



Community and Public Health Advisory Committee Meeting

Wednesday 15 September 2010

2:00pm

**Marie Hosking Room
Level 7, Building 14
Greenlane Clinical Centre
Epsom**

*Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare*



Community and Public Health Advisory Committee For discussion with Board

CPHAC Meeting Date:	
Feedback By:	
DAP	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
KPIs	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
RISKS	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
3.	

KARAKIA

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.

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An “interest” can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction.
- Having a financial interest in another party to a transaction.
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it.
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction.
- Being otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.

Ensure the full nature of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legislation.govt.nz) and “Managing Conflicts of Interest – Guidance for Public Entities” (www.oag.govt.nz).

ADHB BOARD INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Pat SNEDDEN (Chair)	1. Ngati Whatua o Orakei Maori Trust Board	Consultant	Hourly consulting rate	Member of Treaty Negotiation Team in respect of Claim 388 register with Waitangi Tribunal Wholesale supplier of water and waste water services to the Auckland region Has a joint multi-million Healthy Housing programme with Health Board Investigating a comprehensive cross agency intervention related to the Tamaki area including ADHB Oversees implementation of quality programmes in DHB nationwide Crown Negotiator Ngati Kahu Treaty of Waitangi Claim Crown Negotiator Muriwhenua Treaty of Waitangi Claim	3 September 2008
	2. Watercare Services Limited	Director	Fee		
	3. Housing New Zealand	Chair	Fee		
	4. Tamaki Establishment Board	Chair	Fee via HNZC		
	5. Quality Improvement Committee	Chair	Fee		
	6. Chief Crown Negotiator Ngati Kahu Claim	Consultant	Fee		
	7. Chief Crown Negotiator Muriwhenua Forum	Consultant	Fee		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Harry BURKHARDT (Deputy Chair)	1. Replas Ltd	Managing Director and shareholder	Salary	Plastics Manufacturing Company	6 April 2010
	2. Matta Products Ltd	Director and shareholder.		Plastics Manufacturing Company	
	3. Remat Ltd	Director and shareholder		Plastics Manufacturing Holding Company	
	4. Matt I Ltd	Shareholder/Director		Plastics Manufacturing Holding Company	
	5. Matta LLC	Trustee		Plastics Distribution Company USA	
	6. New Zealand Maori Arts and Craft Institute	Chairman	Honorarium	Government owned Maori Tourist operation	
	7. Auckland District Health Board	Deputy Chair, Chair Finance Committee			
	8. ADHB Charitable Trust	Trustee			
	9. Ngati Kuri Trust Board	Deputy Chairman and Treaty Negotiator			
	10. Packaging Council of New Zealand	Executive Member			
	11. Ngati Whatua o Orakei Health Clinic Ltd	Chairman			
Jo AGNEW	1. Senior Lecturer Nursing Auckland University		Salary		21 April 2010
	2. Casual Staff Nurse ADHB		Salary		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board	Self-employed Professional Conduct Committee member Professional Conduct Committee member	Fees Hourly fee Hourly fee	Writer, editor and public relations services Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes Lay member of PCC to assess complaints and determine outcomes	7 August 2009
Dr Chris CHAMBERS	1. Employee, Auckland District Health Board 2. Wife employed by Safekids 3. Associate, Epsom Anaesthetic Group 4. Member, ASMS 5. Shareholder, Ormiston Surgical 6. Surveyor Quality Healthcare NZ				7 July 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	21 April 2010
	2. New Zealand Research Centre for Growth and Development	Board Member	Fee (to Ngati Hine Health Trust)	Governs a leading health sciences research centre	
	3. James Henare Research Centre, University of Auckland	Advisory Board Member	Fee (to Ngati Hine Health Trust)	Advises U o A on Maori research in Northland	
	4. Manaia PHO, Whangarei	Shareholder	Fee (to Ngati Hine Health Trust)	Governs a Whangarei based PHO	
	5. Whanau Ora Task Force	Member	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	6. National Health Board	Member	Fee		
	7. Chair Whanau Ora Governance Group				
Dr Brian FERGUS	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				29 June 2010
	2. Northern (AK) Regional Ethics Committee	Chair	Fee		
Dr Ian SCOTT	1. Shareholder Chair Auckland PHO	Chair	Meeting fee		1 September 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Bob TIZARD	1. Nil				27 February 2008
Seiuli Dr Juliet WALKER	1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure	Self employed contractor	Contract hourly rate	General practitioner services	16 August 2010
	2. Member, National Breast Screening Advisory Committee	Member	Fee	Consultant Pacific Advisor	
	3. Facilitator, RNZCGP General Practice Education Programme Stage II	Contractor	Contracted monthly fee	Educational Support and Training	
	4. ADHB Employee: contracted roster Doctor for Pohutukawa	Contractor	Hourly rate	Forensic sexual assault examinations	
	5. Panel Member, Medical Appeal Board, Work and Income		Fee		
	6. Bader Drive Healthcare	Programme Facilitator	Fee	Clinical Training Support	
Ian WARD	1. Chair, Advisory Board, Healthvision Limited		Fee		3 February 2010
	2. Principal/Director C -4 Consulting Limited			Tender to National Shared Services	

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rev Alfred NGARO	1. 4pm Group Ltd	Consultant	Salary	Community Development Pacific Advisory for ADHB PHAC representative Representative from Family and Community Services national advisory group Development and implementation of a comprehensive social intervention logic for supporting families nationally Development of Auckland Safer City plans Chair management committee for cluster of 13 schools in management improvement initiative Disciplinary and property Committee NGO delivering social services within the Tamaki area	11 May 2009
	2. Pacific Advisory Committee, PHAC	Chair	Fee		
	3. National Task Force for Family Violence MSD	Member	Fee		
	4. Family and Community Services national advisory group	Task Force member	Fee		
	5. Auckland Safer Communities	Advisory Member			
	6. Tamaki Achievement Pathways Schooling improvement	Executive member	Voluntary		
	7. Tamaki College Board of Trustees	Chair	Voluntary		
	8. Tamaki Community Development Trust	Elected Trustee	Fee		
Farida SULTANA	1. Nil	Member	Voluntary		6 August 2008

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lynda WILLIAMS	1. Maternity Services Consumer Council 2. Auckland Women's Health Council 3. Member National Antenatal HIV Screening Implementation Advisory Group 4. Chair Postnatal Distress Support Network Trust Board 5. ADHB Primary Maternity Services Steering Committee	Employee Employee	Salary Salary		4 August 2008
Iain MARTIN	1. University of Auckland 2. Chair Peri-Operative Mortality Review Committee	Employee	Salary		5 May 2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Anne KOLBE	1. Private Paediatric Surgical Practice 2. Employee Communitio NZ 3. Siggins Miller, Australia 4. Head, Auckland Clinical School, School of Medicine, University of Auckland 5. Husband: Employee University of Auckland 6. Risk and Audit Committee Whanganui District Health Board 7. Pharmac Board 8. South Island Neurosurgical Services Expert Panel	Director Senior Consultant Senior Consultant Employee Member Member Chair	Joint Owner Contractor Contractor Salary Fee Fee Fee		4 August 2010

CONFIRMATION OF MINUTES
- WEDNESDAY 21 JULY 2010

Community and Public Health Advisory Committee Minutes

MEETING DETAILS											
Time and Date	2:00pm, Wednesday, 21 July 2010										
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom										
2	ATTENDANCE AND APOLOGIES										
	<p>The Chair declared the meeting open at 2.05 pm.</p> <p>Committee Members</p> <table> <tr> <td>Dr Brian Fergus (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Harry Burkhardt</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Pat Snedden</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Seiuli Dr Juliet Walker</td> </tr> <tr> <td>Ian Ward</td> <td>Lynda Williams</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Taima Campbell – Executive Director Nursing Hilda Fa’asalele – General Manager Pacific Health Janice Mueller – Director Allied Health Dr Celia Palmer - Director of Population Health and Primary Care Aroha Haggie – Maori Health Gains Manager Mazin Ghafel – Epidemiologist Ian Bell – Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Chris Chambers and Rob Cooper.</p>	Dr Brian Fergus (Chair)	Jo Agnew	Susan Buckland	Harry Burkhardt	Dr Ian Scott	Pat Snedden	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	Lynda Williams
Dr Brian Fergus (Chair)	Jo Agnew										
Susan Buckland	Harry Burkhardt										
Dr Ian Scott	Pat Snedden										
Rt Hon Bob Tizard	Seiuli Dr Juliet Walker										
Ian Ward	Lynda Williams										
3	CONFLICTS OF INTEREST										
	There were no declarations of conflicts of interest with any item on the agenda.										
4	CONFIRMATION OF MINUTES 16 JUNE 2010										
	<p>The 8 DAP projects had been developed under the GAIHN umbrella but should be regional.</p> <p>The data on termination rates were over 12 months so was the number of people having terminations. Dr Helen Gemmel had presented to the Pacific Health Advisory Committee confirming the rates and expressing her personal view on the high rates in New Zealand. She would be presenting to the Maori Health Advisory Committee. A big picture view needed to be taken including teenage pregnancies, sexual education and community awareness. New Zealand had the second highest termination rate in the world. There had been a good discussion on education, the dearth of research and more analysis required and communication with the community. ADHB provided a regional service. It was suggested that community leaders be invited to a forum to explain the dilemma facing ADHB to involve the community as part of the solution. This was supported.</p>										

	<p><u>Moved Ian Scott; seconded Pat Snedden</u></p> <p><i>That the minutes of the Community and Public Health Advisory Committee meeting held on 16 June 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
5	ACTION POINTS 16 JUNE 2010
	<p>Asian Health</p> <p>A date for the Hon Pansy Wong coming to a meeting has not been determined.</p>
6.1	Planning and Funding Summary Report
	<p>The MoH had advised on consultation on the Strategic Plan with a move to a Regional Strategic Plan and District Annual Plan in response to that regional plan. This year's DAP and Statement of Intent were not signed but as drafts had been in the public domain.</p> <p>Immunisation rates had reached 87% with the target being 85%.</p> <p>The Regional Eating Disorder Service was now in place.</p> <p>The Auckland Regional Public Health Service had been through a significant restructuring and achieved a reduced cost structure. There was a surplus year end and the budget forward is breakeven.</p> <p>The Board had resolved, in relation to PHOs, a locality approach reinforcing the Primary Care Plan and Celia Palmer was providing a paper on what that could look like with agreement regionally to the DHB approach. Initial discussions with Procure were positive. GAIHN was struggling with what the alliance meant and resistance in the group to allocating funding through a pool. They are in the process of appointing a Chair. They should be able to deliver on the 8 projects and the DHBs were getting in a position to contract using the concept of a host DHB i.e. Counties Manukau as host DHB for Alliance+ and ADHB for the Maori Collaboration.</p> <p>The organisation has broken even and Funding was as expected with a degree of over expenditure in PHOs and pharmacy although mental health is in a healthy position with a surplus. Overall it was a good position. The under funding of mental health was met through vacancies.</p> <p>Access to Diagnostics was being piloted in 6-7 practices with the appropriate software.</p>
6.2	Planning and Funding Indicators Exception Report
	<p>There were no payments being made against unsigned contracts.</p> <p>The outstanding risks on audit issues from NGO audits with a lot of mental health audits being done at the same time would have resolved 70% by the end of July with the rest by mid August. Healthy Housing was in conjunction with Housing New Zealand Corporation and Counties Manukau and was very successful reaching the target.</p> <p>The number of emergency investigations on hazardous substances and new organisms had increased and ARPHS would be asked whether there was a need or concern or any changes in definition.</p> <p>B4 School Checks would not reach the target being 65% for quintile 5. The MoH had been asked not to claw funding back which could be used to transition the service to primary care.</p>
9.1	Enhancing Diabetes Outcomes and Health Targets
	<p>Dr Paul Drury, Clinical Director, Diabetes and Barbara Stevens, Auckland PHO presented to the Committee.</p> <p>Diabetes is a global issue and through migration was in distinctive populations. The estimates of people with diabetes and pre-diabetic were increasing with in 2008/09 a year on year increase of 14.6%. Prevalence rates by age and ethnicity showed high rates for Pacific and Indian followed by Maori, with in the Indian community 5% in their late 30s. Hospitalisations with diabetes as prime</p>

diagnosis had doubled over 8 year. The Diabetes Centre at Greenlane Clinical Centre only undertakes a small part of the diabetes work. Diabetes matters as it is commonest cause of renal failure in New Zealand, especially with non Europeans, is the commonest cause for amputations accounting for approximately 15%, commonest cause of blindness over 65 and doubles the chance of a heart attach/stroke/heart failure.

The diabetes Get Checked started in 2000 and is an audit tool to review and manage diabetes in primary care. Practice results are sent to PHOs but there is no feedback to GPs but generally GPs are managing their patients. Once a person gets into Get Checked the pathway outcomes are quite good. Problems and issues were the inadequate capacity in primary and secondary care for the volumes, inadequate performance in patient data, workload and competency issues in primary and secondary care and reaching and involving Maori, Pacific, Asian and high deprivation populations. Proposed solutions were coordinators taking a locality approach and across the primary/secondary interface sharing best practice in the development and implementation of clinical pathways.

The Committee thanked the presenters and asked that the recommendation 3 be reviewed as it was considered to low.

Pat Snedden left the meeting at 3:45pm.

Moved Ian Scott: seconded Jo Agnew

That the Community and Public Health Advisory Committee recommends to the Board that to enhance diabetes health and outcomes that they:

1. *Fund 3.0 FTE LTC diabetes Coordinators for 24 months and review (est. \$540,000.00 over two years)*
2. *Fund \$500/annum towards population analysis tool annual license for 24 months (\$123,000.00 (over 2 years)).*
3. *Fund diabetes clinical care pathway coordinator for 18 months (est. \$50,000.00)*
4. *Fund a contribution of \$35,000 to support the review and linkage of the existing data collection forms in primary care.*
5. *Fund \$15,000 for consumer representation and input in care pathway development for 18 months then assess ongoing support requirements.*

Total requested: Year 1: \$411,500 Year 2: \$351,500

Carried

The Committee thanked the presenters.

7.1 DAP Projects Report

The report was noted.

8 FEEDBACK FROM THE COMMITTEES

Maori Health Advisory Committee

The Committee had discussed diabetes and regional governance. They have requested a report on *shine involved in the Hohourongo programme and had considered the Ngati Whatua response to regionalisation.

Pacific Health Advisory Committee

There had been discussion on termination rates with a presentation by the Service, had received a presentation on health careers pathway for Tamaki Transformation Project which was endorsed and noted the recent media publicity on HVAZ noting that other DHBs and organisations were enquiring about the programme.

9.2	Tamaki Transformation Project – Pathways to Health Careers (P2HC)
	<p>The presentation explained the structure with employment a key component with P2HC seeking to train and employ 300 health professionals by 2015. Training usually took three years but as some would be part time may take 5 years. The project was to provide employment and improve and transform individuals with the programme principles being learner centred with community involvement.</p> <p>Pat Snedden returned to the meeting at 4:10pm.</p> <p>There was strong community engagement and Margaret Ngapera gave the Committee an insight into the communities' input and enthusiasm. The programme was centred on wrap around support which will include pastoral care and child care as necessary. Pat Snedden as Chair of the Tamaki Transformation Project noted the significance of the project within the greater transformation project and Workforce New Zealand, Des Gorman and the National Health Board, Rob Cooper were extremely supportive.</p>
9.3	Presentation on Alliance Contracting
	This item was deferred.
	NEXT MEETING
	<p>The meeting closed at 4.30 pm</p> <p>The next meeting will be part of the Board Planning Day on Wednesday, 18 August 2010</p> <p>The next scheduled meeting is for 2:00pm, Wednesday, 15 September 2010 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Epsom</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	

ACTION POINTS

- WEDNESDAY 21 JULY 2010

**Community and Public Health Advisory Committee
Action Points from the meeting on Wednesday 21 July 2010**

Item	Detail	Designated	Action
Carried forward	Pansy Wong would be attending a meeting to discuss issues of Asian health. .	Denis Jury	To be advised
Carried forward	A paper on strategies for children to be provided	Denis Jury	October
Carried forward	Presentation on Alliance Contracting	Denis Jury	15 September 2010
Carried forward	Analysis and interpretation of data on contraception, terminations, teenage pregnancies and sexual health particularly for high needs populations	Denis Jury	Ongoing
4	Forum with community leaders to present and discuss the dilemma of termination rates seeking community discussion and involvement to seek solutions	Denis Jury	Part of Pacific Community engagement initiative. First forum planned by year end 2010.

PLANNING AND FUNDING PERFORMANCE

- 6.1 Planning and Funding Summary Report**
- 6.2 Planning and Funding Indicators List and Exception Report**

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Planning and Funding Functional Group

Summary Report

1. Lifting the Health of people in Auckland City Planning

Auckland DHB has agreed additional electives for the 2010 -11 years and as a result the District Annual Plan has been updated to reflect the changes. The document has been re-submitted to the Ministry of Health. It has not yet been signed by the Minister.

At such time as the Annual Plan is formally approved, hard copies will be printed and made available to staff. This document will also be placed on our website.

Consultation and Community Engagement

Ethics approval has been received for research examining acute and elective patients' experience of the journey from home through to admission into hospital. The results will be fed into BSMC work and ADHB service improvement initiatives.

ADHB is taking a lead role in ensuring the Auckland Transitional Authority and incoming Auckland Council are well informed about the Auckland region DHBs' current and future strategy for protecting and improving the health of Aucklanders.

B4SC Programme

The response from the Ministry to ADHB's application for discretion to be applied with regard to the failure to reach target claw back was positive with a reduction in penalty from 20% to 8%. This will enable additional resource to be applied to supporting the transition of the programme to primary care. Discussions with PHOs regarding the transition continue and it is likely that an 'Alliance' contracting model will be utilised.

Mental Health - Secure Rehabilitation

A feasibility study to evaluate the potential for development and to provide an outline business case has been completed. The report indicates that a full business case is warranted so that a more detailed financial analysis can be undertaken. Opportunities for cost savings elsewhere to fund the new service can then be explored. We are currently looking for a suitable project person to undertake this task.

2. Performance Improvement

PHOs and Primary Care - ADHB Whole of System Service Redesign

Government's BSMC Primary Care Policy and requirement for Metro Auckland ways of working has subsumed a range of former ADHB projects and former regional projects into the BSMC Primary Care strategy. ADHB Planning & Funding Primary Care has a lead role in identifying and championing the key integration points between the realigning ADHB structure and the regional work streams that directly impact on the primary secondary care interface, efficiencies, and effectiveness.

Oral Health - Sylvia Park (2 Chair Clinic)

Construction has been completed and the building is being taken over by the lease holders ARDS on 30 August 2010. A dawn blessing of the building was held on 17 August, and a formal opening ceremony is planned for 10 September 2010. It is hoped that a Manea Stone will be ready to be placed in the building at the opening, thus completing the Ngati Whatua protocols. The opening is being attended by the Associate Minister of Health Peter Dunne.

Mental Health Alternative to Admissions

This project is underway and a suitable site has been found for development. The service is expected to be operational by November this year. In the interim we have established a four bed crisis respite service at a house in Hillsborough; this has been contracted with Pathways, the provider for the alternative to admissions service. We have also contracted with Challenge Trust to provide a four bed respite facility to help the acute ward cope with an expected increase in demand during the latter half of this year: this will operate as a step-down facility for over-due discharge patients with the aim of freeing up beds at Te Whetu.

Mental Health - Youth Respite

The contract for this service (implemented to replace the Mind Matters service) has been awarded to Affinity Services. This service will operate as an alternative to admission (step-up and step-down). The service is expected to be operational in late October.

Older People

A project has been developed and has been discussed with clinicians to review all independent placements for older people with a view to assess the feasibility of publishing an RFP and establishing an older people's rehabilitation and longer term stay mental health service; possibly on the model of a retirement village and accessing perhaps existing facilities but with specialist support for mental health in old age (or early onset issues where appropriate).

The potential fund for this service is close to \$1m if all placements and Glenburn funds were pooled, so the project is potentially viable without additional funding and could significantly improve service delivery and outcomes for older people by providing them with an opportunity to be rehabilitated.

3. Live Within Our Means

A verbal review of the funding position will be provided.

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August 2010

Exceptions this month

L76. An increase in H1N1 influenza notifications and in Invasive Pneumococcal Disease cases is driving the increase in Non-TB disease cases (Pertussis, HIB, Hepatitis A,B, C, Measles, Mumps, Rubella, Leprosy, Rheumatic Fever, Meningococcal).

L14., L14b, L14d, L14a. Coverage of all 2 year olds fully immunised dropped slightly to 86% at the end of August 2010. This could be due to an increased number of children with seasonal febrile illness and parents choosing to delay immunisation events. Coverage of Maori 2 year olds fully immunised at the end of August 2010 was maintained at 76%. However Maori rates for this cohort have been progressively dropping from a high of 82% in May 2010 so in view of this it has been decided to reactivate the Maori Immunisation Working Group that was established in early 2009. Timeliness of immunisation events at the milestone ages of 6 months and 18 months remain a significant issue with coverage at 58% and 56% respectively. It should be noted that the 2010-2011 target for the percentage of Maori 2 year olds fully immunised is in fact 85%. Coverage of Pacific 2 year olds fully immunised as at the end of August 2010 was 88% which reflects a 1% increase over the previous month. This is excellent progress. Coverage of Asian 2 year olds fully immunised at 2 years of age was 90% at the end of August 2010. It should be noted that the target for the percentage of Asian 2 year olds fully immunised in 2010-2011 is 93%.

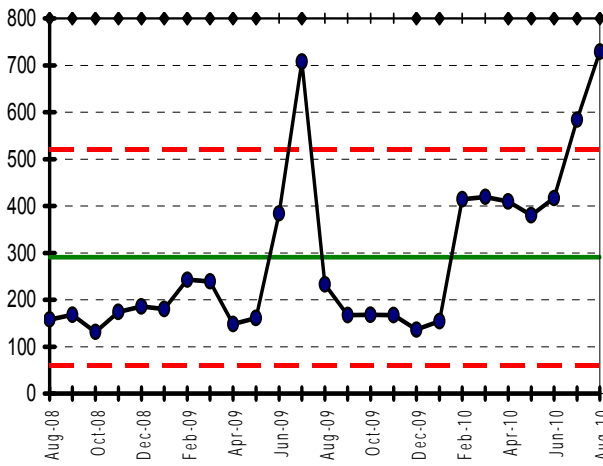
L29, L29b, L29c, L29d. The number is a comparison with the national average. The national average is 100%. Our ADHB rate is to remain below the national (the lower the better). ADHB is doing well in all age groups except age group 45-64. To address the issue ADHB is running many programmes targeting the disadvantaged group and mainly for CVD, diabetes and respiratory infection (the main causes behind the high ASH)

L30, L30b, L30c, L30d. The number is a comparison with the national average. The national average is 100%. Our ADHB rate is to remain below the national (the lower the better). ADHB is doing well in all age groups except age group 45-64. To address the issue ADHB is running many programmes targeting the disadvantaged group and mainly for CVD, diabetes and respiratory infection (the main causes behind the high ASH)

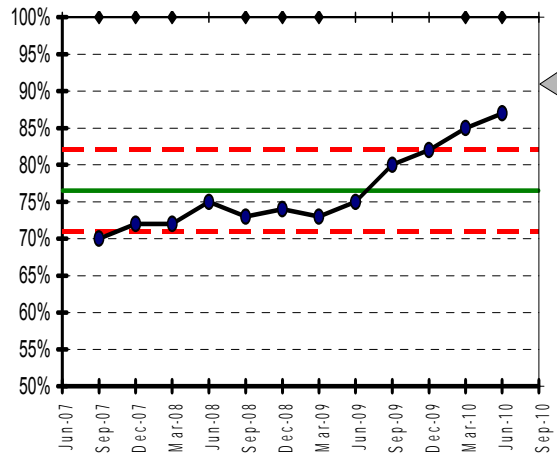
L31, L31b, L31c, L31d. The number is a comparison with the national average. The national average is 100%. Our ADHB rate is to remain below the national (the lower the better). ADHB is doing well in all age groups except age group 45-64. To address the issue ADHB is running many programmes targeting the disadvantaged group and mainly for CVD, diabetes and respiratory infection (the main causes behind the high ASH)

H4. There are 10 High Risk Clinical issues. Two relate to ARRC facilities, eight relate to Mental Health services. The quality facilitators are currently working with the providers to resolve these and have been making good progress. The P&F Manager for MH is also in communication with the MH providers in question to receive updates on progress in achieving compliance with contractual requirements and best practice. The P&F Manager for MH does not believe the issues pose a threat to the welfare of consumers.

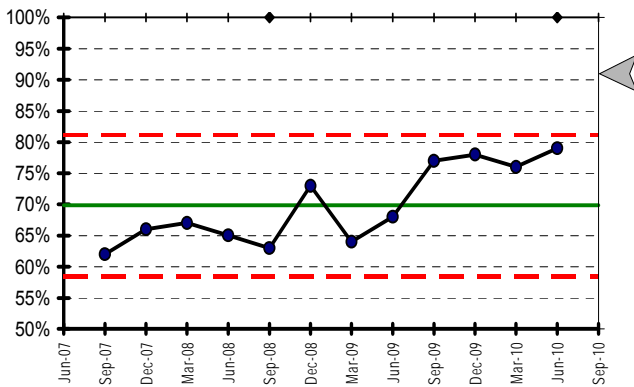
L76. Number of other (non-TB) disease cases notified - Total



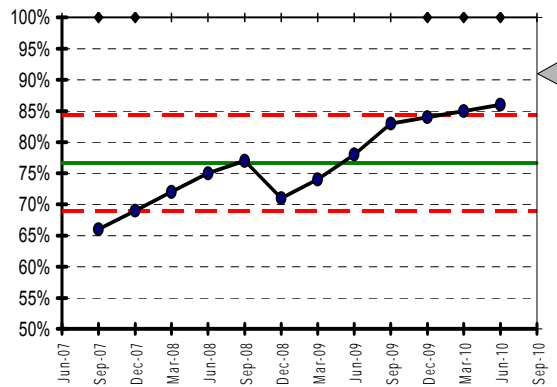
L14. (MOH-04) Percentage of two year olds immunised - Total



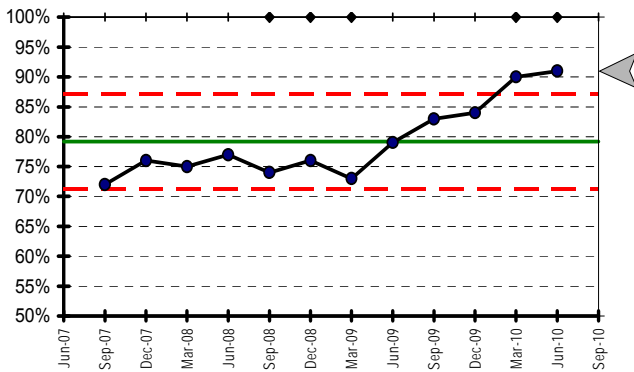
L14. b (MOH-04) Percentage of two year olds immunised -Maori



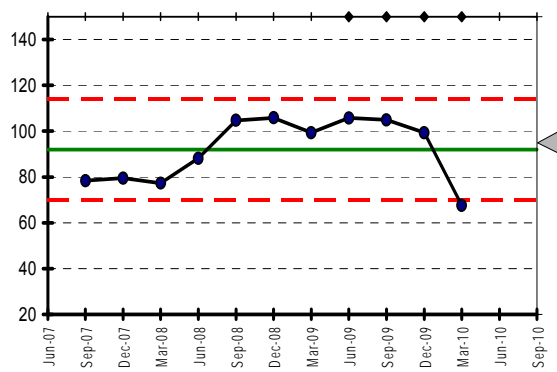
L14. d (MOH-04) Percentage of two year olds immunised -Pacific



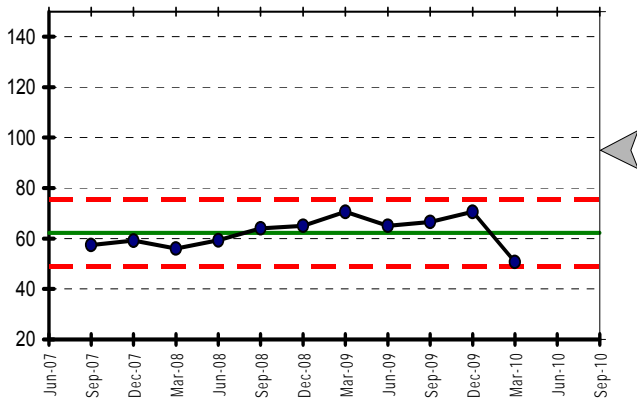
L14. a Percentage of two year olds immunised - Asian



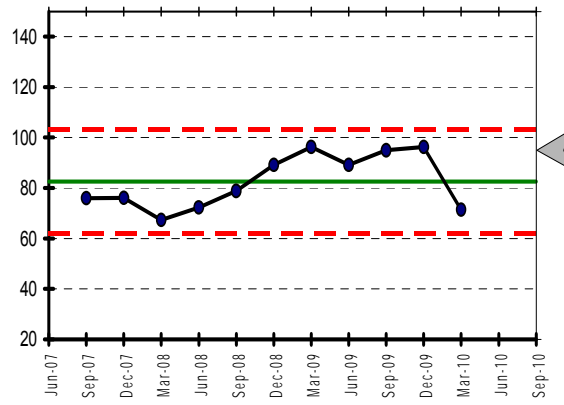
L29.b (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Maori



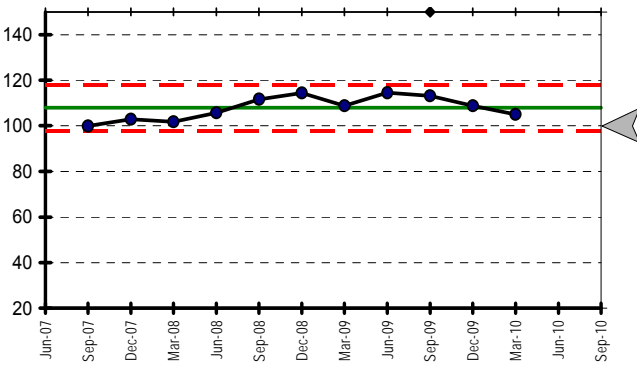
L29.c (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Other



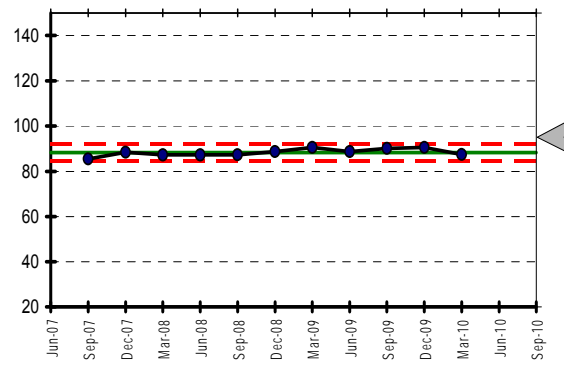
L29.d (POP-15) Ambulatory Sensitive Hospitalisations age <5 years -Pacific

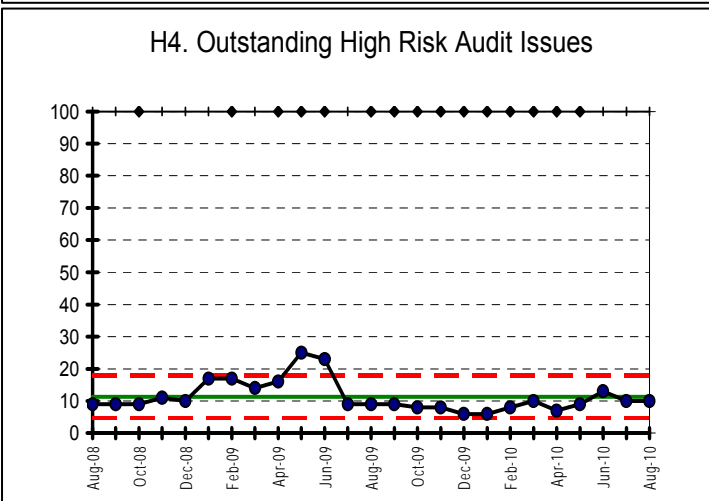
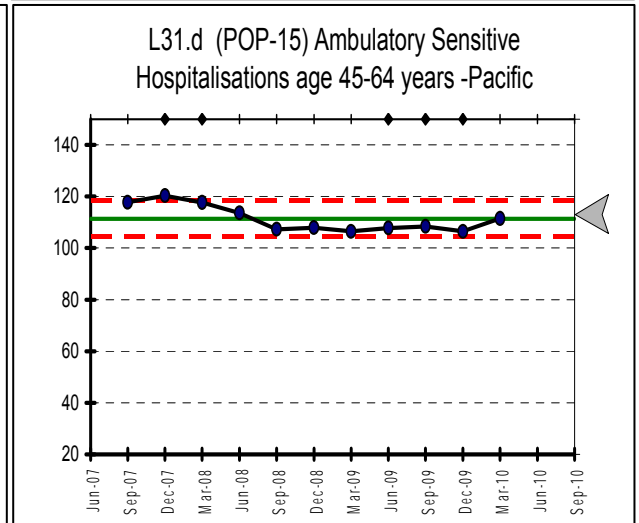
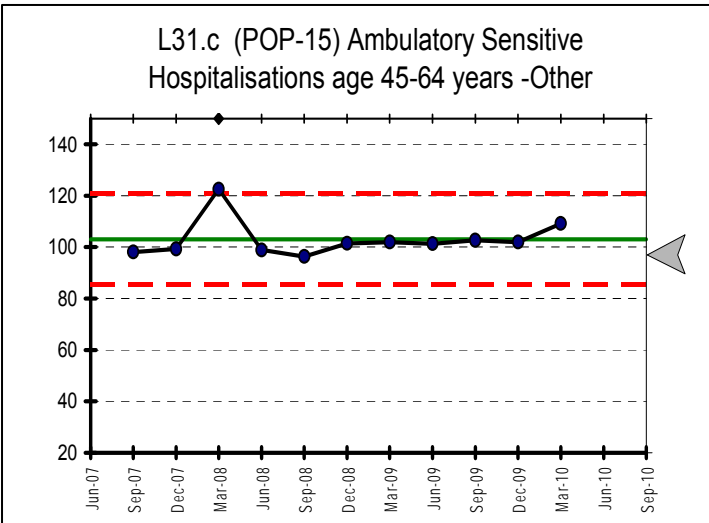
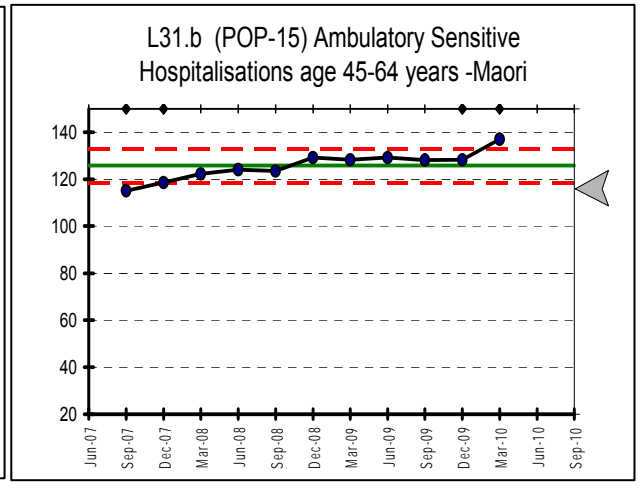
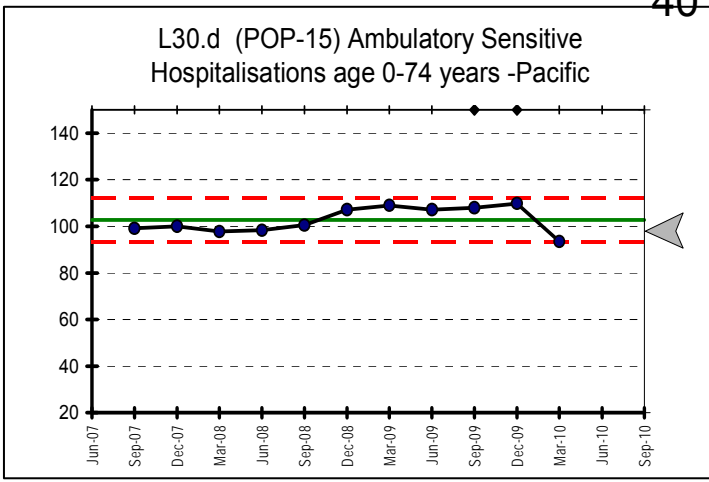


L30.b (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Maori



L30.c (POP-15) Ambulatory Sensitive Hospitalisations age 0-74 years -Other





Planning and Funding KPIs to Review Report

August 2010

KPI's for Review this month

H4. There are 10 High Risk Clinical issues. Two relate to ARRC facilities, eight relate to Mental Health services. The quality facilitators are currently working with the providers to resolve these. The P&F Manager for MH is also in communication with the MH providers in question to work through the issues. The P&F Manager for MH does not believe the issues pose a threat to the welfare of consumers.

L19, L19b, L19d, L19e. narrative to come

L.20, L20b, L20d, L20e narrative to come

L.21, L21b, L21d, L21e narrative to come

L.22, L22b, L22d, L22e narrative to come

L32, L32b, L32c & L32d Percentage of children caries free at 5 years - Total, Maori, Other & Pacific
The percentage of children at age 5 years that are caries free is increasing. This is a sign of improving oral health. The improving results for Maori and Pacific children are particularly encouraging, although there is still a significant gap between the percentage caries free for Pacific and Maori and 'other' children. In the 2009 calendar year only 36% of Pacific and 46% of Maori 5-yr olds were caries free – as opposed to 71% of 'other' 5yr olds. Additional resources have been invested in preschool oral health education and these are particularly targeting improvements in Maori and Pacific groups.

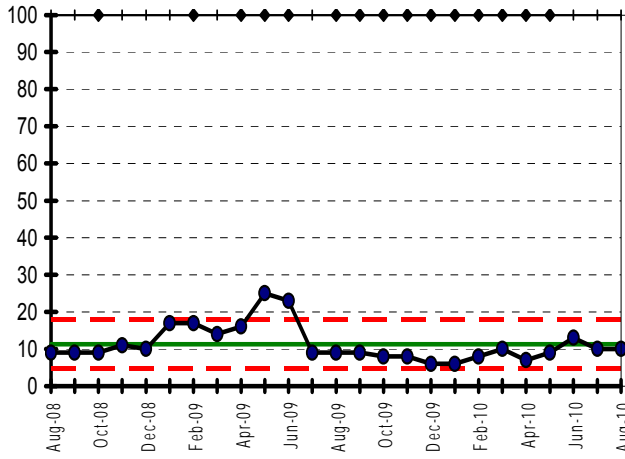
L33, L33b, L33c & L33d Ratio of teeth decayed, missing or filled (DMFT) yr 8 students - Total, Maori, Other & Pacific

A decrease in the DMFT ratio at year 8 is indicative of improving oral health. In the 2009 calendar year there was an increase in the DMFT ratios at year 8 for all groups in the ADHB area as compared to 2008. However there is still an overall improvement since 2006, with Maori rates reducing from 1.6 DMFT to 1.2 DMFT. The largest disparity is for the Pacific cohort, who had on average 1.67 decayed missing and filled teeth in 2009.

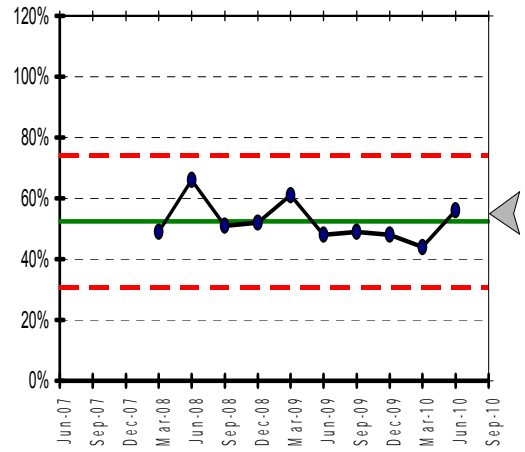
L49 Percentage of adolescent Oral Health utilisation

There are an increasing number of adolescents utilising dental services, as can be seen by the improving graph. Factors attributed to the improvement including better handover processes between school and adolescent service providers, more private dentists contracted to provide adolescent services, and expanding mobile services to high schools.

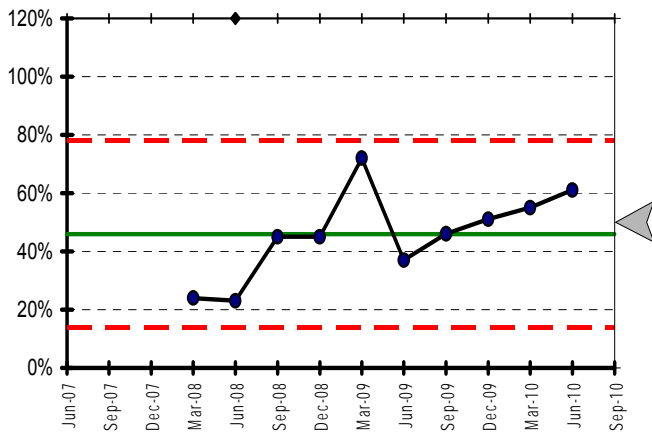
H4. Outstanding High Risk Audit Issues



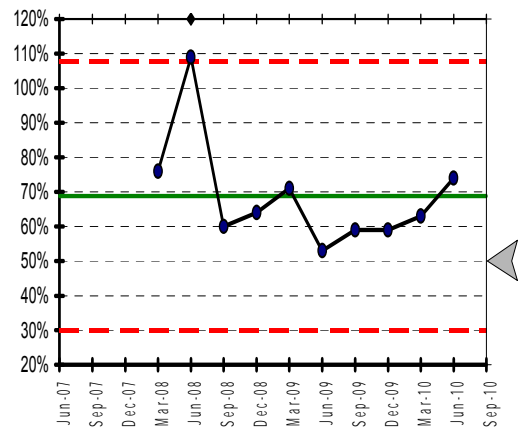
L19. (MOH-06) Diabetes Annual Check -Total



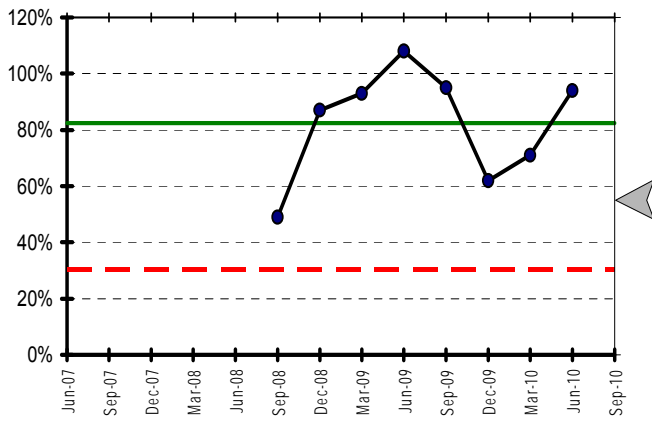
L19.b (MOH-06) Diabetes Annual Check -Maori



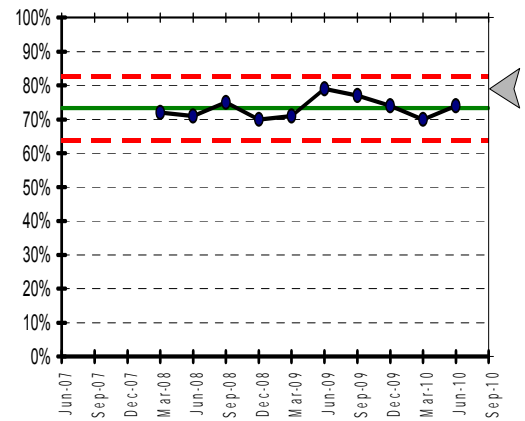
L19.d (MOH-06) Diabetes Annual Check -Pacific



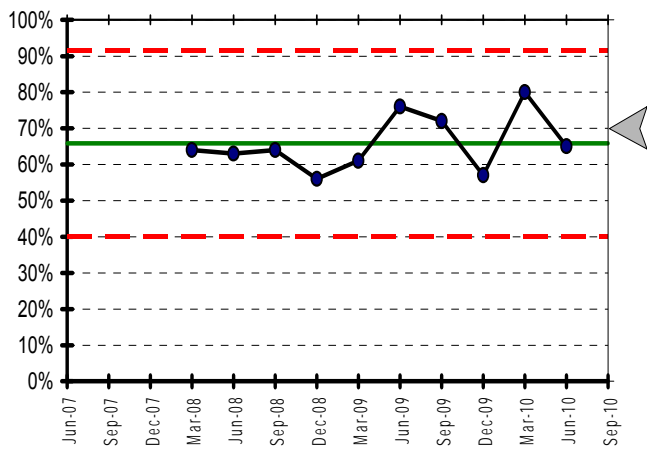
L19.e Diabetes Annual Check -Indian



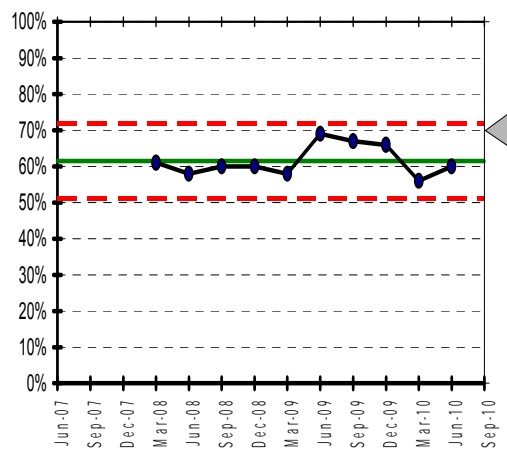
L20. (MOH-06) Get Checked Patients with HbA1c<8 -Total



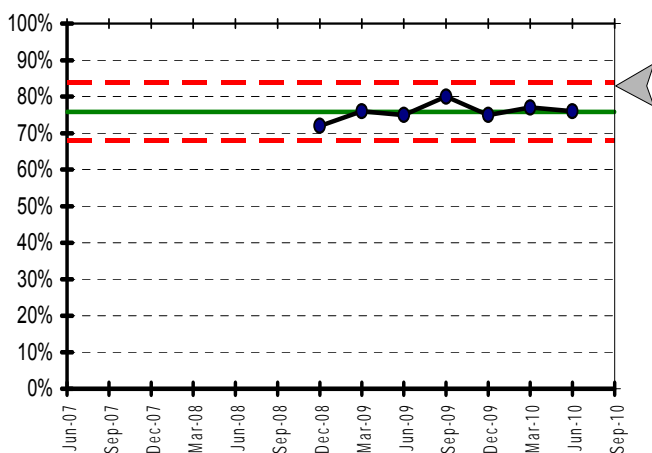
L20.b (MOH-06) Get Checked Patients with an HbA1c<8 -Maori



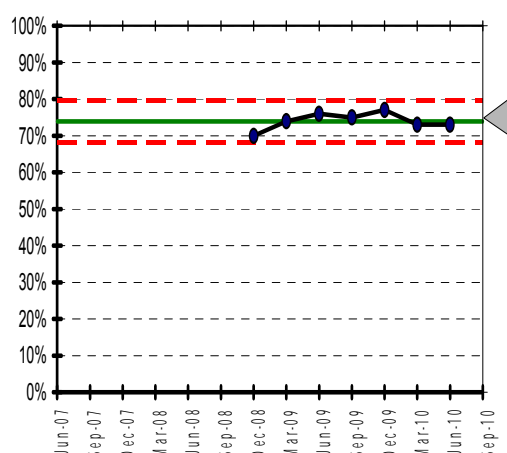
L20.d (MOH-06) Get Checked Patients with an HbA1c<8 -Pacific



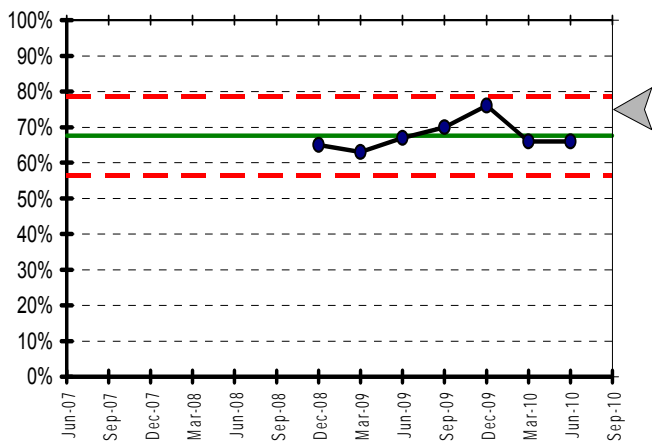
L20.e Get Checked Patients with an HbA1c<8 - Indian



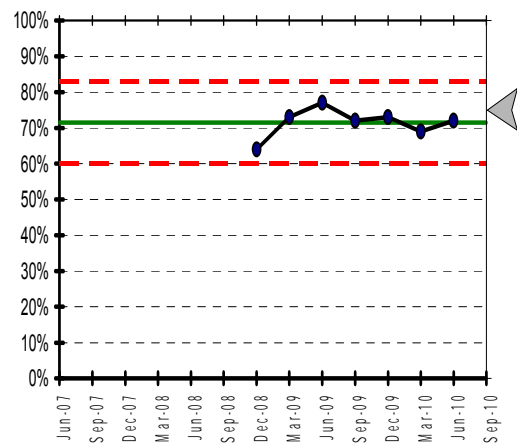
L21. Diabetic Retinal Screening for people with diabetes -Total



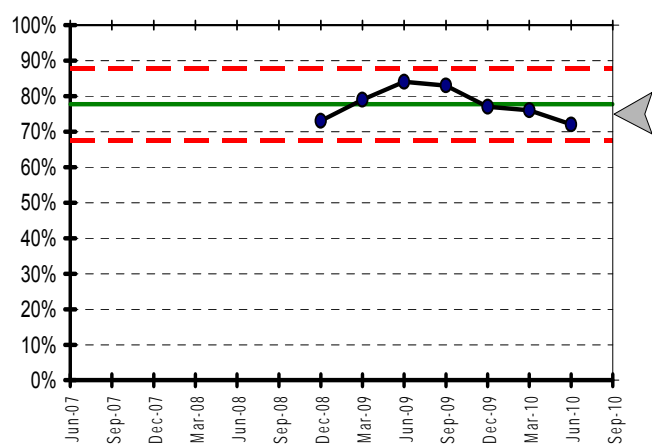
L21.b Diabetic Retinal Screening for people with diabetes -Maori



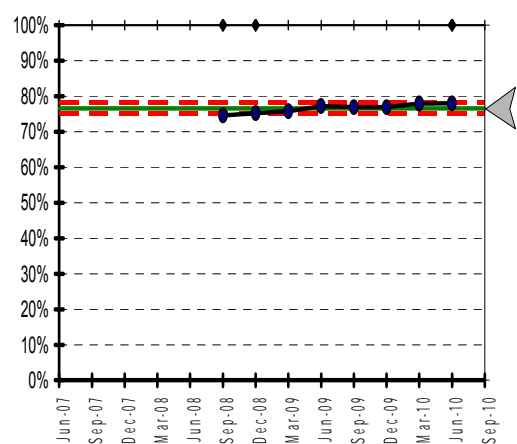
L21.d Diabetic Retinal Screening for people with diabetes -Pacific



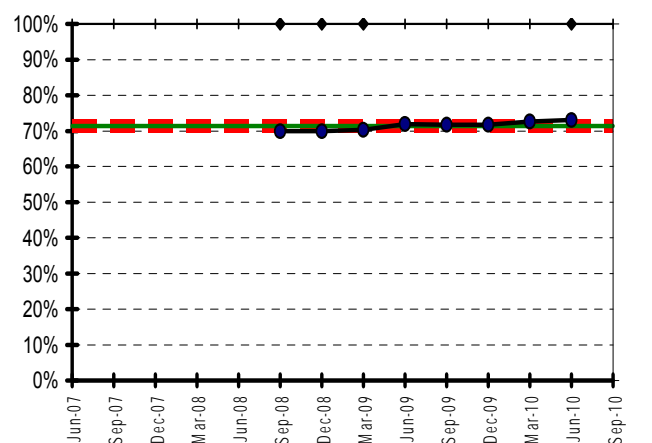
L21.e Diabetic Retinal Screening for people with diabetes -Indian



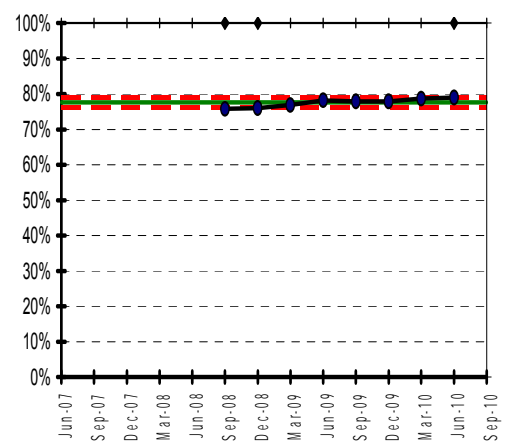
L22. (MOH-06) Cardiovascular risk screening - Total



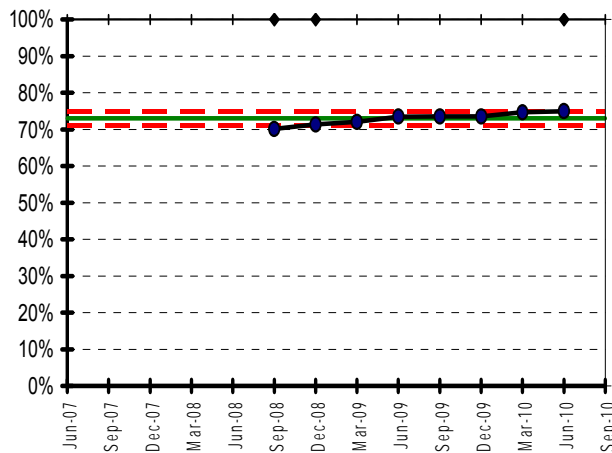
L22.b (MOH-06) Cardiovascular risk screening - Maori



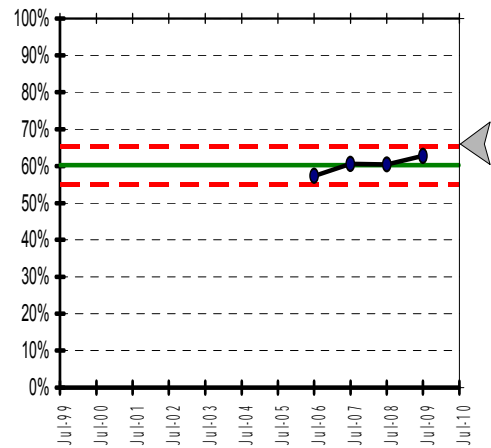
L22.c (MOH-06) Cardiovascular risk screening - Other



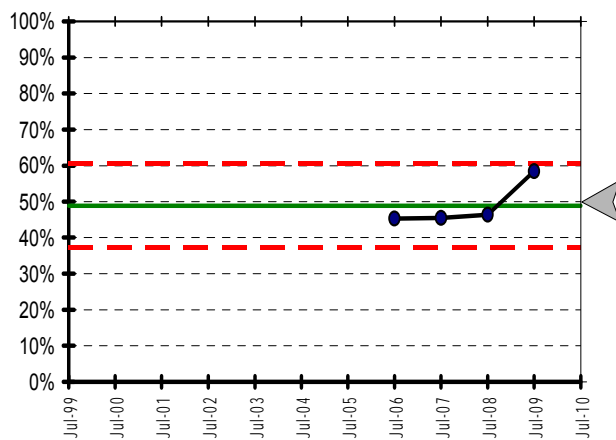
L22.d (MOH-06) Cardiovascular risk screening Pacific ⁴⁵



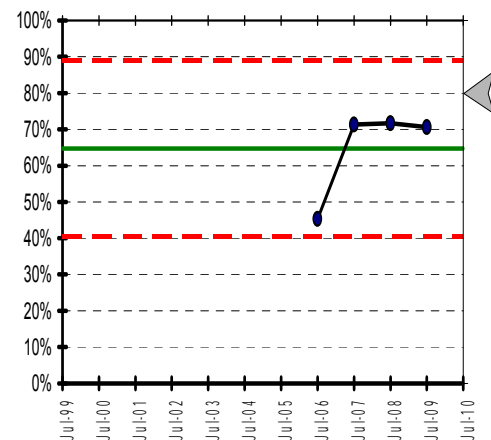
L32. Percentage of children caries free at 5 years -Total



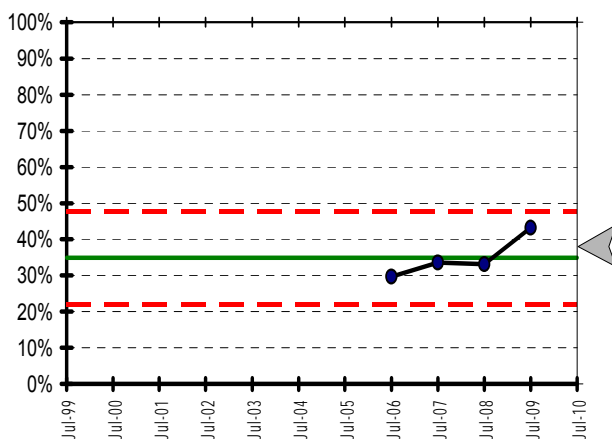
L32.b (POP-05) Percentage of children caries free at 5 years -Maori



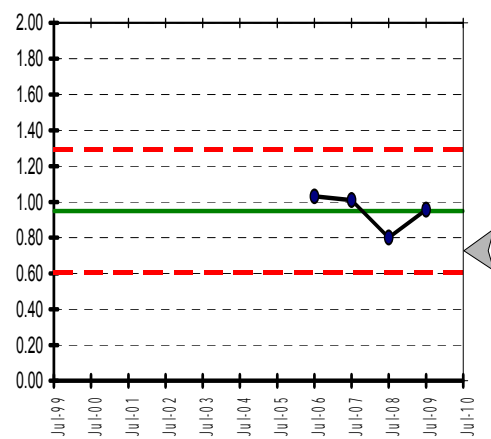
L32.c (POP-05) Percentage of children caries free at 5 years -Other



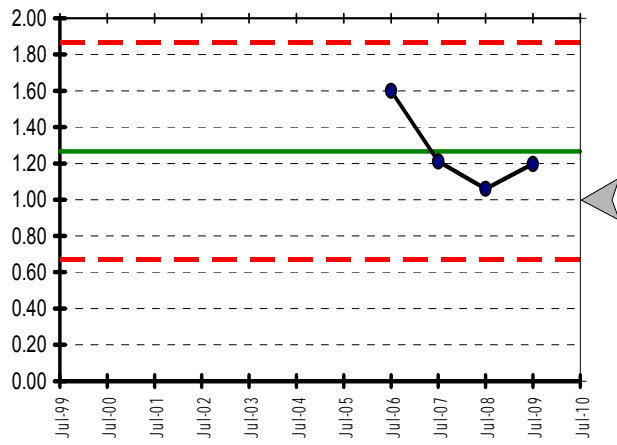
L32.d (POP-05) Percentage of children caries free at 5 years -Pacific



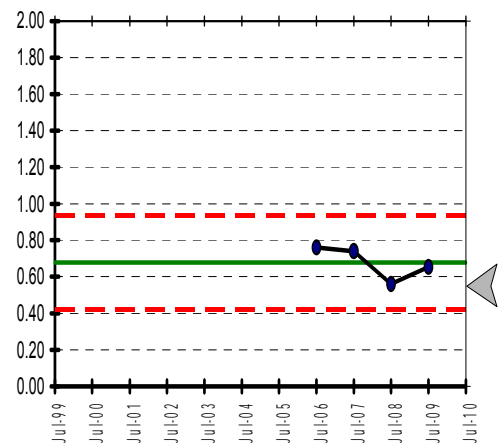
L33. Ratio of teeth decayed, missing or filled (DMFT) yr 8 students -Total



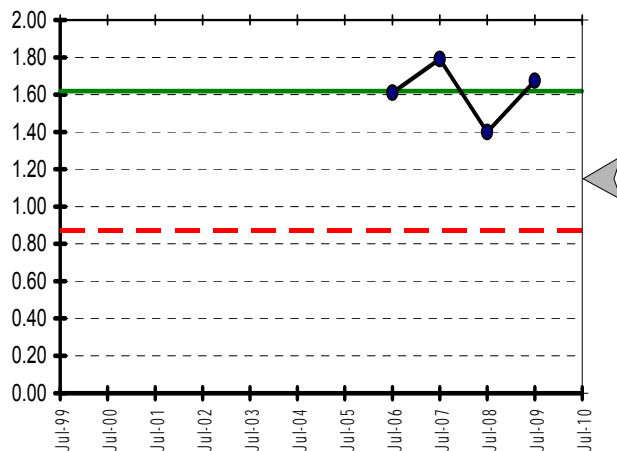
L33.b (POP-04) Ratio of teeth decayed, missing or filled (DMFT) yr 8 students -Maori



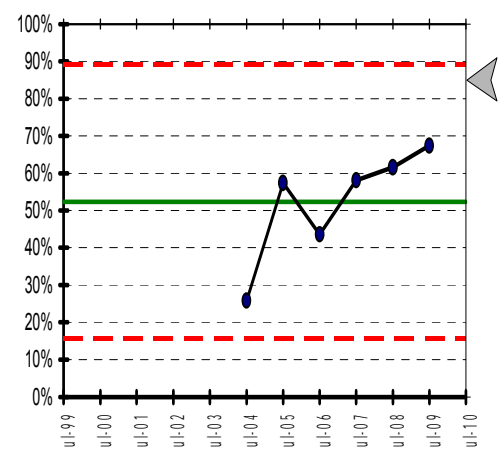
L33.c (POP-04) Ratio of teeth decayed, missing or filled (DMFT) yr 8 students -Other



L33.d (POP-04) Ratio of teeth decayed, missing or filled (DMFT) yr 8 students -Pacific



L49. (POP-14) Percentage of adolescent Oral Health utilisation



IMPROVEMENT ACTIVITIES

7.1 CPHAC DAP Projects Report



Auckland District Health Board

District Annual Plan *2010 - 2011*

22 June 2010

Priority and Developmental Work for 2010-11

Goal 1: Lift the health of people living in Auckland city

High level strategy	Objective	Strategies to achieve objectives
1.1 Reduce inequities in health status	1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	1.1.1.1 Work with the successful primary care business cases and Maori providers within these arrangements to: <ul style="list-style-type: none"> – develop Integrated Family Health Centres/Whanau Ora Centres – develop specific activities that achieve Whanau Ora – develop indicator measures for Whanau Ora – develop a Whanau Ora approach for all services devolved
		1.1.1.2 Implement the year one activities part of the cross DHB:MAPO Whanau Ora framework for 2010 - 2015
		1.1.1.3 Provide leadership in the development of Maori health workforce development
	1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	1.1.2.1 Integrate the Healthy Village Action Zone actions within the appropriate primary care business cases
		1.1.2.2 Participate in determining indicator measures for Pacific health gain in the three regional primary care business cases
		1.1.2.3 Host two Auckland DHB Pacific community leadership meetings to communicate the Auckland DHB Pacific Summit recommendations and the proposed plan
		1.1.2.4 Implement the Pacific best practice guidelines and training at Auckland City Hospital in at least 4 identified clinical areas (orthopaedic outpatient, child diabetes, renal and cardiology services) where there is high Pacific use and high DNA rates
		1.1.2.5 Complete the Healthy Village Action Zone evaluation
	1.1.3 Increase access to services for culturally and linguistically diverse populations	1.1.3.1 Cultural competency training focussed on culturally and linguistically diverse populations for all staff working in primary and secondary health services, with 50% of clinical staff completing at least two of the four on-line modules
		1.1.3.2 Increase the uptake of the Primary Health Interpreting Pilot so that 100% of the non-English speaking population using general practices in Auckland city has access to an interpreter when using General Practice services
	1.1.4 Support disabled people and improve their access to health care and support services	1.1.4.1 20% more clients over 65 are accepted into the Interim Funding Pool
		1.1.4.2 Audit report completed on accessibility: specifically physical access, culture, employment and advocacy
		1.1.4.3 KPIs developed for reporting disability issues and incidents to DSAC along with follow-up actions; for both provider audit and for Ministry of Health spot audit system

High level strategy	Objective	Strategies to achieve objectives
1.2 Improve outcomes in priority areas		
1.2a Children and young people	1.2a.1 Achieve immunisation targets	1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including: 1.2a.1.2 Work with EOI (primary care) respondents on actions to improve immunisation rates to the 91% for Auckland DHB by ensuring that Immunisation Co-ordinator roles are maintained and their effectiveness maximised 1.2a.1.3 Work with other regional DHBs and our primary care partners to achieve a regional immunisation target of 90% of all 2 year olds fully immunised
	1.2a.2 Improve the oral health of children	1.2a.2.1 Increase school dental clinics to six by June 2011 1.2a.2.2 Four new mobile clinics in total established by June 2011 1.2a.2.3 Reduce inequalities in the use of school dental services: <ul style="list-style-type: none"> - improving access by taking services to pre-schools - enhancing oral health education - increasing early enrolment with a focus on Maori and Pacific populations
1.2b Older people	1.2b.1 Home-based support services and restorative homecare initiatives	1.2b.1.1 Introduce the funding methodology for home-based services by July 2010 1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services
	1.2b.2 Quality improvement in residential care	1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations 1.2b.2.2 25% reduction in overall number of complaints from residential care
1.2c Mental health and addictions	1.2c.1 Increase effectiveness across primary, secondary, tertiary services	1.2c.1.1 Continued development of the secondary to primary care shift to achieve target of 90% of mental health clients (achieved through extension of ProGRESS+) 1.2c.1.2 Expand primary mental health; implementation of online therapies, appointment of primary care employment support worker, appointment of CSW in primary care to provide psycho-education and psycho-social interventions; and service navigators/coordinators to manage movement through the system 1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures 1.2c.1.4 Complete the reconfiguration of levels 3 and 4 residential rehabilitation; i.e. to contract for support hours that provide flexibility for consumers to get the level of service required, including residential support where needed 1.2c.1.5 Review and reconfigure the continuum of mental health services to focus on recovery and social inclusion using best practice and evidence based approaches
1.2d Long term conditions	1.2d.1 Strengthen community participation and action	1.2d.1.1 Ensure community participation at a locality level to input into the changes occurring in primary health care as part of the metro Auckland approach to long term conditions

High level strategy	Objective	Strategies to achieve objectives
	1.2d.2 Integration of services across primary and secondary care	1.2d.2.1 Work with our primary care partners to develop care pathways across primary-secondary care for at least two common long term conditions (including diabetes) 1.2d.2.2 Increase the number of GPs using electronic referral systems to at least 10%
	1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	1.2d.3.1 Meet existing target re number of the eligible adult population having their CVD risk assessed 1.2d.3.2 At least 2 cardiac rehabilitation courses are run in the community 1.2d.3.3 At least 10% of retinal screening to be undertaken in the community
	1.2d.4 Support whanau and self resilience	1.2d.4.1 Pilot coaching services to support people with long term conditions in line with evidence base 1.2d.4.2 Work with our primary care partners to improve outcomes for Maori, Pacific people and other high need groups through a range of strategies that involve families and communities
1.2e Palliative care	1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	1.2e.1.1 Service redesign for palliative care agreed, and which aligns the specialist and generalist workforce 1.2e.1.2 Liverpool Care Pathway trial is evaluated with phase 2 undertaken according to the outcome 1.2e.1.3 Review of equipment services so that equipment provision becomes aligned and streamlined by June 2011 1.2e.1.4 ProCare palliative care pilot rolled out and evaluated with 2 other PHOs beginning the programme

More detail on some of these performance measures is included on page 36

Goal 2: Performance improvement: sooner, better, more convenient

High level strategy	Objective	Strategies to achieve objectives
2.1 Efficient and effective health care system		
2.1a Primary health care	2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	2.1a.1.1 Develop a comprehensive metro Auckland primary care plan in collaboration with DHBs and primary care
2.1b Improve primary–secondary system efficiency	2.1b.1 Improve access and efficiency of service delivery	2.1b.1.1 Implement regional e-referrals, health event summaries and electronic outpatient letters
		2.1b.1.2 Increase access to diagnostic radiology for primary care by providing community assessment for up to 4,500 procedures and improving access for 16,000 patients
		2.1b.1.3 Shift minor surgery activity into the community, increasing more convenient primary care based treatments for skin cancer across the metro region from 513 to 1200 per year
		2.1b.1.4 Implement a formalised network across Auckland, proving local access to urgent care that will be integrated with general practice services
		2.1b.1.5 Improve access to primary care for palliative care clients by 15%
		2.1b.1.6 Implement a clinically led “proof of concept” process to more effectively manage the community pharmaceutical budget by facilitating appropriate prescribing and safe use of medicines. Target savings of \$1.5m
	2.1b.2 Reduce acute demand	2.1b.2.1 Increase by 50% across the metro Auckland region the number of Primary Options for Acute Care (POAC) referrals (target of 12,500 patients managed in a community setting)
2.1c Improve quality of hospital care while improving productivity	2.1c.1 Improve service throughput and productivity	2.1c.1.1 Improve cardiac surgery throughput from an average of 17 to 20 bypass procedures per week. Complete implementation of the 10 project work streams (including formalising the private / public relationship and incentive schemes)
		2.1c.1.2 Eliminate unnecessary follow ups to reduce follow up rate by 10%
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.1.3 Improve performance against the Emergency Department six-hour measure from 76% to 95% by implementing project solutions in the adult and children’s acute flow projects
		2.1c.1.4 Improve adult operating room productivity by 6% by implementing the productive operating theatre programme/lean improvement programmes (UK NHS Productive Operating Theatre Programme)*
		2.1c.1.5 Improve ward productivity by 3% by increasing the number of wards in Adults and Mental Health services using Releasing Time to Care from 6 to 24

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery 2.1c.1.7 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding 2 operating rooms providing capacity for increasing volumes; construction planned to commence early 2011 2.1c.1.8 Improve the patient experience while improving productivity by implementing service improvement projects in: <ul style="list-style-type: none"> - General medicine - Orthopaedics - Radiology - Paediatrics general surgery - General surgery - Ophthalmology
	2.1c.2 Improve mainstream effectiveness	2.1c.2.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches 2.1c.2.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori 2.1c.2.3 Over the long term reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rate from 9.6% to 9% in 2010-11) 2.1c.2.4 60% of discharge letters to Pacific people include another primary health care provider
	2.1c.3 Improve relapse prevention planning in mental health	2.1c.3.1 Greater than 95 percent of long term mental health clients have up-to-date relapse plans by July 2011
	2.1c.4 Hospitalised smokers given assistance to stop smoking	2.1c.4.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2011 2.1c.4.2 450 pregnant women enrolled into smoking cessation programme per annum
	2.1c.5 Reduce waiting times for oncology	2.1c.5.1 Radiation therapy will commence within four weeks from FSA, by December 2010 2.1c.5.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology 2.1c.5.3 Implement lung and bowel tumour stream models by June 2011
	2.1c.6 Increase elective surgical discharges to 10,227	2.1c.6.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway <ul style="list-style-type: none"> - Implement new model of care and workforce roles in the Greenlane Surgical Centre - Maintain past elective surgery improvement by including primary care in the

High level strategy	Objective	Strategies to achieve objectives
		referral pathways and patient management – Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
2.2 Improve leadership capability	2.2.1 Strengthen Clinical Leadership model	2.2.1.1 Refine, implement and monitor integrated governance model 2.2.1.2 Monitor and report against “In Good Hands” implementation
	2.2.2 Improve Senior Leadership Team Performance	2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement 2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care
2.3 Improve Clinical Quality and Professional Governance	2.3.1 Implement regional clinical networks	2.3.1.1 Provide leadership in cancer and cardiac clinical networks 2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care
	2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management
		2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas
		2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process
2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s		
2.3.2.5 Implement Senior Leadership Team ‘Walk-around’ safety programme i.e. growth and training in clinical leadership		
2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement		
2.3.2.7 Evaluation against Health Excellence Framework		
2.3.2.8 Continue roll out of Cornerstone accreditation across primary care 2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System		
2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity	

High level strategy	Objective	Strategies to achieve objectives
2.4 Strengthen the health workforce	2.4.1 Ensure workforce capability is matched to service delivery current and future	2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces 2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme 2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015) 2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme 2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%
2.5 Information management	2.5.1 Improve the resilience and availability of core IT systems	2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time 2.5.1.2 KPI reporting for end-to-end application performance in place 2.5.1.3 IMTS user satisfaction increases by >10% against previous year 2.5.1.4 Number of unplanned system outages reduced from >20 to <5 per month 2.5.1.5 Tier 1 system availability increases to >99.95%
	2.5.2 Improve corporate records and knowledge management	2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance 2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)
	2.5.3 Improve data quality	2.5.3.1 Ministry of Health data quality targets met
2.6 Planning 2.6 Planning (cont)	2.6.1 Long term planning and change management	2.6.1.1 Undertake any Strategic Planning work as advised to meet Ministry of Health requirements and deadlines 2.6.1.2 Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030: <ul style="list-style-type: none"> – description of future models of care across the continuum of care – plan the shape, size, setting, and location for future services and inter district flow patients – provide the strategic context for major future developments and business cases – develop workforce response to current and long term service plans via regional and the national workforce planning – increase the focus on regional planning and collaboration with the regional primary care business cases 2.6.1.3 Any potential service, funding or planning changes arising from the implementation of the National Health Board and the NZHD Amendment Bill are identified and responded to

* Refer to appendix 8

Goal 3: Live within our means

High level strategy	Objective	Strategies to achieve objectives
3.1 Break-even position maintained		
3.1a Manage revenue	3.1a.1 Ensure revenue received for services provided	3.1a.1.1 Reconfigure renal services in response to Waitemata DHB repatriation and manage any associated risks 3.1a.1.2 Manage funding and other changes arising from the National Health Board and other Ministerial Review Group recommendations 3.1a.1.3 Participate in the national pricing process, particularly risk arising for 2011–12 paediatrics tertiary adjuster 3.1a.1.4 The impacts of any service reconfigurations are managed within Vote Health parameters
3.1b Cost management	3.1b.1 Improve processes	3.1b.1.3 Align systems (national and regional) where shared services across the region or the country results in greater administration efficiency
	3.1b.2 Manage labour resources	3.1b.2.1 Manage the FTE cap for management and administration staff 3.1b.2.2 Improve HR payroll processing and leave management 3.1b.2.3 Manage industrial relations (MECA) and assess draft proposals against outcomes and against financial and sustainability risks
	3.1b.3 Enhance asset and supply chain management	3.1b.3.1 Asset Management Plan alignment with the Long Term Services Plan 3.1b.3.2 Leverage national /regional procurement initiatives 3.1b.3.3 Progress procurement strategy (national and regional) and supply chain processes
3.2 Sustainable balance sheet		
3.2a Manage cash	3.2a.1 Sustainable cash management	3.2a.1.2 Cash/Financing Plan aligns with Asset Management and Long Term Services Plans

Group Pack Report

Group/Committee: Community and Public Health Advisory Committees



Goal Level Summary

DAP Projects - total projects: 20

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	17	17	5	3	1	5	2	0	14	2	0	16	0	0	16	0	0	1	0	1	0
2 Performance improvement	3	2	0	0	0	2	0	0	3	0	0	3	0	0	3	0	0	0	0	0	0
3 Live within our means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	20	19	5	3	1	7	2	0	17	2	0	19	0	0	19	0	0	1	0	1	0
Total %	100%	95%	25%	15%	5%	35%	10%	0%	85%	10%	0%	95%	0%	0%	95%	0%	0%	5%	0%	5%	0%

Goal: 1 Lift the Health of the people in Auckland City

High Level Summary - total projects: 17

High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan		Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red	
			Define	Measure																	Analyse
1.1 Reduce inequalities in health status	10	10	4	1	2	2	0	0	9	0	0	9	0	0	9	0	0	1	1	0	0
1.2a Improve outcomes for children and young people	2	2	0	1	0	0	1	0	2	0	0	2	0	0	2	0	0	0	0	0	0
1.2b Improve outcomes for older people	2	2	0	0	2	0	0	0	1	1	0	2	0	0	2	0	0	0	0	0	0
1.2c Improve outcomes for mental health and addictions	4	4	0	0	0	3	0	0	3	0	0	3	0	0	3	0	0	1	0	1	0
1.2d Improve outcomes for long term conditions	6	6	1	1	2	2	0	0	4	2	0	6	0	0	6	0	0	0	0	0	0
1.2e Improve outcomes for Palliative care	1	1	0	0	0	0	1	0	1	0	0	1	0	0	1	0	0	0	0	0	0
Total #	17	17	5	3	1	5	2	0	14	2	0	16	0	0	16	0	0	1	0	1	0
Total %	100%	100%	29%	18%	6%	29%	12%	0%	82%	12%	0%	94%	0%	0%	94%	0%	0%	6%	0%	6%	0%

Objectives

Objective	Objective Owner	Comment
1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	Aroha Haggie (ADHB)	
1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	Hilda Faasalele (ADHB)	On track with projects. Healthy Village Action Zones Steering Group established.
1.1.3 Increase access to services for culturally and linguistically diverse populations	Denis Jury (ADHB)	Increasing numbers of primary care providers now included in the primary interpreters initiative and as a consequence increasing utilisation is evident
1.1.4 Support disabled people and improve their access to health care and support services	Denis Jury (ADHB)	Overall projects progressing well with the exception of devolution of the Interim Funding Pool, where there is still difficulty getting specifics from the MoH (and the region, depending on the final process decided by the MoH) about how funding skews are going to be addressed.
1.2a.1 Achieve immunisation targets	Denis Jury (ADHB)	Progressing according to plan with the current focus being on primary care data integrity. Increased focus on maori rates as decreasing intervention rates have been apparent over the last 2 months.
1.2a.2 Improve the oral health of children	Denis Jury (ADHB)	Progressing according to plan, and formal opening of the Sylvia park clinic on 10 sept which Assoc Minister Dunn attended.
1.2b.1 Home-based support services and restorative homecare initiatives	Denis Jury (ADHB)	Casemix and packages of care progressing to plan. Currently completing funding arrangements for 2010/11 prior to the introduction of casemix.

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1.2b.2 Quality improvement in residential care	Denis Jury (ADHB)	Satisfactory progress, although relations with ARC providers have been a little strained over the issue residency and eligibility letters sent to providers.
1.2c.1 Increase effectiveness across primary, secondary, tertiary services for mental health and addictions	Denis Jury (ADHB)	Satisfactory progress across all projects.
1.2d.1 Strengthen community participation and action for long term conditions	Denis Jury (ADHB)	Initial discussions commencing as part of the tamaki transformation project.
1.2d.2 Integration of services across primary and secondary care for long term conditions	Andrew Coe (ADHB)	Progressing according to plan. ADHB TeleHealth project was the winner of the Telecommunications Industry Innovation Awards for 2010.
1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	Andrew Coe (ADHB)	Good progress, with focus on cardiac rehab and process development for diabetic retinal screening.
1.2d.4 Support whanau and self resilience for long term conditions	Aroha Haggie (ADHB)	RFP for self management programmes currently in the market place.
1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	Andrew Coe (ADHB)	Progressing to plan with current work underway to extend the Liverpool Care Pathway programme to a further three private hospitals.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Develop Care Pathways for people with Long Term Conditions	National	Define				The telehealth project is complete and a new one to be started is an exiting outcome. Good to hear about other discussions on alternate mechanisms for improving information sharing and role integration .
Increase access and capacity to community diabetic eye screening	National	Analyse				A detailed implementaion plan will give us more surity of progress.

Legend: Red - , Orange - , Green - 

Goal: 2 Performance improvement

High Level Summary - total projects: 3

	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Define	Measure	Analyse	Do/ Check Improve	Act Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
High Level Strategy																					
2.1a Efficient and effective Primary health care	1	1	0	0	1	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	2	2	0	0	0	2	0	0	2	0	0	2	0	0	2	0	0	0	0	0	0
2.1c Improve quality of hospital care while improving productivity	1	0	0	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
2.2 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.3 Improve Clinical Quality and Professional Governance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.4 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.5 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.6 Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	3	2	0	0	0	2	0	0	3	0	0	3	0	0	3	0	0	0	0	0	0
Total %	100%	67%	0%	0%	0%	67%	0%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	0%	0%	0%	0%

Objectives

Objective	Objective Owner	Comment
2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	Andrew Coe (ADHB)	Active participation continues at national, regional and local level regarding primary care planning and implementation. Current focus is on contribution to the Northern Region Regional Service Plan to meet the 30 sept deadline.
2.1b.1 Improve access and efficiency of service delivery for primary–secondary system	Andrew Coe (ADHB)	All primary care DAP projects progressing well with most moving according to plan. The pharmaceutical project was slow to start but is now well underway and skin lesions has been slow, but is progressing.
2.1b.2 Reduce acute demand	Andrew Coe (ADHB)	Extended POAC regional project on track

Exceptions

There are no projects that have been marked as an exception

**FEEDBACK FROM
MAORI HEALTH
ADVISORY COMMITTEE
AND
PACIFIC HEALTH
ADVISORY COMMITTEE**

PAPERS

9.1 A Locality Approach for Auckland

9.2 Alliance Contract Presentation

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Community and Public Health Advisory Committee Paper

Date	Wednesday 15 September 2010
To	Community and Public Health Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Greenlane Clinical Centre
Author	Andrew Coe Planning & Funding Manager Primary Care and PHOs Andrew Old Medical Advisor Population health and Quality Improvement
Functional Group	Planning and Funding
Subject	A Locality Approach for Auckland
1.	<p>Background</p> <p>The metro-Auckland DHBs and the three Better, Sooner, More Convenient (BSMC) business cases have all pointed to a locality approach to the planning and provision of services across Auckland as a way to address duplication, equity and integration issues while enhancing the overall efficiency of the system. For Auckland DHB (ADHB) this is a reconfirmation of the approach agreed in our Primary Health Care Plan 2008.</p> <p>To enhance the business cases and gain further traction at the local level, this document seeks to develop an approach to the locality concept for use within ADHB. This includes the associated structures and processes to support this approach and is consistent with agreed regional directions.</p> <p>This paper draws heavily on work undertaken across all three DHBs and aims to move forward their agendas in this area.</p>
2.	<p>Recommendations</p> <ol style="list-style-type: none"> 1. Approve the locality health service delivery approach as described. 2. Approve the staging of localities for planning as outlined (Section 7.3)
3.	<p>Note the next steps in the process for locality planning as outlined (Section 9.0)</p>

A 'Locality Approach' for Auckland v2

A proposal for changing the way we view the planning and delivery of healthcare

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1. Introduction & Purpose

The metro-Auckland DHBs and the three Better, Sooner, More Convenient (BSMC) business cases have all pointed to a locality approach to the planning and provision of services across Auckland as a way to address duplication, equity and integration issues while enhancing the overall efficiency of the system. For Auckland DHB (ADHB) this is a reconfirmation of the approach agreed in our Primary Health Care Plan 2008.

To enhance the business cases and gain further traction at the local level, this document seeks to develop an approach to the locality concept for use within ADHB. This includes the associated structures and processes to support this approach and is consistent with agreed regional directions.

The locality approach described will provide an operational framework to facilitate:

- Implementation of the ADHB Primary Health Care Plan 2008
- Delivery of BSMC via the three business cases
- Truly integrated health service planning and delivery across the whole spectrum of care
- Enhanced community engagement through structured links with elected Local Boards, and deliberate strategies to connect with local populations in a continuous rather than episodic way
- An inter-sectoral approach to health service planning and delivery

This paper draws heavily on work undertaken across all three DHBs and aims to move forward their agendas in this area¹²³⁴⁵.

¹ Taking a neighbourhood approach in ADHB, A think piece informed by literature, March 2009 Auckland DHB

2. Definition of a locality

For the purpose of this paper a **locality** (also known as a neighbourhood) is defined as a geographic area that encompasses all people usually resident in the area. A **locality approach** aims to place local communities at the heart of health service planning and delivery, and better co-ordinate and integrate health services at the locality level.

3. Rationale for a locality approach

A focus on localities enables us to understand and address health priorities from communities' perspectives. In addition localities will help address some of the key pressures on the health system, particularly the local co-ordination needed to respond to the increase in chronic conditions, improve prevention, address persistent inequalities and workforce shortages, and enhance productivity and efficiency.

Specific opportunities include:

- The ability to engage communities in a continuous cycle of planning and improvement allowing them to shape services at a local level
- Organising health providers around local populations should greatly assist integration of services for patients and communities
- Planning and coordination of services around a number of primary care practices in a geographical area allows those primary care practitioners with specialist interests or skills to provide care for a larger population
- Localities are a logical and efficient means to enable the delivery of a wider range of services closer to where people live and work, particularly through the shift in services from secondary care to primary/community based settings
- Thinking and planning in a locality enables interaction with other NGOs, health promotion services, local government and other community and non-health services that can support the drive to improve health outcomes
- There is potential for sharing members of a scarce workforce (such as nursing or podiatry) across a number of practices
- There is potential to improve equity by adapting services to take into account local issues
- Primary care has been most successful where it is strongly linked with local communities and encouraging and strengthening this linkage can lead to improved access to services. Supporting community involvement and participation at a community decision making level has also been shown to improve health outcomes

² Primary Care – coordination and integration, a discussion paper. March 2009

³ Takiwa Ora (Locality Approaches) Overview and implementation plan. Counties Manukau DHB 2009

⁴ Models and structures to support Better, Sooner, More Convenient Primary Care – Counties Manukau District August 2009

⁵ Discussion Paper on Locality Planning, Tom Robinson and Vanessa Sealak Waitemata District Health Board, 2010

4. Assumptions

The proposed approach is based on a number of assumptions:

- Planning and delivery of health care in localities is a 'given' as per previous commitments
- Primary Health Organisations (PHOs) will continue to be the predominant entities responsible for delivering primary health care in the near future
- All organisations will work collaboratively in the best interests of the served population

5. Principles to support a locality approach

The locality approach places communities at the centre of health service planning

Planning health services at a locality level offers an unprecedented opportunity to understand community health priorities through meaningful engagement and allow those communities to shape the provision of local services. There are a number of examples where good community engagement has led to increased community ownership of issues wider than health (e.g. the Ranui project in WDHB and HVAZ in Auckland DHB) and a locality approach allows us to build on learnings from those experiences.

Organisational configuration needs to adapt to support the locality approach described

An extension of the previous principle in that existing organisational boundaries and structures (e.g. DHBs and PHOs) need to adapt to best support community health outcomes.

The locality approach should foster and enhance integration and coordination of care

The approach allows us to link secondary care and community providers with other health service providers working in the community. This might include having named specialists to support primary care practitioners in the area or creating opportunities for discussion across all nursing roles in communities.

The locality approach must maintain a focus on Māori health

Whilst we may wish to see an increasing focus on locality populations we need to remember that all organisations involved have an obligation to maintain a focus on the needs of their Māori populations. Planning, funding, and delivery of services to Māori, either through mainstream services or Māori specific services, could occur at district, locality, PHO or other provider levels. Decisions will need to be made to what extent this responsibility will be undertaken at each level.

The locality approach must improve the health of Pacific people.

This approach should strengthen and support the diverse Pacific communities to identify their needs, harness resources and respond in an effective and cohesive way to address these high needs. Opportunities to ensure the Pacific patient journey is simple, clear and without barriers will be an aim of this approach. Stronger links between health services and also other agencies at a District, locality and PHO level should better support Pacific families to receive the assistance required.

The locality approach must enhance our ability to reduce inequalities

Communities should be supported to identify their needs and priorities and harness resources to meet them. The opportunity provided by defining localities within local government boundaries will enhance the ability of agencies to work together to better support those people and families who require assistance from multiple organisations.

Local health needs assessment will be a key feature of the planning process

National and regional priorities will form the minimum available services at the local level but in addition needs assessments at the local level will increase our understanding of community needs within these areas and allow appropriate decisions to be made. The Local Government Commission has spent considerable time to ensure wards represent communities of interest based upon; “residents’ sense of identity with and belonging to a community, the ability to meet residents’ needs for services (both council and non-council services), and the ability to represent the interests and reconcile conflicts of the community.”

The locality approach should address issues of capability and capacity within primary care

The implementation of the locality approach will maximise the use of a scarce workforce. There may be ways in which practices can share the resource of, for example, a specialist nurse, or run joint chronic disease management clinics. Better use of the community nursing teams and community support workforce (including social services) should also be an aim of this approach.

Funding flows will be directed to identified locality priorities

It is expected that increasingly a proportion of the flexible funding pool currently available to PHOs will be spent at the locality level. The contract will likely sit with the named PHO and as a minimum will deliver on the model of care determined regionally and signed off by the regional ALT (or equivalent). Local activities that are required will require supplementary contract processes.

The locality approach will be developed in a way that does not unnecessarily increase bureaucracy, costs or delay decision-making

It is not intended through the locality approach to introduce further structures but to enable better connections and communications. It can be more a way of thinking and implementation than about structure, more of way of linking people across a system and maximising resource currently in different sectors while pursuing the same outcome.

6. Proposed Localities

Localities with a population of between 50-100,000 people are estimated to be required to gain the full benefits of a locality approach. This population size aligns well with the new wards defined for the Auckland SuperCity which again has advantages in being able to work closely with our local government partners.

In determining ward boundaries the Local Government Commission identified three communities of interest: perceptual (a sense of identity with an area); functional (reasonable economy of scale to meet requirements for physical and human services; and political (ability of elected body to represent interests)⁶. These are also relevant to primary healthcare and an integrated health system.

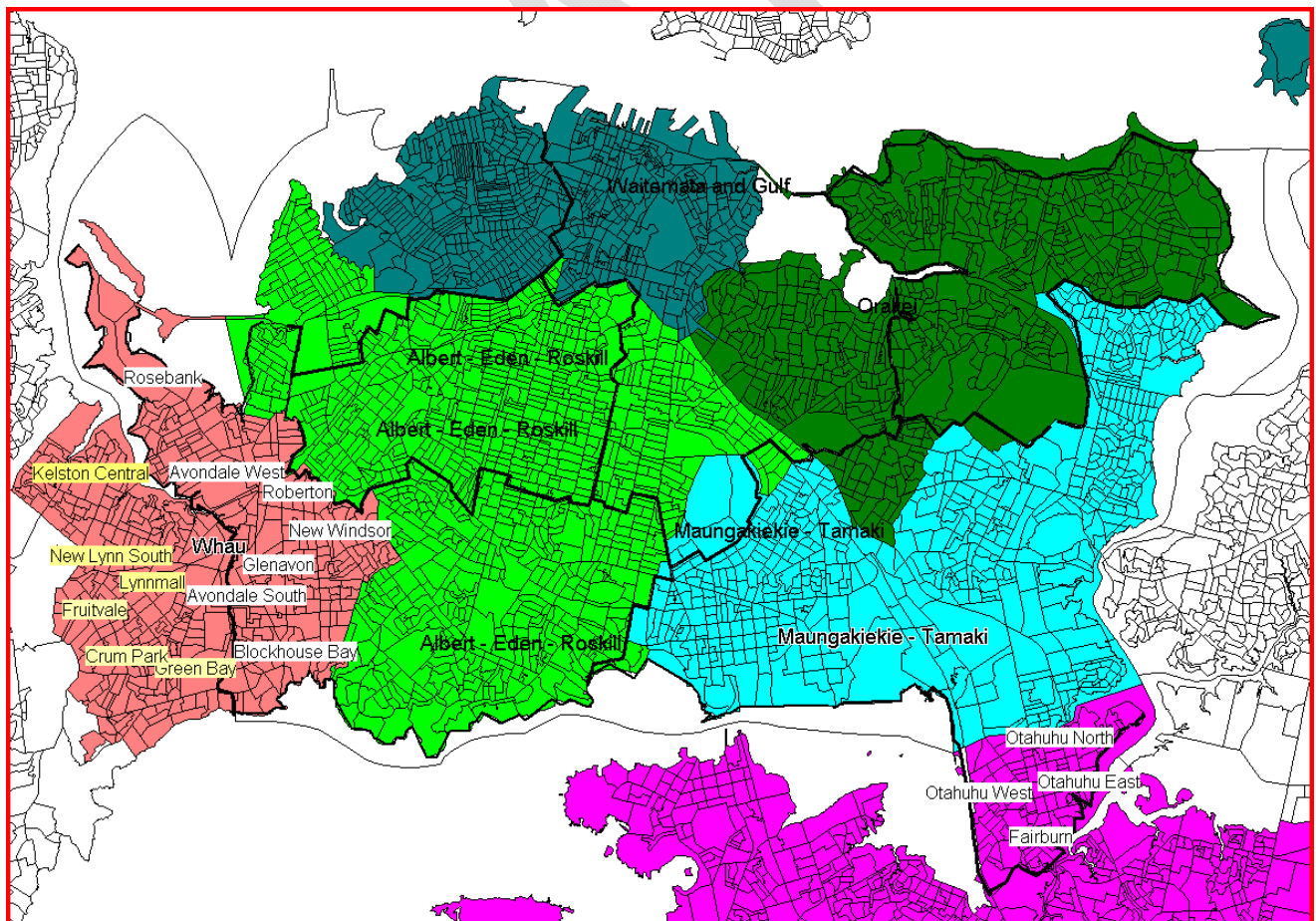
Previously it has been suggested that the new SuperCity wards themselves form the boundaries for our locality planning. We now believe there is utility in considering localities around the new Local Board areas rather than wards, as the Local Boards provide a ready community interface for locality planning. In many cases there is a single Local Board for a ward but where they have been split, the separation also makes sense from a health planning perspective. For example, this would mean considering the ward of ‘Waitemata and Gulf’ as three localities (Waitemata, Waiheke Island and Great Barrier Island).

⁶ Tasks and Approach on Auckland Governance Reforms, Local Government Commission, 2009

Under this proposal Auckland DHB would have **seven** localities exclusively and share parts of two others. Where current DHB boundaries overlap (in Whau and Manukau wards) negotiations will have to be entered into with those DHBs as to how best manage those areas. It is proposed that the preferred solution is to undertake a process of re-aligning DHB boundaries to match the local government boundaries but in recognition that this process takes time, a host DHB model is suggested as a first step.

Figure 1: Proposed Health Localities (see Appendix 1 for further detail)

Local Board / Health Locality	Ward	Population	DHB
Whau	Whau	76,400	Waitemata and Auckland DHB
Albert / Eden	Albert / Eden / Roskill	98,800	Auckland DHB
Puketapapa	Albert / Eden / Roskill	56,100	Auckland DHB
Waitemata	Waitemata and Gulf	70,000	Auckland DHB
Waiheke Island	Waitemata and Gulf	8,420	Auckland DHB
Great Barrier Island	Waitemata and Gulf	820	Auckland DHB
Orakei	Orakei	81,100	Auckland DHB
Maungakiekie Tamaki	Maungakiekie Tamaki	73,000	Auckland DHB
Mangere-Otahuhu	Manukau	75,900	Auckland and Counties Manukau DHB



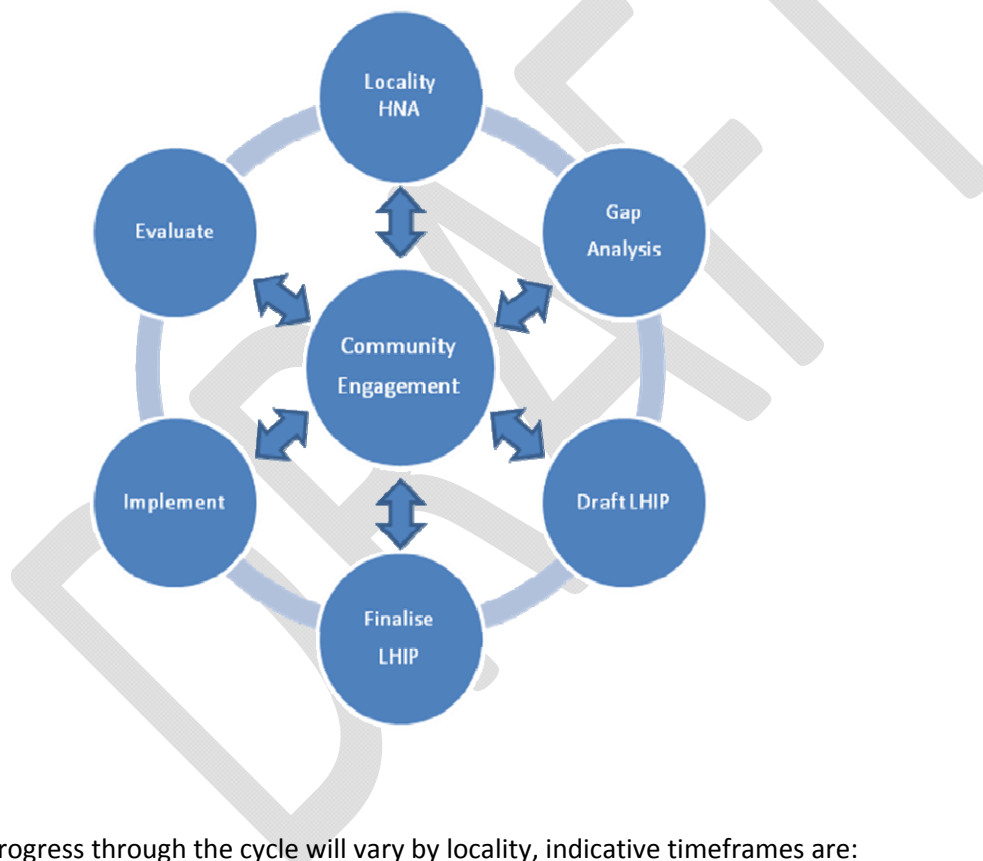
7 Implementing a Locality Approach

7.1 At the Locality Level

The approach proposed is an adaptation and enhancement of the broader DHB planning cycle. Key steps include:

1. Community engagement (occurs first and is continuous throughout)
2. Locality health needs assessment
3. Gap analysis
4. Development of strategic priorities with the local community
5. Development of a draft 'Locality Health Improvement Plan' (LHIP)
6. Prioritisation & funding decisions
7. Finalisation of the LHIP
8. Implementation monitoring
9. Outcome evaluation

Figure 2: The Locality Approach Cycle



While progress through the cycle will vary by locality, indicative timeframes are:



This whole cycle could therefore be expected to repeat on a 2-3 year basis which would align with the Local Board planning cycle (see next section).

7.1a Community Engagement

Community engagement is a central plank of this locality approach and is intended to be a continuous process throughout the planning cycle. As noted above, the new Super City Local Board areas are proposed to be health localities for the purposes of this approach. These Boards will be delegated direct responsibility for community engagement, proposing local bylaws, and making decisions on and overseeing local projects, activities and assets. They will also be responsible for preparing 3 yearly local board plans which will be strategic documents providing a vision for the locality and will show how the local board, by working with others, will contribute to achieving the local vision. It will also guide local board input into development of regional strategies, policies and plans. Given this mandate, community engagement with and through the Local Boards is appropriate for the implementation of this approach.

The Boards will be established as of 1 November 2010 and it is proposed that the DHB present this locality approach to the new Board Chairs as soon as possible after this date. Early engagement will allow the opportunity to weave the health locality approach into their three yearly local board planning cycle and there are great opportunities for shared community consultation and engagement activities.

In addition to engagement with and through the Local Boards we can engage existing community health groups directly through the HNA process (see below).

7.1b Locality Health Needs Assessment

In July 2009, ADHB published a Health Needs Assessment (HNA) for Waiheke Island. The report was a milestone for the DHB as it was the first time a locality based HNA had been attempted, and completed, in partnership with the local PHO (Auckland PHO).

Undertaking Locality HNAs acknowledges and highlights that, although we are a single DHB, there are significant differences within our population that we need to understand if we are to promote health and deliver appropriate health services for all. As such, locality HNA is a key plank of a locality approach for healthcare planning and delivery. Locality HNAs will include information on the local workforce, including capability and capacity of primary care, and apply an equity lens in comparisons.

In order to achieve the best understanding of health need at a locality level a mixed HNA approach is suggested, drawing on elements of epidemiological, comparative, community-based and corporate HNA models. In essence, the required information falls into two distinct groups being quantitative (the epidemiologic data) and qualitative (information gained directly from members of the community and healthcare providers). For practical purposes, the two parts could be undertaken separately and then combined.

Quantitative Information

There are a plethora of sources of health information and the level of detail available at the locality level varies by locality and by source. Where the locality of interest aligns with other statistical units, such as local body boundaries or census area units, then there is a greater likelihood of meaningful data being available. This is another reason for aligning our localities with local body boundaries. Notwithstanding that, it needs to be noted that a large amount of health data is not available below district or territorial authority level so the range of information is more limited than for district-wide HNA and consequently the deep and breadth of locality HNA will be smaller.

Qualitative Information

While epidemiologic data can paint part of the picture, in order to properly understand local health priorities it is important to get information directly from the community and from the health providers that serve them. A locality approach is ideally suited to getting to this level of detail.

When identifying stakeholders it pays to think outside the traditional health sphere. While important to speak to local health providers (GPs, plunket etc), other agencies also play key roles in the health of the local community. Examples include education providers such as schools, welfare agencies such as Work and Income NZ, ethnic groups/organisations such as local iwi, and other local bodies such as ratepayers associations and churches etc.

Several tools and techniques can be employed and which are most useful will depend on the specific locality.

Possibilities include:

- A stocktake of previous community engagement activity and outcomes. This is particularly suggested as it shows having “done your homework” before engaging with communities who may have already been involved in similar work in the past
- Use of a Project Reference Group involving representatives from the main health providers, the community, the Local Board, NGOs, community leaders (e.g. churches), local PHO(s), the DHB and other stakeholders (see ‘a note on stakeholders’ below)
 - Consideration could be given to having this group established in an ongoing way, as a ‘Locality Health Council’ or similar, to provide a conduit between the health authorities, the Local Board and the community. This Council could be established as a reporting sub-committee of the Local Board
 - Identification of a dedicated Locality Liaison person within the DHB for each locality would support this ongoing engagement
- Interviews with identified key stakeholders
 - Purposive or ‘snow-ball’ sampling can work well here with subsequent interviewees being identified by earlier ones
- Focus groups either generally (i.e. community at large), or aimed at priority populations such as particular age groups, ethnic groups, or other communities of interest
- Community surveys can also be useful in getting input from a broad range of people and can be done cheaply using online tools (e.g. web-based surveys and online panels with participation invited through advertising in local newspapers, shops, viral email etc). A “Delphi-technique” where respondents get to see collated results and change their original response if what others have said changes their mind is a good method for gaining iterative feedback.

It is good practice to circulate the results of such surveys back to the community through local media, online and face-to-face discussion.⁷

- Utilising established networks where community groups or programmes/projects, such as the Tamaki Transformation Programme and Healthy Village Action Zones, already exist
- Consideration of a kaupapa Māori approach may be useful in some areas

Overall, an ‘Action Research’⁸ and/or ‘Co-design’⁹ framework is suggested as a good way of ensuring community engagement and ownership of the whole cycle of activity. As noted previously, engagement with and through the Local Boards will be a key aspect of community engagement throughout the process.

7.1c Gap Analysis

Once the Locality HNA is complete and signed off by the Steering Group / Locality Health Council then a gap analysis can be undertaken. This can be thought of as an extension of the HNA process and involves comparing local information with other localities and the district overall to highlight key differences, focusing on areas of need (gaps).

7.1d Development of strategic priorities with the local community

The logical conclusion of the HNA and Gap Analysis process is agreement with the local community, through the representative Steering Group, on what the key priorities for short, medium and long term action are. This process is likely to require a further round of engagement to present the results of the HNA and Gap Analysis and seek feedback on the key areas of need that have been highlighted.

7.1e Development of a draft Locality Health Improvement Plan (LHIP)

Following the completion of an agreed set of regional priorities a local health improvement plan can be written. This plan would be based around the agreed priorities and translate the identified needs into concrete actions. In essence, if the locality HNA, Gap Analysis and agreed priorities provide the ‘what’, the LHIP provides the ‘how’.

7.1f Prioritisation and funding decisions

Once the draft LHIP has been agreed by the locality, it is put forward for consideration to a district level group charged with allocating funding across the district. In the medium term, we would hope to move to a level of local fund holding that would allow some of these decisions to be taken at a local level.

7.1g Finalisation of the Locality Health Improvement Plan (LHIP)

⁷ Note, online surveys alone are not likely to garner a representative cross-section of the community so they should be used in conjunction with other engagement methods.

⁸ Action research is an interactive inquiry process that balances problem solving actions implemented in a collaborative context with data-driven collaborative analysis or research to understand underlying causes enabling future predictions about personal and organizational change (Reason & Bradbury, 2001)

⁹ Within a health context, co-design (also known as experience based design or co-production) is “... a method of designing better experiences for patients, carers and staff”. It involves patients and staff exploring the care pathway and the emotional journey patients experience along it, capturing experiences, then working together to understand these experiences and improve them. (NHS Institute for Innovation and Improvement. The EBD approach - Guide and Tools. Coventry: NHS Institute for Innovation and Improvement, 2009)

Taking into account available funding and assessment of need across the district the LHIP can be finalised and timelines for action included. Unfunded priorities should remain part of the plan to be revisited when circumstances change.

7.1h Implementation monitoring

Who is responsible for implementing the LHIP will vary by locality but ideally it should be a shared accountability between the DHB, local PHO and community. Where a Locality Health Council is established this entity would be ideally placed, with all key stakeholders represented, to take a monitoring role.

7.1i Outcome evaluation

As with Implementation Monitoring above, Outcome Evaluation should be a key part of the cycle. Although the last item on the list, it is of most use in informing the next round of planning and so in this sense can merge with the Locality HNA. If we establish a recurring 2-3 year cycle then trend analysis as part of the HNA will become a useful tool to describe how we are doing in advancing the health of the local population.

7.1j Digging deeper

While we would expect the cycle above to be completed consistently across each locality, some areas will have identifiable sub-populations that are worthy of focus within the broader approach. The Tamaki Transformation Programme area of Maungakiekie-Tamaki is a good example of where a separate 'spotlight' analysis might be appropriate.

7.2 At the Regional and District Levels

There is a need to develop in more detail clarity around the planning and services provision that will need to be undertaken at the Auckland district and metro-Auckland levels (e.g. strategy, frameworks such as long term conditions) as distinct from localities.

The aim is to ensure sufficient activity is undertaken at the regional and district levels to ensure consistency and reduce duplication but not to stifle change and activity that needs to occur locally.

There is also an opportunity to establish and/or strengthen relationships with pan-locality organisations such as Ngati Whatua o Orakei, the National Māori Coalition and Alliance Health + business cases to explore how they might be placed to support development at the locality level.

7.3 Staging of approach

The number of localities that can be progressed at any one time will be dependent on the resources available (see next section). In terms of the order in which localities are engaged, it is proposed that this is based on a two factors, one being areas of high needs and the other being areas where there is existing activity to build upon.

On this basis it is proposed that the order of locality engagement is:

1. Maungakiekie-Tamaki
(to build on the work of the Tamaki Transformation Programme)
2. Puketapapa
3. Albert / Eden
4. Waitemata
5. Orakei
6. Great Barrier Island
7. Waiheke Island

Engagement in Whau and Mangere-Otahuhu will be dependent on arrangements made with Waitemata DHB and Counties-Manukau DHB respectively.

8. Enabling a Locality Approach

The background paper highlights a number of principles in relation to taking a locality approach (copied in Appendix 2). The enablers below build on these principles to create a series of recommendations for consideration.

8.1 Establishment of an Implementation Steering Group and/or Working Group

The establishment of an over-arching Steering Group to drive and monitor the implementation of the locality approach is essential. This group should have high level DHB representation and could include key primary care and community leaders. A suggested make-up is:

- Chairs of each of the Local Boards (seven)
- Chairs of each of our PHOs (currently five)
- Chief Planning and Funding Officer
- GM Māori Health
- GM Pacific Health
- Chief Medical Officer
- Director of Population Health and Primary Care
- Manager, Primary Care and PHOs.

In addition, it may be useful to have an Implementation Working Group consisting of key Planning and Funding managers responsible for the day to day driving of the programme:

- Locality Approach Project Manager(s)
- Director of Population Health and Primary Care
- Manager, Primary Care and PHOs
- Manager, Population Health
- Population Health Analyst
- Planning and Funding Manager, Health Inequities
- Planning and Funding Manager, Māori Health
- Planning and Funding Manager, Pacific Health
- Planning and Strategy Manager
- Community Consultation Manager

8.2 Dedication of specific project resource

In order to progress a locality approach, dedicated project resource will be required. The exact level depends on the speed with which we wish to deploy but a fair assessment is that 1.0 FTE is likely to be able to progress work in no more than two localities (dependent on a range of factors) at any one time

8.3 Adoption of a host PHO model

Making the best use of resources will require that PHOs commit to a model that has only one PHO as the host PHO for each locality. That PHO would be expected to take a lead role in working with the DHB to provide services in the area and would be expected to take and incorporate advice from other PHOs that have specialist information about a community of interest within the locality. It is not expected that there

will be the same number of PHOs as localities but rather that PHOs will work together in localities where there are more than one operating, with one acting as 'host'.

8.4 Adoption of a host DHB model

As with 4.3 above, the adoption of a host DHB model where localities cross DHB boundaries (Whau and Manukau) is the preferred approach. The details of how both these 'host' models will work in practice needs to be worked through.

8.5 Mapping of activity: Regional – District - Local

A mapping of the activity described in 7.2 needs to occur prior to beginning any meaningful work at the locality level to ensure clarity of how the various pieces fit together.

8.6 Confirmation of funding flows and contracting arrangements

There is a need to confirm how funding will flow and how contracts will be established to support the locality approach. While much of the locality cycle can be completed without this information, it is critical to the development and agreement of the LHIPs.

8.7 Wide sector engagement

There is a need to continually engage with other key stakeholders including our DHB and PHO partners, NGOs, and local government to ensure alignment across the region.

8.8 Developing 'locality liaison' roles within existing FTE

A further enabler would be to consider allocating each of the seven localities to a specific Planning and Funding Manager to act as the key contact for that locality within the DHB. Providing localities with a single point of contact at the DHB would go a long way to building strong community relationships with groups of providers, community organisations and the like. An extension of this idea would be reconfigure current Planning and Funding portfolios to include management responsibility for specific localities.

8.9 Alignment of hospital based specialists

In order to extend the locality thinking into hospital practice it is suggested that hospital specialists 'adopt' one or more localities. For example, referrals to Neurology would be allocated first to the Neurologist for that locality. That Neurologist could develop relationships with GPs in those localities, delivering CME sessions etc and being the go-to contact for phone advice. Although allowances would need to be made for areas of sub-specialisation and ensuring that access remained consistent across the localities, this approach holds great potential for better integrating care between community and hospital providers.

There is also scope for applying the same principle for community nurses and other outreach health professionals and services.

9. Next Steps

1. Engagement and consultation with wider stakeholders including neighbouring DHBs, PHOs, NGOs, Business case consortia, and ARPHS on the proposed approach
(Sept – Oct 2010)
2. Pilot aspects of the approach within the Tamaki area, in conjunction with the Tamaki Transformation Programme
(Sept – Dec 2010)

3. Further develop, in conjunction with our DHB and PHO partners, the host DHB & PHO models (Sept – Oct 2010)
4. Begins negotiations with Waitemata DHB and Counties-Manukau DHB about re-aligning DHB boundaries with local government boundaries, including consideration of the financial implications (Sept – Nov 2010)
5. Develop clarity around the planning that will need to be undertaken at the metro-Auckland and district levels (e.g. strategy, frameworks such as long term conditions) as distinct from the locality, and how the approach will enhance the implementation of business case plans (Sept – Nov 2010)
6. Gain Board endorsement for the approach (Nov 2010)
7. Appoint Locality Project Manager(s) and form Implementation Steering and Working Groups (Nov 2010)
8. Engage with newly elected Local Boards (request meetings with Board Chairs once elected) (Nov 2010)
9. Initiate the locality approach cycle within Maungakiekie-Tamaki, building on the pilot experience with the Tamaki Transformation Programme (Nov 2010)
10. Initiate activity in further localities dependent on resourcing (Nov 2010 onwards)

Appendix 1: Local Board Arrangements

Ward	Local board	Population estimate*	Subdivisions	Population estimate*	Number of members (% deviation from average population per member**)
Rodney	Rodney	54,100	Wellsford Warkworth Dairy Flat Kumeu	5,550 16,700 6,470 25,400	1 (-7.7%) 3 (-7.4%) 1 (+7.6%) 4 (+5.6%)
Albany	Hibiscus and Bays	88,800	Hibiscus Coast East Coast Bays	42,500 46,300	4 (-4.3%) 4 (+4.3%)
	Upper Harbour	49,000	None		6
North Shore	Kaipatiki	85,900	None		8
	Devonport-Takapuna	57,300	None		6
Waitakere	Henderson-Massey	109,600	None		8
	Waitakere Ranges	49,000	None		6
Whau	Whau	76,400	None		7
Albert-Eden-Roskill	Albert-Eden	98,800	Owairaka Maungawhau	48,900 49,900	4 (-1.0%) 4 (+1.0%)
	Puketapapa	56,100	None		6
Waitemata and Gulf	Waitemata	70,000	None		7
	Waiheke	8,420	None		5
	Great Barrier	820	None		5
Ōrākei	Ōrākei	81,100	None		7
Maungakiekie-Tāmaki	Maungakiekie-Tāmaki	73,000	Maungakiekie Tāmaki	28,500 44,400	3 (-8.8%) 4 (+6.6%)
Manukau	Mangere-Otahuhu	75,900	None		7
	Otara-Papatoetoe	80,300	Otara Papatoetoe	34,200 46,100	3 (-0.6%) 4 (+0.5%)
Te Irirangi	Te Irirangi	128,100	Howick Pakuranga Botany	42,700 41,900 43,600	3 (-0.1%) 3 (-1.9%) 3 (+2.0%)
Manurewa-Papakura	Manurewa	86,600	None		8
	Papakura	44,900	None		6
Franklin	Franklin	64,200	Wairoa Pukekohe Waiuku	20,200 30,300 13,750	3 (-5.7%) 4 (+6.1%) 2 (-3.7%)

* These are rounded 2009 population estimates provided by Statistics New Zealand.

Because they are rounded estimates, the total subdivision population does not equal the local board population in some cases.

** '+' denotes under-representation and '-' denotes over-representation

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Community and Public Health Advisory Committee Paper

Date	Wednesday 15 September 2010
To	Community and Public Health Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Greenlane Clinical Centre
Author	Denis Jury, Chief Planning and Funding Officer Greenlane Clinical Centre
Functional Group	Planning and Funding
Subject	Presentation on Alliance Contracting
1.	Introduction Denis Jury will present on Alliance Contracting

10

CONFIRM

10.1 Action Points for next CPHAC Meeting

10.2 CPHAC Feedback to Board

Use Forms at beginning of Meeting Pack

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GENERAL BUSINESS

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APPENDICES

No Appendices

PAPER IN PUBLIC EXCLUSION

13.1 Update on Contract Reviews

Community and Public Health Advisory Committee Agenda

MEETING DETAILS	
Time and Date	2:00 p.m. – 5:00 p.m. Wednesday, 15 September 2010
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre
Members	Dr Brian Fergus (Chair), Jo Agnew, Susan Buckland, Harry Burkhardt, Dr Chris Chambers, Rob Cooper, Dr Ian Scott, Pat Snedden, Rt Hon Bob Tizard, Seiuli Dr Juliet Walker, Ian Ward, Rev Alfred Ngaro, Farida Sultana, Lynda Williams
Apologies	
In Attendance	Garry Smith, Dr Denis Jury, Taima Campbell, Hilda Fa'asalele, Naida Glavish, Janice Mueller, Ian Bell.

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5	Action Points - Wednesday 21 July 2010	025
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7	Improvement Activities 7.1 DAP Projects Report	047
8	Feedback from Maori Health Advisory Committee and Pacific Health Advisory Committee	063
9	Papers 9.1 A Locality Approach for Auckland 9.2 Alliance Contract Presentation	065
10	Confirm 10.1 Actions Points for next CPHAC Meeting 10.2 CPHAC Feedback to Board	089



Community and Public Health Advisory Committee Agenda

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12	Appendices - There are no Appendices	093
13	Paper in Public Exclusion 13.1 Update on Contract Reviews	095
NEXT MEETING		
	Date and Time: 2:00 p.m. – 5:00 p.m. Wednesday, 20 October 2010	
	Venue: Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre	

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare