistrictPHC">http://www.awhinahealthcampus.co.nz/Portals/0/Documents/Education/PrimaryCare/Surveys/WDistrictPHC</a> NursingSurveyReportFINALJuly2012.pdf) • Poster presentation for WDHB Health excellence awards.</td>
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</table>
4. **Locality Activities**

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<tr>
<td>Locality Approach</td>
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<td><strong>Locality Plans</strong>&lt;br&gt;• Jointly agreed locality plan for Auckland West locality submitted to the Ministry of Health by 31 December 2012.&lt;br&gt;• Jointly agreed locality plans for Auckland Central and Auckland North localities submitted to the Ministry of Health by 31 March 2013.</td>
<td><strong>Activities to be completed next reporting period:</strong>&lt;br&gt;• A new overarching project plan for both ADHB and WDHB localities development and various annual plan activities and deliverables around integrated care.</td>
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<td>Integrated Health Networks</td>
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<td>• Three Integrated Health Networks in place (2 in WDHB, 1 in ADHB).</td>
<td>• Clinical director roles for the North and Central Health Networks will be advertised in September and appointed in October.</td>
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<td>• West Auckland</td>
<td>• The West Locality Urgent Care workstream has been set up and the initial meeting will be convened on the 6th of September.&lt;br&gt;• The Diabetes model of Care work stream is planned to begin in October.&lt;br&gt;• The Child Health model of care work stream begins in October.&lt;br&gt;• GP cluster meetings will be scheduled at New Lynn and Henderson early November to present the initial workstream findings and to ensure that GP’s who are not part of the workstreams have the opportunity to input and feedback.</td>
<td>• The scopes for the three clinical work streams is to be agreed and meetings arranged.&lt;br&gt;• Steering group meeting is to be convened.</td>
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<td></td>
<td>2-3 clusters have already been identified in West Auckland. As other networks are established further, IFHC developments and surrounding clusters will be identified.</td>
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<td>• Finalisation of online health needs assessment survey to go live in September.</td>
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|           | ![Orange] | • Whanau House in Henderson delivering new models of integrated care by June 2013 (engagement with surrounding practices in Q1, developing a new model of care in Q2 and implementation in Q3/4) | • Minor alteration required within the DHB space within Whanau House. The following services are ready to occupy the space when alterations completed.  
  - Child and Family (C&F) Youth Justice Assessments  
  - C&F Continence Clinic  
  - C&F Vision Hearing Testing  
  - Violence Protection Programme  
  - Marinoto West  
  - Gateway assessments  
  - Paediatric Clinic for Paed and Nurse  
  - Midwives Drop in service for social work issues  
  - Newborn Hearing Screening  
  - Oral Health Mobile Dental Clinic | • Delayed signing of Capex paper to approve alteration will delay service delivery |
<table>
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<td>• Other secondary services will be approached when a confirmed alterations completion date.</td>
<td>The construction company has asked for an extension as the building schedule is behind.</td>
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<td>• New Lynn Integrated Family Health Centre operational and delivering new models of care in line with West Auckland’s locality plan by 2013-14</td>
<td>• New Lynn IFHC is progressing with building work due to be completed in February 2013.</td>
<td>The New Lynn doctors are currently advertising for a Practice Manager. All agreed that change management is key to develop new nursing pathways within the centre.</td>
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<td>• The WDHB West Auckland primary care team and the New Lynn doctors have discussed the extra nurse’s capability required. To work with the Nursing Integration team to develop pathways and up skilling of current and new nursing staff.</td>
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<td>• Co-design process in place to explore new models of care within the development of Waiheke Integrated Family Health Centre by June 2013.</td>
<td>• This work will progress once the service development and provision Workstream kicks off in Central.</td>
<td>• Waiheke IFHC development has not been considered as a priority development for Central as yet.</td>
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<td>• Implementation of new models of care in collaboratively agreed priority areas within Alliance Health + Integrated Family Health Centres (engagement with surrounding practices in Q1, developing a new model of care in Q2 and implementation in Q3).</td>
<td>• Discussions are underway as to how best to progress this.</td>
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<td>• Review current integrated care models being delivered in rural settings (Rodney) by December 2012 for potential networking between Integrated Family Health Centres in 2013/14.</td>
<td>• The rural services scoring tool (RSST) has been reviewed by the MoH and a process has been in place with the Rural GP network. The implications of</td>
<td>• IFHC locations for North have not yet been agreed.</td>
</tr>
<tr>
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<td>this review have still to be finalised. All rural contracts are undergoing an internal review to align with this process and locality development.</td>
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## 5. Primary Care Operational Matters

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| Unstable PHO practice affiliation | • Continuing practice moves between PHOs affects discretionary contracts.  
• Eight NHC affiliated practices transferred from ProCare to Waitemata PHO in WDHB in Quarter 1 and in Quarter 2 and 5 will transfer back to ProCare. | • A paper developed to present to the regional working group to progress issues. | • PHO notifying the DHB of potential moves to ensure easier transition of discretionary contracts. |
| SIA and HP plans            | • All PHOs have provided the DHB with their SIA (Services to Improve Access) and HP (Health Promotion) plans. | • Plans have been circulated to all DHB staff and feedback has been collated and given to PHO. | • Draft principles have been developed to provide feedback to PHO and guide plans in the future |
| Unspent funds               | • A paper was been drafted to go to ADHB and WDHB’s Audit and Finance Committee for the October 2012 meeting however the day this was due an updated instruction was received from the MoH on the OPF (Operating Policy Framework) requirements. This has pushed the reporting deadlines to January 2013 and altered some previously stated definitions and processes. The DHBs have until 12 October to respond to these changes and a regional response is being drafted between primary care and the financial analysts. | • Outstanding reports to be collected against PHOs of interest.  
• Respond to OPF changes by 12 October.  
• Advise PHOs of new requirements. | • There are still a number of outstanding issues for those PHOs that have ceased trading still to be resolved. |
5.2 Planning and Funding Update

Recommendation:
That the report be received.

Prepared by: Dr Denis Jury (Chief Planning and Funding Officer ADHB), Dr Debbie Holdsworth (Chief Planning and Funding Officer WDHB), Julie Helean (Manager Planning and Service Development ADHB), Janine Pratt (Group Planning Manager WDHB), Tim Wood (Group Funding Manager WDHB) and Cliff La Grange (Group Finance Manager WDHB)

Glossary

DHB - District Health Board  
HPA  - Health Promotion Agency  
HSC  - Health Sponsorship Council  
PCC  - Palliative Care Council  
PHO  - Primary Health Organisation

1. Summary

This report updates the Committees on Auckland and Waitemata DHBs’ Planning and Funding activity for the month of September 2012.

2. Summary of activities in common

2.1 Planning
Refer to the 2013/14 Planning Approach agenda item for a more detailed update.

2.2 Funding

*Biological Treatment of Infertility Service Review*

The review of the biological treatment of infertility is nearing completion.

The scope of this review is that of services provided in the northern region of New Zealand as defined by the four DHBs: Auckland, Counties Manukau, Northland and Waitemata. The review will be cognisant of the DHBs need to consider if a tender process should be undertaken in the future and what would be a preferred provider service delivery model. However, the review will not provide advice on value for money or provider configuration opportunities.

The review will not be required to consider future funding models, or if a tender should occur or not.

Review of the national framework and pricing units, and PGD (pre-implantation genetic diagnosis) funding are out-of-scope

The Steering Group (Dr Andrew Brant (WDHB), Dr Lynne Sadler (ADHB), Dr Simon Edmonds (CMDHB), and Tim Wood (WDHB)) have now considered the report of the Australian reviewers and the feedback from Fertility Associates, Fertility Plus and Repromed.
A report, including recommendations, from the Steering Group is in the process of being finalised. When the final report is available, as per the Terms of Reference of the review, the report will be tabled with the Regional Funding Forum and the Regional Chief Executives meeting for approval.

Once the report has been through the abovementioned forums a report will be available for tabling at the CPHAC meetings of the four DHBs.

In parallel with the service review, work is being undertaken to consider future procurement options. The procurement options can now be finalised based on the Steering Group recommendations. This advice will also go through the abovementioned forums along with the Steering Group report.

Cardiovascular Risk Assessment Campaign – Health Promotion Agency
The Health Promotion Agency (HPA) is a new Crown Entity set up on 1 July 2012 to:
- Promote health, wellbeing and healthy lifestyles
- Prevent disease, illness and injury
- Enable environments that support health and wellbeing and healthy lifestyles
- Reduce personal, social and economic harm.

It also has functions specific to providing advice and research on alcohol issues.

The HPA was formed by the merger of the Alcohol Advisory Council (ALAC), the Health Sponsorship Council (HSC) and some health promotion programmes previously delivered by the Ministry of Health.

The Minister of Health has approached the HPA to deliver a national initiative to
- Increase public awareness of the need for cardiovascular risk assessments
- Steer people to primary care practices for a cardiovascular risk assessment (CVRA).

The HPA planned approach is:
- A national launch on 25 September 2012 (timed to be close to World Heart Day on 29 September) through the use of a national celebrity (Buck Shelford) to generate interest and create national momentum and action. Post-launch, the emphasis will move to regional initiatives drawing on existing local ‘champions’ as spokespeople. The HPA is also working closely with the National Heart Foundation (including clear messages around using their Know Your Numbers website www.knowyournumbers.co.nz) and PHARMAC through the One Heart Many Lives campaign.
- Working with interested PHOs to determine how we localise our national approach on the ground. The HPA are particularly interested in exploring opportunities to work with PHOs that have low CVRA rates, which could benefit from such a localised approach.

The national target audiences are:
- Māori, Pacific and South Asian males 35-74 years
- Māori, Pacific and South Asian females and all other ethnic groups of males 45-74
- All other ethnic groups of females 55-74.

The key messages of the campaign are:
- ‘Go to your family doctor or nurse and have a health heart check’.
- Cardiovascular disease (heart disease and stroke) is New Zealand's biggest killer. Heart disease claims one New Zealand life every 90 minutes.
- Many heart disease deaths are premature and preventable.
- Do it for your family.
National Immunisation Register and Immunisation Outreach Request for Proposal
The Request for Proposal for a single Auckland DHB and Waitemata DHB service for the National Immunisation Register and the Immunisation Outreach has been released. The closing date for submissions is 25th October 2012. The preferred provider is expected to start delivery of services in Waitemata from 1 April 2013 and in Auckland from 1 July 2013.

New Principles of Government Procurement

The aim is to provide a plain English statement of Principles that is easier for both agencies and suppliers to understand and apply. It is essential that all government agencies take the Principles into account when buying goods and services. There is an expectation that the new Principles will be reflected in how agencies plan and manage their procurements and achieve best value-for-money results.

Palliative Care Council of NZ - Needs Assessment
The Palliative Care Council is responsible for providing the Minister of Health with independent strategic advice on issues related to palliative care and end-of-life care. They provide advice on seven main areas:
- Access to essential services for people with life-limiting and life-threatening illnesses
- Service models/frameworks for palliative care services
- Palliative care end-of-life care needs of specific population groups
- Workforce requirements
- Equity of Access
- Sector data and information
- Palliative and end-of-life research.

In 2011, the Palliative Care Council of New Zealand (PCC) released the Phase 1 report of the National Health Needs Assessment for Palliative Care (HNA), which provided estimates of the need for palliative care across the District Health Board regions (www.palliativecarecouncil.govt.nz).

A draft Phase 2 report has been consulted upon during August and September 2012. This part of the HNA has brought together a large amount of information on the provision of palliative care in New Zealand to determine how well current service provision is meeting the population’s need for palliative care. The Council explored palliative care capacity in a wide range of primary palliative care providers (general practice, district nursing, aged care and hospitals for example), and conducted an extensive survey of hospices and hospital palliative care services to inform this report.

The health needs assessment will be useful in informing future palliative care and end-of-life care service developments.

3. Waitemata DHB Update

3.1 Funding
Before School Check Request for Proposal
The Before School Check service Request for Proposal has been released. The closing date for submissions is 4 pm on 22 October 2012. It is planned to have the service with the preferred provider in place from 1 April 2013.
3.2 Funder Finance

The August 2012 consolidated core result for the Waitemata Funder was $1.1m favourable to budget for the month and $1.4m favourable to budget for the year to date.

Funder NGOs

The August core result for Funder NGO was $123k favourable to budget for the month and $404k favourable to budget for the year to date. This is a net position across all of the Funder NGO services with no significant influencing factors at this time. There has been a change in PHO General Practice membership during this quarter with eight practices representing approximately 70,000 enrollees moving from ProCare PHO to Waitemata PHO. The consequence of this change is fiscally neutral to both ADHB and WDHB as PHO Core Services are subject to a default national wash-up that is processed at the beginning of each quarter.

Funder IDF

The August core result for Funder IDF was $965k favourable to budget for the month and $1.0m favourable to budget for the year. The favourable position mostly results from the positive impact in 2012/13 of a change in the year-end accounting treatment by Auckland and Waitemata of un-discharged WDHB patients in Auckland facilities at 30 June 2012. Expenditure relating to WDHB IDF outflow patients at ADHB over year-end has been accounted for by WDHB in 2011/12 (prior to discharge) resulting in the equivalent upside on discharge in 2012/13.

4. Auckland DHB Update

4.1 Family Partners in Care

The Family as Partners in Care programme is proceeding according to plan. Data is being gathered and three case studies are underway about the engagement of family at ADHB – the current state, challenges and solutions. The case studies are:

1) The transition of cardiology patients from paediatric to adult services
2) Te Whare Awhina’s role in enabling family to be partners in patient care
3) Dementia assessment, admission and care planning.

Further case studies will be developed. Participation in the HQSC’s ‘Partners in Care’ programme is proving beneficial. Attendance at a 4-day intensive training seminar and two site-visits to providers recognised as having successfully made a shift toward patient and family centred care have been confirmed. All the above activity will be used alongside guides on the topic to develop a business-case to “build the case for a change in culture” due December 2012 as detailed in Auckland DHB’s Annual Plan.

4.2 Oral Health Business Plan Implementation

Implementation is progressing to plan and budget, with the Orakei Primary School Clinic opening planned for late November 2012 (although the clinic is now treating patients) and completion of the Greenlane Clinic late October. The final clinic at May Road Primary is planned to start treating patients from February 2013.

4.3 Aged Residential Care

The ADHB contract with Tiverton House Rest Home has now been terminated. Meetings were held with relatives and residents to explain the situation and all 23 residents were reassessed and transferred to new facilities. A temporary manager was in place at Tiverton for two weeks whilst this transition occurred.
Interviews are underway for a permanent clinical manager at Sylvia Park Rest Home to replace the temporary manager. The corrective actions plan has been completed and submitted to ADHB and the MoH for sign off.

4.4 More Heart and Diabetes Checks (CVD Risk Assessment)
See Primary Care Report.

4.5 Diabetes Care Improvement Package (DCIP)
See Primary Care Report.

4.6 Funder Finance
For the month of August 2012 the funding accounts show a deficit of $1m compared to a budget deficit of $2.25m, a favourable variance of $1.2m., YTD the actual deficit is $1.35m compared to a budgeted deficit of $2.5m, a favourable variance of $1.1m. The YTD variance is split between a favourable variance for the “funder” of $1.9m combined with “provider” unfavourable variance of $0.8m.

The main features of the YTD result are a favourable budget variance in Personal Health and Med/Surg of $2.3m. Mental Health is unfavourable to budget by $359k, Health of Older Peoples favourable to budget by $26k and unfavourable variance of $0.8m in Provider services.

Mental Health YTD unfavourable variance to budget by $359k is primarily a timing difference.

Health of Older People is unfavourable for the month by $107k and YTD favourable variance of $26k. There is additional revenue predominantly from MOH funding for the Long Term Conditions for Chronic Health Conditions (LTS-CHC) contracts that that the MOH has devolved to the DHBs. This additional revenue is offset by the higher costs for these services. Initial information is that the MOH funding is insufficient to fully cover the costs of these contracts.

All targets in the Business Transformation Project have been achieved in August and YTD.
**Key message**

We are modernising the way we buy goods and services and we want everybody to be aware that there are different ways of creating competition and getting the best from our suppliers.

So, when we buy, our five principles are as follows:

1. **Plan and manage for great results**
   - Identify what you need and then plan how to get it.
   - Set up a team with the right mix of skills and experience.
   - Involve suppliers early – let them know what you want and keep talking.
   - Take the time to understand the market and your effect on it. Be open to new ideas and solutions.
   - Choose the right process – proportional to the size, complexity and any risks involved.
   - Encourage e-business (for example, tenders sent by email).

2. **Be fair to all suppliers**
   - Create competition and encourage capable suppliers to respond.
   - Treat all suppliers equally – we don’t discriminate (this is part of our international obligations).
   - Give NZ suppliers a full and fair opportunity to compete.
   - Make it easy for all suppliers (small to large) to do business with us.
   - Be open to subcontracting opportunities in big projects.
   - Clearly explain how you will assess suppliers’ proposals – so they know what to focus on.
   - Talk to unsuccessful suppliers so they can learn and know how to improve next time.

3. **Get the right supplier**
   - Be clear about what you need and fair in how you assess suppliers – don’t string suppliers along.
   - Choose the right supplier who can deliver what you need, at a fair price and on time.
   - Make it easy for all suppliers to do business with us. It’s essential to give suppliers enough time to prepare and send in their proposals.
   - Encourage and be receptive to new ideas and ways of doing things with suppliers.
   - Make it worthwhile for suppliers – encourage and reward them to deliver great results.
   - Identify relevant risks and get the right person to manage them.

4. **Get the best deal for everyone**
   - Get best value for money – account for all costs and benefits over the lifetime of the goods or services.
   - Make balanced decisions – consider the social, environmental and economic effects of the deal.
   - Encourage and be receptive to new ideas and ways of doing things – don’t be too prescriptive.
   - Take calculated risks and reward new ideas.
   - Have clear performance measures – monitor and manage to make sure you get great results.
   - Work together with suppliers to make ongoing savings and improvements.
   - It’s more than just agreeing the deal – be accountable for the results.

5. **Play by the rules**
   - Be accountable, transparent and reasonable.
   - Make sure everyone involved in the process acts responsibly, lawfully and with integrity.
   - Stay impartial – identify and manage conflicts of interest.
   - Protect suppliers’ commercially sensitive information and intellectual property.

**Why are the principles important?**

These principles form the foundations of good procurement practice. It is essential that all government agencies take them into account when buying goods and services.

Good procurement is about making sound commercial decisions and making it easy and worthwhile for suppliers to sell to us. We’re changing the way we buy – find out more at: [www.procurement.govt.nz](http://www.procurement.govt.nz)