



Community and Public Health Advisory Committees Meeting

Wednesday, 1st May 2013

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 ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind

As we seek to be of service to those in need.

Give us the courage to do what is right and help us to always be aware

Of the need to be fair and transparent in all we do.

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

Well Being to All.

**AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
1st May 2013**

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
 Ailsa Claire – ADHB, 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: Tim Jelleyman and Ailsa Claire

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)

PRESENTATION

2.00pm CVD Target - Andrew Coe (Group Manager Primary Care, Waitemata and Auckland DHBs) and PHO representatives

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES

2.30pm 2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 20/03/13..... 1

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 2.55pm 4.2 The International Residential Assessment Instrument–InterRAI Long Term Care Facility Tool Update.. 19

5 STANDARD MONTHLY REPORTS

3.10pm 5.1 Planning and Funding Update 22

3.25pm 6 GENERAL BUSINESS

3.30pm 7 RESOLUTION TO EXCLUDE THE PUBLIC 26

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Professor (Adjunct) 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	01/11/12
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 Director – Trusts Community Foundation Ltd	20/03/13
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

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 Committee Member – Lottery Northland Community Committee	11/03/13
Co-opted Members		
Dr Tim Jelleyman	Head of Division (Medical) - Child Women and Family Services, WDHB Member - Active Clinic Network for Greater Auckland Integrated Health Network Member - ASMS Chair - Child Health Network, Northern Regional Health Plan Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland	13/03/13
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 2013**

NAME	FEB	MAR	MAY	JUNE	JULY	Sept	OCT	NOV
Lee Mathias (ADHB / WDHB combined Committees Chair and ADHB Deputy Chair)	✓	✓						
Warren Flaunty (ADHB / WDHB combined Committees Deputy Chair)	✓	✓						
Dr Lester Levy (ADHB and WDHB Chair)	✓	✓						
Max Abbott (WDHB Deputy Chair)	✓	✓						
Jo Agnew	✓	✓						
Peter Aitken	x	✓						
Judith Bassett	✓	✓						
Pat Booth	✓	✓						
Susan Buckland	✓	x						
Chris Chambers	✓	✓						
Sandra Coney	✓	✓						
Rob Cooper	^	^						
Robyn Northey	✓	✓						
Christine Rankin	✓	✓						
Allison Roe	x	✓						
Gwen Tepania-Palmer	✓	x						
Co-opted members								
Dr Tim Jelleyman	✓	✓						
Eru Lyndon	x	x						

x 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 20th March 2013

Recommendation:

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

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 20 March 2013

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna,
commencing at 2.04p.m.

COMMITTEE MEMBERS PRESENT:

Lee Mathias (Committee Chair) (ADHB Deputy Chair)
Warren Flaunty (Deputy Committee Chair) (WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair) (present from 2.06p.m.)
Max Abbott (WDHB Deputy Chair) (present from 2.38p.m.)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Allison Roe (WDHB Board member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT: Ailsa Claire (ADHB, Chief Executive)
Debbie Holdsworth (WDHB, Acting Chief Planning and Funding Officer)
Denis Jury (ADHB, Chief Planning and Funding Officer)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Marty Rogers (ADHB and WDHB, Manager Maori Health Gain, Planning and Funding)
Carol Stott (ADHB, Strategy and Planning Manager)
Tim Wood (WDHB, Group Manager, Funder NGOs)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Adrian Collier, Pfizer
Anne Curtis, Health Link North
Lorelle George, Waitemata PHO
Tracy McIntyre, Waitakere Health Link
Edith McNeill, Te Whanau o Waipareira
Craig Murray, Waitemata PHO
Alastair Sullivan, White Cross Healthcare
Brian O'Shea, ProCare
Lynda Williams, Auckland Womens Health Council

LEAVE OF ABSENCE: Rob Cooper

APOLOGIES: Apologies were received and accepted from Susan Buckland, Gwen Tepania-Palmer and Eru Lyndon (apology received later in the afternoon).

WELCOME Lee Mathias welcomed those present.

KARAKIA Members participated in a karakia.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no declarations of interest with regard to the agenda.

2.06p.m. – Lester Levy present.

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 13 February 2013 (agenda pages 1-10)

Resolution (Moved Warren Flaunty/Seconded Tim Jelleyman)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 13 February 2013 be approved.

Carried

Matters Arising:

Well Child Programme

Denis Jury and Carol Stott updated the Committee on this. Reporting on the programme to CPHAC had been awaiting receipt of full reports from the Ministry of Health. The Ministry has now advised that it has found that some providers had not been reporting on this to the Ministry. As a result it is not possible to provide an analysis to CPHAC without that full data. It will be important to ensure that data is kept going forward.

Resolution (Moved Lee Mathias/Seconded Jo Agnew)

That the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees express their disappointment to the Ministry of Health at the unavailability of accurate data relating to the Well Child Programme on which to base their decisions for the future.

Carried

3. DECISION ITEMS

There were no decision items.

4. INFORMATION ITEMS

4.1 Prime Minister's Youth Mental Health Project (agenda pages 11-13)

Tim Wood (Group Manager Funder NGO, Waitemata DHB) and Ruth Bijl (Associate Planning and Funding Manager, Auckland DHB) were present for this item.

It was agreed that it would be worthwhile to obtain for Committee members a transcript of Sir Peter Gluckman's speech at the launch of the report, *Improving the Transition*.

Tim Wood introduced the paper. He advised that with regard to the application of savings from the decrease in community pharmaceuticals drugs funding to priorities for the Youth Mental Health initiatives, the issue of expected increases in funding for those initiatives for future years and how that might be expected to be achieved had been raised with the Ministry of Health.

Matters covered in discussion and response to questions included:

- Tim Wood advised that he was not aware of any national evaluation process for the Youth Mental Health Project as a whole, but some elements of it had certainly been evaluated previously.
- Auckland DHB's School Based Health Services - having 94.7% of Year 9 students in nine mainstream schools (including all decile 1-3 schools) receive a HEEADDSSS wellness check in 2012 is an achievement to be proud of. With regard to the intention to extend these assessments to more "high risk" students, Ruth Bijl noted the definition of "high risk" as those who start at a school after the usual Year 9 intake and those students facing significant disciplinary action. In further discussion it was noted that the last year of school, as a key transition point, would ideally be a good time to carry out a further check, but cost is a constraint.
- The additional cost if Auckland DHB's School Based Health Services were extended to all Decile 4 and 5 schools has been calculated at \$350,000. Currently there are two Decile 4 and one Decile 6 schools in the programme.
- Services to Maori had not been discussed in this paper because of the Youth Mental Health Project emphasis on extending the access criteria for youth primary mental health care services from Maori, Pacific and under-served to all youth aged 12-19 years.
- It was agreed that it would be useful for Tim Jelleyman to discuss his suggestions on an approach to resource allocation involving inputs and outputs with Tim Wood.

The paper was received.

4.2 The White Paper for Vulnerable Children (agenda pages 14-21)

Carol Stott (Strategy and Planning Manager, Auckland DHB) and Dr Tim Jelleyman (Head of Department Medical – Child Women and Family Services, Waitemata DHB) presented this report. Carol Stott introduced the report, including noting that the White Paper and Action Plan would have significant impact on District Health Boards and they had tried to highlight where they thought the major implications will be.

Matters covered in discussion of the report included:

- There was a range of perspectives as to whether the approach is creating a whole new infrastructure for protecting vulnerable children or is more about better linkages of existing support services.
- Tim Jelleyman pointed out that what the Government will be measuring is number of hospitalisations, but what has to be dealt with is a continuum of need.
- Carol Stott noted that the new local Children's Teams are likely to be situated within District Health Boards.

- Ailsa Claire advised that she had attended a presentation about the Whangarei demonstration site for Children's Teams. The way the approach was described, it involved a pooling of resources to focus on individual children, with the infrastructure being there to support if needed. The presenter saw great potential in the approach.

Resolution (Moved Lee Mathias/Seconded Jo Agnew)

a) **That the report be received.**

b) **That the Committee notes the current activity aligned with the Government White Paper and Prime Minister's priority of reducing assaults on children.**

Carried

4.3 Cervical Screening Update (agenda pages 22-80)

Dr Peter Sandiford (Public Health Physician, Waitemata DHB), Dr Sue Crengle (Public Health Physician, Waitemata DHB) and Ruth Bijl (Associate Strategy and Planning Manager – Women's and Youth Health, Auckland DHB) presented this report. Peter Sandiford introduced the report.

Matters covered in discussion of the report included:

- Chris Chambers suggested that in view of the inconsistencies on ethnicity data between the various databases used for different purposes, the solution might be having one downloadable national database on ethnicity which could be referred to for all purposes. The suggestion that this might be an approach worthwhile for the Ministry of Health to consider was supported at the meeting.
- The wide ranging approach to improving cervical screening coverage, not just concentrating on the ethnicity data issue, was endorsed.
- Concern was expressed at ethnicity coding at general practice level and the intention to work with PHOs and practices to improve standards of ethnicity coding supported.
- It was noted that correct ethnicity data is important not only to measure performance, but also because it helps focus on those who have not been screened.

The progress report was received and the authors thanked for the quality of the report.

2.38p.m – Max Abbott present.

5. STANDARD MONTHLY REPORTS

5.1 Primary Care February Update (agenda pages 81-120)

Andrew Coe (Group Manager Primary Care) and Stuart Jenkins (Clinical Director Primary Care) were present for this item. The paper was taken as read.

Matters covered in response to questions and in discussion included:

- The low percentage of PHO enrolment for Maori compared to total PHO enrolment (page 83 of the report) links to the same ethnicity classification issue that had been highlighted in the Cervical Screening report. Andrew Coe noted that it will be important to get down to practice level to make this issue more real for those responsible.
- There are currently no performance indicators concerning acute care in primary care. It will be important to develop something that covers arrangements practices have in place for after hours care.

- The Board Chair emphasised that the 54% result for More Heart and Diabetes Checks for Auckland DHB (page 84 of the agenda) is unacceptable performance. This is being reinforced in meetings and in letters to the PHO Chairs. The message to the PHOs and to primary care is that there really is no additional funding for this. A very significant amount of money is allocated to primary care and accepting that involves performance to the parameters of that funding. It is important to get alongside providers to ensure that they understand what is required, much of which is just fundamental medical care that should be done anyway. In some areas there is starting to be a response, but overall progress is still way behind what is needed.
- The Committee Chair referred to the television campaign involving Buck Shelford creating demand for CVD assessments and the importance of the providers then being able to deliver those assessments.
- There was a discussion of the fee for service model for primary care and whether that impacted negatively on primary care, and on whether co-payments may be underestimated as a barrier to people accessing primary care when they need it. It was also suggested that the issue is more that the current model is not population based and that the localities approach will help address that.
- The Board Chair suggested that the idea that the existing model for primary care might be wrong should not be dismissed entirely. For a market model to work there needs to be symmetrical information. In this case the population has very asymmetrical information. Another problem with the current situation is the expectation of added payment for everything extra done. The problem with incentives is that they may have a short term effect, but not a long term one. Incentives come to be seen as entitlements. He is very open to the idea of looking at different models and trialling them in different places. Another decision that may need reviewing is whether having large scale PHOs is the best solution; smaller organisations might provide more fertile ground for innovation.
- Co-payments were discussed and concern expressed that a small number of general practices are still charging substantial fees for children under six. In answer to a question, Andrew Coe confirmed that the decision does come back to the practice as an independent entity, however the market is driving them in the direction of providing free care to under six year olds. It is hoped to achieve this objective through a collaborative approach.
- Concern was expressed that contracts with the PHOs are too passive when it comes to the obligation to serve the needs of the population.
- The Board Chair commented on an Indian Community Health Event he had attended recently. This had been an extremely well attended and successful event, entirely a community initiative supported on a voluntary basis. He suggested that there is a big opportunity to encourage and support such events and that it would be worthwhile to consider providing some DHB assistance to enable them to do more at events like this.
- The Committee Chair noted that the concerns with non performance on primary care targets remained the same areas, particularly CVD checks, diabetes and advice to quit smoking.
- With after hours services, Andrew Coe commented on the need for a whole of system approach so that people know where to go when their general practice is closed, including other clinics in the area that are open for longer hours on that day. Practices need to take responsibility for such arrangements and information on them. Co-ordination of such arrangements is part of the Localities approach.
- Stuart Jenkins noted that health targets for primary care are casting a light over problems in the sector, cracks in the system are becoming clearer and they are starting to be addressed. Current engagement is occurring with the PHOs to get over the issue of confidentiality at practice level. Information needs to be available at practice level and shared, including which practices are effective and why.

The report was received.

5.2 Planning and Funding Update (agenda pages 121-125)

Debbie Holdsworth and Denis Jury introduced the report.

The Committee acknowledged with thanks the excellent contribution made by Frank Booth, who had recently resigned as Manager of the Auckland Regional Public Health Service after five years in that role.

In response to questions, Tim Wood advised that the Community Laboratory Schedule Review is a national process, with project management from DHB Shared Services in Wellington. It has wide involvement from the sector, involving a substantial amount of work by pathologists reviewing all tests. The intention is to rationalise what has been a very disparate situation across the country. While there had been discussions on this over the last six years, the key work has occurred in the last year.

The Committee Chair noted that there is no intention to have a fixed schedule binding on the future. Tim Wood confirmed that part of the review is to look at the process for future changes to the schedule.

The report was received.

6. General Business

There was no general business.

7. Resolution to Exclude the Public (agenda page 126)

Resolution (Moved Robyn Northey/Seconded Jo Agnew)

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:

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Draft Plans	<p>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.</p> <p>[NZPH&D Act 2000 Schedule 3, S.32 (a)]</p>	<p>Obligation of Confidence</p> <p>(i) The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence.</p> <p>[Official Information Act 1982 S.9 (2) (ba)]</p> <p>Negotiations</p> <p>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.</p> <p>[Official Information Act 1982 S.9 (2) (j)]</p>

Carried

3.25p.m - 3.55p.m – public excluded session.

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

The meeting concluded at 3.55 p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA
DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY
COMMITTEES HELD ON 20 MARCH 2013

CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 22 April 2013

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 13/02/13	5.2	<u>Planning and Funding Update</u> - Update for CPHAC on progress with alignment of hospices in Waitemata DHB.	Tim Wood	CPHAC 01/05/13	Included in CPHAC Agenda – Item 4.1
CPHAC 20/03/13	4.1	<u>Sir Peter Gluckman’s Speech at launching of <i>Improving the Transition</i></u> – copy of transcript to be obtained for CPHAC members.	Paul Garbett		Actioned – e-mailed on 4 th April.
CPHAC 20/03/13	1.1 public excluded	<u>Whanau Ora</u> – progress update requested for next meeting	Marty Rogers/Andrew Coe		A detailed report on advancing Whanau Ora centres went to Waitemata DHB Board on 10 th April and is going to the Maori Health Gain Advisory Committee on 24 th April and the Auckland DHB Board on 15 th May.

3.1 Orientation of NGO Contracts to Support Health Targets and Better Public Health Services Targets

Recommendation:

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

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

Prepared by: Leanne Catchpole (Team Leader Health of Older People and Healthy Lifestyles, Waitemata DHB) and Kate Sladden (Acting Planning and Funding Manager, Health of Older People, Auckland DHB)

Glossary

ARPHS – Auckland Regional Public Health Service
DHB – District Health Board
NGO – Non Government Organisation

1. Purpose

The purpose of this paper is to seek the Boards' agreement to add smokefree and nutrition clauses to the terms and conditions of all contracts as they are entered into or varied.

2. Background

Waitemata and Auckland DHBs intend to link NGO contracts more closely to enhancing support for achieving Better Public Health Services targets and national health targets. In the first instance, the focus will be on the inclusion of smokefree and nutrition clauses in DHB contracts with NGO providers.

Smokefree

Tobacco smoking continues to be the single biggest cause of preventable sickness and death in New Zealand, in particular through its major contribution to cardiovascular disease (including heart disease and stroke), cancer (in particular lung cancer) and chronic obstructive pulmonary disease (COPD). Tobacco also impacts significantly on child health through its direct effects during pregnancy and indirect effects in childhood e.g. respiratory tract conditions and ear disease.

Health providers can all contribute to the government strategy to achieve *Smokefree Aoteroa 2025 – a smokefree future for our children*. Being role models for smokefree lifestyles in health organisations, is important and achievable, particularly through two distinctive measures – the creating and embedding of a comprehensive Smokefree Policy and ensuring that health professionals have the skills to support people to quit.

The Ministry of Health Tobacco Control contract with Waitemata and Auckland DHBs requires the DHBs to provide leadership related to tobacco control within the DHB area, which

may include “supporting all services contracted by the DHB to establish and/or maintain smokefree environments”.

The Waitemata DHB draft Annual Plan 2013-14 includes the following deliverable under ‘Better Help for Smokers to Quit’ section:

“The DHB will require all new/renewed NGO contracts to have a comprehensive Smokefree Policy by June 2014”.

All NGO mental health providers across the Auckland region had smokefree policy and training clauses added to their contracts in July 2012.

Nutrition

Food has a major influence on the population’s health. Poor nutrition is contributing to an increasing community burden of chronic disease, principally type 2 diabetes, coronary heart disease, stroke, as well as cancer. Key nutrition related risk factors for these diseases are sub-optimal body mass index (BMI), elevated total blood cholesterol, elevated systolic blood pressure and low vegetable and fruit intake. Approximately 40% of all deaths in New Zealand have been attributed to the joint effects of these risk factors whilst obesity alone accounts for 80% of preventable disease.ⁱ

In Auckland and Waitemata DHBs, 21% and 20% respectively of the population is obese with a disproportionate burden borne by Maori and Pacific people.ⁱⁱ

Auckland and Waitemata DHBs need to show high level leadership and use their influence and levers to support actions to improve population nutrition.

The addition of a nutrition clause in NGO contracts was an action within the Auckland and Waitemata DHBs’ Healthy Food Environment Policy’ paper endorsed by CPHAC at the November 2012 meeting.

3. Proposed Clauses

Smokefree

The Planning and Funding Teams are intending to add new clauses under the terms and conditions section of all contracts when initiated or varied. The first clause is to encourage contracted providers to provide smokefree environments for all patients, staff and visitors. A second clause is proposed that requires all registered health professionals to have completed basic training so they can support people to quit smoking. The recommended online training takes approximately 45 minutes to complete.

The proposed clauses are below:

1. The Provider is required to have a comprehensive Smokefree Policy from 30 June 2014 applying to all staff, patients/clients, families/whanau and visitors, facilities and vehicles. This is to ensure provision of a smokefree environment for all staff, patients, family/whanau and visitors. This policy must comply with the Smokefree Environments Act 1990 and its amendments, the Health and Safety in Employment Act 1992 and its amendments.
2. The provider is to ensure that all registered health professionals employed in this service have completed smokefree training, at a minimum the <https://smokingcessationabc.org.nz> online training.

All Waitemata providers (except mental health providers) with active contracts have been sent the proposed clauses and invited to provide feedback to the DHB by the end of April 2013. The Planning and Funding Team will review the feedback before finalising the clauses.

Auckland DHB is currently developing their process for implementing the smokefree clauses.

The DHBs have Smokefree staff that are able to assist organisations with development of their policies and provide advice if required. Sample policies and further information to assist providers will also be available through the web.

For Aged Related Residential Care (ARRC) contracts, the DHBs have been advised we are unable to add local clauses to the terms and conditions section of contracts. We will therefore seek to include the proposed clauses through the national review process in 2014. We will however offer to support ARRC providers that wish to revise their smokefree policies and/or provide training to their staff during the coming year.

Nutrition

A Working Group with representatives from Auckland DHB, Waitemata DHB Nutrition Services and ARPHS has been established to develop a nutrition clause and compile sample policies to assist NGO providers in this area. Implementation of this clause is likely to be a staged approach across the two DHBs. The intent of the clause will seek to limit energy dense low nutritional foods, beverages and excessive portion sizes.

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- i. ⁱ Ministry of Health and University of Auckland. *Nutrition and the Burden of Disease: New Zealand 1997-2011*. Wellington: Ministry of Health; 2003.
 - ii. ⁱⁱ Ministry of Health. *A Portrait of Health: Key results of the New Zealand Health Survey*. Wellington: Ministry of Health; 2008.

4.1 Palliative Care Services in the Waitemata District – Model of Care Update

Recommendation

That the report be received.

Prepared by: Sarmila Gray (Project Manager Planning and Funding, Waitemata DHB)

Glossary

CVD - Cardiovascular Disease
DHB - District Health Board
ELT - Executive Leadership Team
MOH - Ministry of Health
PHO - Primary Health Organisation

1. Executive Summary

The purpose of this information paper is to update the Waitemata DHB Community and Public Health Advisory Committee on 'The Development of a Model of Care for Palliative Care Services in the Waitemata district'. This progress report describes the background and context of this project, the activities undertaken so far and the potential risks and mitigation strategies.

The provision of palliative care services in the Waitemata district is complex and varied with a number of contracted and non-contracted providers using different models of care. This creates inequity of access and inconsistencies and fragmentation with service provision. Sustainability of specialist palliative care workforce to meet present and future needs is also a challenging issue. To ensure Waitemata residents have equitable access to high quality, integrated and effective palliative care services, a district-wide model of care is essential with a strong focus on robust clinical leadership and governance, better outcomes, and sustainability of workforce.

In the past there has been more than one attempt to develop a model of care without success, mainly due to the lack of a common vision amongst the stakeholders who grappled with their own priorities and challenges. Based on past experience as well as suggestions from the providers, it was unanimously agreed that an independent chair would be appointed to provide leadership and oversight to the project. This is to ensure all stakeholder views are considered and treated fairly and the focus remains on doing what is best for the patient. As a result, John Robertson (background - Appendix 1) was appointed as the independent Chair and commenced in this role as of 22 March 2013. Planning and Funding Waitemata DHB and the Hospices jointly undertook the recruitment process and the selection panel consisted of Group Manager - Planning and Funding, Waitemata DHB, CEO - Hospice North Shore and Chair - Hospice West Auckland.

Meetings have so far been held between the independent Chair and the Chairs and the CEOs of the three hospices, the PHO senior management and the Waitemata DHB's Hospital Palliative Care Team. There is consensus for a district wide model of care amongst the stakeholders. However, considering past history of strained relationships, significant challenges lie ahead.

This will require working through the different views and opinions and guiding the stakeholders to come to a consensus and, at times, agree to compromise along the way. Thus,

going forward, a slow but steady approach is being adopted to allow sufficient time for effective engagement and development of relationships based on trust. It is envisaged that a governance group will be formed within the next 6-8 weeks. The governance group, once formed, would decide the details of the working group(s) as appropriate.

In the mean time, a discussion paper is being developed to be tabled at the first governance meeting to facilitate structured discussion and objective decision making. The paper will present a gap analysis of the current service provision and suggest a process for developing a model of care and the proposed principles and make up of an integrated model based on literature review and local as well as overseas experiences. While engaging with stakeholders, potential candidates who could sit on the governance group are being identified. These are people who have the ability to look at the big picture at a district/regional/national level and plan for the future and are not constrained by organisational boundaries. Meetings with Planning and Funding Counties Manukau DHB and Auckland DHB, the combined Waitemata-Auckland DHB Maori Health Gain Team and relevant personnel at the Ministry of Health are scheduled in the near future to ensure the model of care being developed has regional consistency and is culturally appropriate and in line with national directions.

In essence, developing a standard model of care is a fairly challenging task as it requires bringing together a number of stakeholders with conflicting and, at times, competing priorities to come to a consensus. However, a sustainable future for palliative care in the Waitemata district can be achieved with robust governance and leadership to ensure stakeholders are engaged from the outset and trusting relationships are built and to guide them to work through their differences to reach an agreement for the greater benefit of the patients.

The project goal is to develop a consistent, integrated and coordinated model of care for palliative care services in order to ensure that the provision of palliative care within the Waitemata district is timely, high quality, equitable, efficient, and sustainable.

2. Introduction/Background

At present, palliative care services are provided within the Waitemata district by a range of contracted and non-contracted providers. The primary care teams, district nurses, community service providers and aged residential care staff provide generalist palliative care, whilst specialist palliative care is provided by Waitemata DHB Hospital Palliative Care Team as well as by the three hospices (North Shore Hospice, Hibiscus Hospice and Hospice West Auckland). With multiple providers using different models of care, service provision is neither consistent nor integrated creating fragmentation, inefficiency and inequity of access. In addition, the roles and responsibilities of the different providers across the palliative care continuum are not clearly delineated or agreed. There are also pressing issues with workforce sustainability - developing and retaining adequate palliative care capacity and capability to meet present and future needs.

The growing population and the changing demography to an increasingly elderly population are likely to be the most important sources of increased future palliative care needed in New Zealand. In addition, the ethnic and religious diversity of our society, people living alone or in residential care and overall socio-economic status all contribute to an increasing need for palliative care. Nationally by 2026, the number of adult patients who will benefit from palliative care is expected to increase by 23.5% while for children and young people the expected increase is 5%.¹ It is estimated that within the Waitemata district, the number of adults (20 years+) per year who would benefit from palliative care, would jump from estimated

¹ National Health Needs Assessment for Palliative Care. Phase 1 Report: Assessment of Palliative Care Need. June 2011

1,576 in 2006 to 2,174 in 2026 representing an increase of 37.9%. On the other hand, for children and young people (below 20 years of age), the corresponding increase is estimated to be 11% (from 27 in 2006 to 30 in 2007).

Alongside increasing demand, the palliative care user profile has also been changing locally and internationally. The future users are more likely to be older, non-cancer patients from different cultural backgrounds with multiple co-morbidities and complexities who choose to spend the last days of their lives at home where possible rather than in an institution. This will be further worsened by increasing health disparities. Thus, to provide high quality, equitable, cost-efficient and seamless palliative care services, an innovative district wide service delivery model will be required going forward. It is recognised that the principles of a future model will need to be in line with the national directions set by the Ministry of Health. Also regional consistency across the three DHBs in the Auckland region needs to be considered. The development of a new model will require a whole systems approach and effective collaboration and partnership between the various players within the sector led by a robust clinical governance and leadership framework.

3. Progress/Achievements/Activity

The following table presents the progress to date.

No	Activity	Status	When
1	Draft scoping paper developed and circulated for feedback	Completed	Nov 2012
2	Scoping paper finalised	Completed	Dec 2012
3	One on one engagement: WDHB CEO and Planning and Funding Group Manager with the Hospice CEOs and Chairs	Completed	Jan 2013
4	One on one engagement: Planning and Funding Group Manager with the PHO senior management	Completed	Jan 2012
5	One on one engagement: Planning and Funding Group Manager with the Waitemata DHB Palliative Care Team	Completed	Jan 2013
6	Engagement with the hospices to agree the recruitment process for the Independent Chair role	Completed	Feb 2013
7	Recruitment process jointly undertaken by WDHB and the hospices for the Independent Chair role	Completed	Feb - Mar 2013
8	Appointment made to the Independent Chair role	Completed	Mar 2013
9	Attended the Palliative Care Road show organised by the Ministry of Health	Completed	Mar 2013
10	Independent Chair met with the key stakeholders (hospices, PHOs, WDHB Hospital Palliative Care Team)	Completed	Mar-Apr 2013
11	Discussion paper for the governance group	In progress	May 2013
12	Wider and repeat stakeholder engagement	In progress	Ongoing

4. Risks/Issues

The risks and mitigation strategies related to developing a district wide model of care are presented below.

Risks	Implications	Likelihood	Impact	Mitigation
Lack of or limited stakeholder buy-in regarding the need for a district-wide standard model of care	Without a standard model of care Waitemata residents won't have equitable access to high quality, integrated and effective palliative care services. Limited ability to maintain sustainability of palliative care specialist workforce.	Medium	High	Robust leadership and governance framework. Engage and involve stakeholders from the outset to secure buy-in. Focus on developing a common vision. Build relationships based on trust and loyalty.
Stakeholders have conflicting priorities and agendas limited by organisational boundaries, unable to look at the district wide big picture.	Palliative care services within the Waitemata district is likely to remain varied, inequitable and fragmented. All Waitemata residents will not have access to best possible care within the resources available to us.	Medium	High	Apply independent perspective to best represent the interests of the stakeholders. Ensure all stakeholder views are considered without prejudice, and a consensus is reached that leads to the best possible outcome for the patients within the available resources.
Lack of partnership and teamwork amongst stakeholders	Lost opportunity for stakeholders to share learning and complement each other and strengthen the sector. Patients miss out on equitable care.	Medium	High	Robust leadership to facilitate a constructive and supportive working relationship amongst stakeholders with support from the WDHB Executive Leadership Team (ELT)
Inability to reach consensus despite having bought into the concept of a standard model	Non-aligned services across the district with gaps and overlaps. Resources not utilised in the most effective way across the district. Sustainability of specialist workforce compromised. Patients miss out on equitable service.	Medium	High	Strong leadership to guide the group to achieving mutually agreed measurable outcomes in a timely manner. Foster a realistic approach that certain internal changes might be necessary to develop and implement a consistent, coordinated and sustainable model.

Risks	Implications	Likelihood	Impact	Mitigation
Ineffective leadership	Project fails to deliver the agreed outcomes in a timely manner.	Low	High	Establish robust governance framework accountable to the Waitemata DHB ELT. Coherent, independent leadership and oversight. Ensure the group has authentic identity, intention and agenda.
Change in Waitemata DHB's overall strategic priority and structure.	Resources may need to be redirected to other priority areas leaving insufficient resource to complete this project appropriately	Low	High	The governance group with the ELT to provide leadership and guidance on how to adapt to the change in direction.
Change in the Ministry of Health direction regarding the future of palliative care in New Zealand	Rework will require additional resource if the model needs modifications	Low	High	The governance group and ELT to provide leadership and guidance on how to adapt to the change in direction.
Time/cost/resource constraints	Project delayed or incomplete	Low	High	Redistribute resource from other areas – decision to be made by the ELT.
ADHB-WDHB Bilateral Collaboration – services provided by the two DHBs are aligned	Lack of alignment and not in line with the collaboration principles	Low	Low	Auckland DHB to be kept informed of the project status and consulted as required.

5. Conclusion

Waitemata DHB is committed to ensuring timely access to high quality, equitable, cost-efficient and seamless palliative care services for its population. However, the provision of palliative care services within the Waitemata district is fragmented, varied and complex with a range of providers providing different levels of service, using different models of care that lack integration. Thus, developing and implementing a model of care that ensures palliative care services across the district are consistent, seamless and sustainable is fairly challenging. A robust governance and leadership framework is required to engage with stakeholders from the outset, build trusting relationships and guide them to work through their differences to reach a consensus for the greater benefit of the Waitemata patients.

Appendix One

John Robertson is a Chartered Accountant and holds a MBA from the University of Washington. An accredited member of NZ Institute of Directors, John brings a wealth of executive management and governance experience gained over the last thirty years with a range of public as well as private enterprises in New Zealand and overseas. Some of John's previous governance roles were with Dental Council of NZ, Council of the Electricity and Gas Complaints Commission, Infrastructure Auckland, Sealegs Corporation, Iddison Vietnam Ltd, Zealous International Incorporated to name a few.

Over the years John has held governance roles with several charitable organisations including South Auckland Hospice and Pacific Foundation for Education and Health. In the 1990s John chaired two Select Committees - Foreign Affairs and Defence, and State Enterprises. He was also the chair of Auckland Mayoral Forum. During 2008-09 John as the Dean of the Faculty of Business, Manukau Institute of Technology led the transition of Schools to a Faculty. Currently John holds multiple chair roles with Kaipara District Council, Auckland Museum, MOTAT and Fishpond Ltd and, is a board member with Regional Facilities Auckland.

In 2008 John was awarded the Companion of Queen's Order in recognition of public services as well services to local body affairs. He was also a Member of Parliament as well as the Mayor of Papakura District Council.

4.2 The International Residential Assessment Instrument- InterRAI Long Term Care Facility Tool Update

Recommendation:

That the report be received.

Prepared by: Katrina Lenzie-Smith (Health of Older People Programme Manager, Waitemata DHB)
Endorsed by: Tim Wood (NGO Planning and Funding Manager, Waitemata DHB) and Denis Jury
(Chief Planning and Funding Officer, Auckland DHB)

Glossary

ARRC	- Age Related Residential Care
DHB	- District Health Board
iLTCF	- interRAI, Long Term Care Facility assessment tool
interRAI	- A suite of assessment tools for older people
RN	- Registered Nurse
TAS	- Technical Advisory Services

1. Executive Summary

This report provides an update on matters relating to the Ministerial mandate to accelerate the roll-out of the International Residential Assessment Instrument (InterRAI), Long Term Care Facility Tool (iLTCF) into Age Related Residential Care (ARRC) by June 2014. A detailed report will be submitted to the Auckland and Waitemata DHB Boards on 15 and 22 May 2013.

InterRAI was developed by an international collaborative network of researchers in over 30 countries committed to improving health care for people who are elderly, frail, or disabled. It provides a standardised mechanism for assessing older people. The goal of the interRAI collaborative is to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high quality data about the characteristics and outcomes of people served across a variety of health and social services settings.

Where those countries have successfully implemented interRAI, the instruments provide confident, reliable and valid data from multiple settings enabling cross-sector and cross-national comparisons for developing effective strategies to respond to global challenges related to population aging, complex care, and the expansion of disability¹.

2. Training and Funding

The implementation of interRAI Long Term Care Facility (iLTCF) Assessment training is nationally managed, with the 20 DHBs funding the implementation costs. In 2011, the total cost of interRAI training in ARRC was estimated to be \$10.8m. The \$10.8 million was levied on DHBs by the National Arm of Central TAS on a Population

¹, Hirdes JP, Ljunggren G., Morris JN, Frijters DHM, Soveri HF, Gray L, Bjorkgren M, and Gilgen R. Reliability of the interRAI suite of assessment instruments: a 12-country study of an integrated health information system *BMC Health Services Research* 2008, 8:277.

Based Formula basis over the four years. These costs included software licensing, hardware, hosting fees, maintenance, training, implementation support, and project management. In 2012, the 20 DHB Chief Executive Officers approved additional funding to support the accelerated rollout which reduced from five years to four years.

InterRAI iLTCF training is free, however every ARRC facility is required to release each Registered Nurse (RN) trainee for 50-55 hrs to achieve competency. Each ARRC facility, irrespective of size, can apply to the National interRAI project team for a laptop to undertake the interRAI iLTCF training, with the laptop remaining with the ARRC facility post training.

The training schedule for interRAI iLTCF is managed and delivered by the national interRAI project team at a regional and local level. Each cohort averages eight trainees alongside one interRAI trainer, over a 12 week period. Approximately 80% of trainees reach competency.

The revised project plan noted that there were 673 certified ARRC facilities in New Zealand, with an estimated 2,000 plus RNs needing interRAI training. This excluded facility managers, nurse managers and enrolled nurses.

Collectively, there are 123 certified ARRC facilities in Auckland and Waitemata DHBs. The total number of RNs either engaged in training, or trained in the interRAI iLTCF in ARRC facilities across Waitemata and Auckland DHB, is 31/123.

At April 2013, there were less than 150 Registered Nurses in 100 ARRC facilities throughout New Zealand, trained and competent to use the interRAI. Therefore, across New Zealand, the up-take of interRAI iLTCF training ranges from 10 to 25% - for Auckland and Waitemata DHBs, this is currently at the upper range of 25%.

3. Software Hosting

In 2011, the National Health IT Board on behalf of DHBs, entered into an agreement with Momentum Healthcare Ltd to supply the software to deliver a system to the required functional specifications. The selection of Momentum enabled the software to be delivered using the infrastructure developed as part of the National DHB interRAI Implementation Project (2008-2012). The software is delivered via two 'host' DHBs: Canterbury and Taranaki DHBs, who collaborate to create a single virtual host service to manage the interRAI software on behalf of users. Canterbury DHB is the host for the DHBs in the Northern Region.

Both 'hosting' and systems performance have created delays in assessment data entry. These have been related to range of technical IT issues such as portable devices, browser versions, port and WI-FI viability, and band width of the connection to the system. These issues can be compounded if an ARRC facility is 'stand alone' and computer competence is limited.

There is also likely to be an under reporting of Momentum performance issues as these are perceived to be part of the interRAI package. Issues such as screens freezing, data disappearing, assessment data being locked and the system timing out, are some of the issues thought to be under reported.

The National Project team has suggested that DHBs take a collegiate approach with their interRAI Lead Practitioners and Systems Clinicians in the roll out of interRAI in ARRC. This creates additional pressure on the DHBs and discreetly moves the technical expertise issues to the DHBs.

4. Issues and Risks

The risks associated with the implementation of interRAI iLTCF have been formally raised with DHB Shared Services and the National interRAI Project Team. These include:

- Throughout New Zealand, less than 150 RNs are competent in the use of interRAI iLTCF. Auckland and Waitemata DHBs' District Annual Plan requires 100% of ARRC facilities using or training their nurses to use the interRAI iLTCF by 30 June 2014. This will be a major challenge due to the small number of interRAI trainees currently recruited (note: trainees are currently recruited by the national project team)
- Both 'hosting' and systems performance have created delays in assessment data entry. These have been related to range of technical IT issues such as portable devices, browser versions, port and WI-FI viability, and band width of the connection to the system
- Ongoing national and local technical, host and system performance issues are precluding ARRC providers from signing up to interRAI iLTCF training
- Local data management solutions to share interRAI data at the clinical and strategic levels are yet to be established across our DHBs
- The time to complete an interRAI assessment varies from DHB to DHB. One of the factors impacting on this time is technical expertise and IT solutions
- One Laptop per facility means that a facility with 120 beds is dependent on one Registered Nurse undertaking an interRAI iLTCF on each resident in the facility
- DHBs have no means or mechanism to ensure compliance of the 123 ARRC in Auckland and Waitemata DHBs, yet the DHBs are accountable for compliance
- Post June 2015, ongoing costs to support business as usual arrangement are yet to be formalised by the national interRAI Project Teams, DHBs, and the ARRC sector.

5. Mitigation

We will continue to raise concerns with the national project team while simultaneously working with them to mitigate and solve risks in preparation for eventual handover. Specific mitigation strategies at this point are:

- Monthly meetings with the national project team
- Seeking reassurance from the national interRAI project team that the revised project plan represents good value for money and that there will be no further budget blow-out necessitating increased DHB expenditure
- Coordination and liaison around interRAI is occurring across the four DHBs in the Northern Region to reduce duplication and effort
- Promoting interRAI to the ARRC sector at every opportunity to increase uptake
- The Health of Older People Clinical Network Group has identified interRAI as one of its five major work streams in the Regional Health Plan for 2013/14 and is likely to provide a regional governance role.

6. Conclusion

Waitemata and Auckland DHBs are committed to working with the national interRAI Project team and wish to support the National Team in the roll-out of interRAI into our 123 ARRC facilities. This will be discussed in more detail in the Auckland and Waitemata DHB Board paper on 15 and 22 May 2013.

5.1 Planning and Funding Update

Recommendation:

That the report be received.

Prepared by: Denis Jury (Chief Planning and Funding Officer Auckland DHB), Debbie Holdsworth (Chief Planning and Funding Officer Waitemata DHB), Julie Helean (Manager Planning and Service Development Auckland DHB), Janine Pratt (Group Planning Manager Waitemata DHB), Marty Rogers (Joint Maori Health Gain Manager), Andrew Coe (Joint Integrated Primary Care Manager), Tim Wood (Group Funding Manager Waitemata DHB) and Cliff La Grange (Group Finance Manager Waitemata DHB)

Glossary

CVD – Cardiovascular Disease
DHB - District Health Board
MOH – Ministry of Health
NGO – Non Government Organisation
PHO – Primary Health Organisation
MHG – Maori Health Gain
MOU – Memorandum of Understanding

1. Summary

This report updates the Committees on Auckland and Waitemata DHBs' Planning and Funding activity.

2. Summary of activities in common

2.1 Planning

Annual Plans for 2013-14 were submitted to the National Health Board on 22 March. The draft plans will now be reviewed with formal feedback due on 3 May. The deadline for submitting final plans is 17 May. Final sign-off of the revised Annual Plans will be via the May meetings of the Board.

2.2 Primary Care

The focus for the integrated primary care team for this reporting period has been on planning for next year, the achievement of health targets and locality planning. We have continued to work collaboratively with all the PHOs across Auckland and Waitemata DHBs' catchments on key issues identified for the planning workshops with a particular focus on late Ministry of Health Advice with regards to specific primary care and integration expectations. We are confident that we will receive formal endorsement of our final plan from all of our primary care partners.

Health Target Performance

It has been acknowledged that the current aggregate DHB performance against primary care health targets is unacceptable and needs to be addressed. All of our PHO Executives and their Boards have endorsed the specific measures and associated targets for both 2012/ 2013 and 2013/2014; our focus has been on achieving the CVD targets by year end. PHOs have

produced individual plans to ensure that they meet the targets and weekly performance monitoring is in place.

Locality Development

Planned activity via our locality approach continues with the first locality establishment governance group having taken place. General agreement has been reached with regards to the direction of travel and actions based on the meeting are now underway. A proposed approach detailing the implementation of Whanau Ora centres across Auckland and Waitemata has been submitted to both the Auckland and Waitemata Boards. It has been suggested that this approach is aligned with the Locality work.

After Hours Network

The current arrangements for the Auckland Regional After Hours Network expire 30 June 2013. Commitment to continue funding for the next 12 months is being sought from the three metro Auckland DHBs. Auckland DHB has confirmed their funding which is contingent on ongoing funding from both the PHOs and the Ministry. The paper is being considered by the Waitemata DHB Audit and Finance Committee on 1 May 2013.

There is an agreement the longer term direction of travel is aligning after hours response with our localities. The next 12 months provides a transition period for locality options to be further developed. It also provides the opportunity to better understand the relationship between the A&M data and ED activity as there is currently insufficient data to draw any real conclusions as to the impact of subsidised after hours care. The University of Auckland evaluation will also be completed and available to inform future decision making.

PHO Agreement

The DHBs and MOH are in the process of negotiating a new PHO Agreement (Version 1). The existing contract expires 30 June 2013. The national GMs have agreed that the current PHO Agreement should be extended to the end of September 2013 to allow time for the negotiations to conclude and for the appropriate DHB ratifications to be put in place for the new Agreement. The MOH have taken this feedback on board and are going to consider the request.

2.3 Maori Health Gain

Collaboration is well and truly behind us with the team focussing on the Annual Plan and Maori Health Plan developments, MOU relationships, the development of a Whanau Ora – Policy framework, supporting PHOs to deliver against Maori Health targets, influencing strategic developments across both DHBs, contract reviews and a range of projects to support and enhance services achievement and contribution to Maori Health Gain. These projects include:

Clinical Governance

In order to support the growing Maori clinical team, a clinical governance structure is currently being developed. The key objectives of the roopu will be:

- The provision of the highest quality of care to Māori patients and whānau
- The provision of best practice for Māori patients and whānau – including the implementation of the Tikanga Best Practice guideline (TBPG)
- Early identification of issues that may be affecting clinical and/or Māori best practice and actions to address these
- To provide support for growth and development of Maori specific clinical roles.

Cervical Cancer

A pilot project is underway to remove the ethnicity data disparities between the NHI register, PHO register and the NCSP register. It is expected that this project will show an increase in screening participation. All PHOs in the Waitemata region are supporting this work by either

allowing access to the information (contact details) within their practices or carrying out the work themselves. It is hoped that once this work has been completed in Waitemata, the same process can be rolled out to the Auckland DHB practices. Running alongside the roll-out of this project, will be an evaluation process to ensure learning ‘opportunities’ for change in approach at every step of the process.

Locality Planning – Primary Care

This is a large piece of work that is being carried out in Primary Care which is leading to the development of Integrated Family Health Centres. Participation in the planning activities has been shared amongst the MHG team and the MOU partners, with Waipareira participating in the West developments, Ngati Whatua in the North and the MHG team in the central developments. Part of the locality planning process has been to ensure sound engagement with local communities. In discussions with the MOU partners, it has been decided that rather than try and get Maori whanau to participate in “Healthlinks forums”, a locality based “Whanau Ora” forum will be facilitated. These forums will include providers from across the health and social sector and whanau.

3. Waitemata DHB Update

3.1 Funder Finance

The March 2013 consolidated core result for the Waitemata Funder was \$2.4M favourable to budget for the month and \$8.1M favourable to budget for the year to date.

Funder NGOs

The March 2013 core result for Funder NGO was \$1.0M favourable to budget for the month and \$4.3M favourable to budget for the year to date.

The year to date favourable position includes an upside of \$2.1M relative to PHO First Contact Capitation Services (payments based on number of PHO enrolees) and PHO Fee for Service deductions receivable. As previously reported, this position takes into consideration any offsetting variances in IDF caused by changes in General Practice memberships between ProCare PHO (hosted by Auckland DHB) and Waitemata PHO.

The year to date favourable position also includes various other lesser value upside variances across Health of Older Persons Services (\$653k), Mental Health Services (\$575k) and Primary Care Demand Services (\$1.0M). Primary Care Demand Services is a grouping of expenditure relating to General Medical Subsidies, Practice Nurse Subsidies, Rural Bonus and Immunisation. However, as previously noted, while Health of Older Persons is in aggregate marginally favourable, there continues to be strong demand growth across Private Hospital Services, Dementia Services and Home Based Support Services.

Community Pharmacy now reflects a break even position although there is still uncertainty and risk relating to the impact of the national strategy changes that are occurring concurrently within Community Pharmacy Services. These changes are as previously reported. The reduced level of monthly expenditure is promising, although there is always the opportunity for additional expenditure coming through as retrospective adjustments to historical claims.

Funder IDFs

The March 2013 core result for Funder IDF was \$1.3M favourable to budget for the month and \$3.8M favourable to budget for the year to date. The main factor contributing to the favourable result continues to be the net positive year to date inpatient wash-up position receivable in the most part through the MOH default wash-up process. This is mostly

reflective of lower acute utilisation of Waitemata domiciled patients at Auckland DHB facilities.

4. Auckland DHB Update

4.1 Patients and Family as Partners in Care: Upgrading Family Amenities

Most of the family and whanau rooms and amenities in our facilities are in poor condition and we do not have enough of them. As part of Auckland DHB becoming more patient and family centred, the A+ Trust has agreed to fund the upgrade of existing facilities and create new ones. The cost of this is likely to be \$150k.

4.2 Oral Health

Fourteen fixed clinics, consisting of one existing clinic refurbishment and thirteen new fixed clinics are now complete and operational.

The official opening of the May Road clinic on 5 April was well attended by Auckland DHB staff, ARDS staff, Local MP (Phil Goff), May Road School staff and children and guests. Additional changes to the May Road car park have been requested by the project team to allow better access to the car park and better turning circles for dental vans. These final changes are scheduled for end of April 2013.

The opening of the Greenlane clinic will be held on 19 April. This will mark the completion of all the dental clinics under the Oral Health Business Case.

4.3 Rheumatic Fever

The Ministry of Health has requested that Auckland DHB focuses on establishing a school-based throat swabbing programme in the first instance. It is possible that funding for a programme to address the wider upstream determinants of Rheumatic Fever, in particular housing, will be included in Budget 2013. Planning for a phased implementation of a throat swabbing programme in 15 identified schools across Auckland DHB is underway and a Business Case for funding (\$575,000 2013/14) will be presented to the Ministry in mid April.

4.4 Mental Health Child & Youth Work Stream

Work continues to progress well. The comprehensive stock take of services across a range of health and non-health providers has now been completed and mapped. Consultations are close to completion. Work has started on identifying a possible structure for multiple interventions that are self-directed by the consumer. The expectation is that the work-stream will require significant changes across multiple providers to produce better wraparound services for vulnerable children and youth.

4.5 Funder Finance

For the month of March 2012, the funding accounts show a deficit of \$2.3m compared to a budget deficit of \$4.0m, a favourable variance of \$1.7m. YTD the actual surplus is \$18.1m compared to a budgeted surplus of \$9.1m, a favourable variance of \$9.1m. The YTD variance is split between a favourable variance for the “funder” of \$14.2m combined with “provider” unfavourable variance of \$3.3m.

The main features of the YTD result are a favourable budget variance in Personal Health and Med/Surg of \$11.4m, Mental Health favourable to budget by \$0.7k, Health of Older Peoples favourable to budget by \$2.1k and an unfavourable variance of \$3.3m in Provider services.

7. Resolution to Exclude the Public

Recommendation:

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:

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
<p>1. Minutes of the Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting with Public Excluded 20/03/13</p>	<p>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.</p> <p>[NZPH&D Act 2000 Schedule 3, S.32 (a)]</p>	<p>Confirmation of Minutes</p> <p>As per resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.</p>
<p>2. Presentation – Future Development</p>	<p>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.</p> <p>[NZPH&D Act 2000 Schedule 3, S.32 (a)]</p>	<p>Commercial Activities</p> <p>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</p> <p>[Official Information Act 1982 S.9 (2) (i)]</p> <p>Negotiations</p> <p>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.</p> <p>[Official Information Act 1982 S.9 (2) (j)]</p>
<p>3. Capitation Funding</p>	<p>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.</p> <p>[NZPH&D Act 2000 Schedule 3, S.32 (a)]</p>	<p>Commercial Activities</p> <p>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</p> <p>[Official Information Act 1982 S.9 (2) (i)]</p>