Community and Public Health Advisory Committees Meeting

Wednesday, 10th August 2011

2.00pm

Venue

Waitemata District Health Board
Boardroom
Level 1, 15 Shea Tce
Takapuna

2.1 Confirmation of the Minutes of the Waitemata District Health Board Community and Public Health Advisory Committee Meeting held on 13 July 2011

Recommendation:

That the Minutes of the Waitemata District Health Board Community and Public Health Advisory Committee Meeting held on 13 July 2011 be approved.

Minutes of the meeting of the Waitemata DHB

Community & Public Health Advisory Committee

Wednesday 13 July 2011

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna
commencing at 1.02 p.m

COMMITTEE MEMBERS PRESENT:

Warren Flaunty (Committee Chair)
Max Abbott (Deputy Board Chair)
Pat Booth
Sandra Coney
James Le Fevre
Christine Rankin
Allison Roe
Gwen Tepania Palmer (present from 1.14p.m)
Tim Jelleyman (Co-opted member)
Lyvia Marsden (Co-opted member)
Deborah Dalliessi (Co-opted member)

ALSO PRESENT: Dale Bramley (Chief Executive Officer)
Debbie Holdsworth (Acting Chief Planning and Funding Officer)
Paul Patton (Director of Communications)
Tim Wood (Acting Group Funding and Primary Care Manager)
Imelda Quilty-King (Community Engagement Co-ordinator)
Paul Garbett (Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item.)

PUBLIC AND MEDIA REPRESENTATIVES:

Tracy McIntyre, Waitakere Health Link
Margaret Willoughby, Rodney Health Link
Lynda Williams, Auckland Women's Health Council
Lance Norman, Deputy CEO, Waitemata PHO

LEAVE OF ABSENCE: Rob Cooper

APOLOGIES: **Resolution** (Moved Max Abbott / Seconded Pat Booth)

That the apologies from Lester Levy and Wendy Lai, and the apology for late arrival from Gwen Tepania Palmer, be accepted.

Carried

WELCOME The Committee Chair welcomed those present and congratulated Dale Bramley on his appointment as Chief Executive Officer. He noted that this would be his last meeting as Chair of CPHAC as the new combined meeting arrangements for Auckland and Waitemata CPHAC Committees would commence in August. He thanked all Committee members, staff members and representatives of the Health Links for their support. He also noted that it was pleasing to see the Misuse of Drugs Amendment Bill proceeding through the House of Representatives, as six years previously the Board had first raised the issues relating to pseudoephedrine.

DISCLOSURE OF INTERESTS

There were no notifications of additions or amendments to interests that had been previously advised by members.

There were no identified conflicts of interest for this agenda. Warren Flaunty noted that he had been given a Board accountability relating to the Bowel Screening Programme, but that this should not affect his ability to participate in consideration of agenda item 4.3 on this topic.

PART I – Items considered in public meeting.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed in the agenda, except that Item 4.1 was considered before Item 3.1.

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Community and Public Health Advisory Committee Meeting held on 8 June 2011 (agenda pages 1-10)

Resolution (Moved Sandra Coney / Seconded Tim Jelleyman)

That the Minutes of the Community and Public Health Advisory Committee Meeting held on 8 June 2011 be approved.

Carried

Matters Arising:

No issues were raised. It was noted that the presentation by Health Workforce NZ would be at the August Board Meeting.

3 DECISION ITEMS

3.1 The Feasibility of a Study to Determine Correlations between Child Immunisation Uptake and Use of Screening by their Parents (agenda pages 11-14)

Peter Sandiford, Public Health Physician, was present for this item.

Sandra Coney detailed her deep concerns with the proposed study. She emphasised that cervical screening is a sensitive issue for women, and historically had involved stigmatisation, particularly for Maori women. She advised that the proposed study is already controversial, and has the potential to undermine the confidence of some women in putting their name on the cervical screening register and their confidence in the National Health Index. She queried how useful the results of the study would be as it is well known that one of the biggest barriers to screening is cost, whereas immunisation is free. She noted that with the Government rolling out the use of the National Health Index (NHI), there is public concern about the use of NHI numbers and sensitivity around matching records - and this proposal went further by matching information about separate people by looking at NHI numbers. She suggested that rather than the proposed study, the Board might wish to pilot an intervention using a whanau ora approach.

There was an extensive discussion of the issues involved and matters covered included:

- Support for adopting a whanau ora approach in improving access for Maori to screening and immunisation – approaching families over a broad range of issues.
- Support for the objective of the proposed study – that it is important to establish linkages, even if this particular study is not appropriate because of the sensitivity around cervical screening.
- That in primary care the Dr Info system does enable general practitioners to identify for individual patients a whole list of multiple problems needing addressing. It might not be difficult for them to expand that to get a picture of whole families. However that approach would really be up to the PHOs to encourage. Lyvia Marsden advised that they had found an approach combining Dr Info and the development of family trees to be effective.

Lynda Williams (Auckland Women's Health Council) was invited to comment and emphasised how sensitive the issue of the Cervical Screening Register and privacy of data had been when the system was set up – and the promise that the information would be kept and protected on a separate database.

Resolution (Moved Sandra Coney/Seconded Warren Flaunty)

(a) That the proposed exploratory study not be endorsed and not be proceeded with.
(b) That a report be prepared for CPHAC on other approaches to address the issues raised.

Carried

4 INFORMATION ITEMS

4.1 Quality Use of Medicines (agenda pages 15-20)

John Kristiansen and Angela Lambie, QUM Project Managers, were present for this item. They noted that projects are on track and that they are continuing to work with other District Health Boards to share resources.

In response to questions, the Committee was advised:

- With regard to the Pictorial Asthma Medication Plan, the way it is being rolled out to general practices is mainly by offering it and hoping that the tool will sell itself to them. Work is also being done to provide support and to demonstrate the tool. The number of practices involved to date is not huge, and development of involvement requires time to get out and meet the practices. The focus remains to concentrate on practices with a significant number of Maori and Pacific patients.
- The website for the Pictorial Asthma Medication Plan is www.pamp.co.nz. While the number of people who used the website can be tracked, they have not introduced a registration system, as they did not want any barriers to use. Also a registration system would have required a much more advanced website to protect privacy.
- The Online Education to Junior Doctors does not involve pass/fail tests. The aim is to make sure that the doctors read and assimilate the material, and if they give a wrong answer to a question, the software sends them back to re-try.

4.2 Healthy Lifestyles (agenda pages 21-26)

Leanne Catchpole, Maternity, Child, Youth, Oral Health and Healthy Lifestyles Team Leader, summarised the report. She noted that with the funding now being received from the Ministry of Health for "quit smoking" services, good progress is being made, including an agreement

with the provider arm to provide "quit smoking" advice to elective surgery patients prior to surgery and with quit smoking services to staff members.

In answer to a question, Leanne Catchpole advised that with regard to follow up services for discharged hospital patients who have started a quit smoking programme, home visits can be arranged to support Maori, Pacific or Asians through the relevant services, but for Europeans that was not available and the support source was via the Quitline telephone service, or through their general practitioner. Information on the smoking interview is now included in the hospital discharge summary which goes back to the patient's general practitioner. Max Abbott suggested that strengthened follow through would be important to achieving a higher level of lasting success for people endeavouring to give up smoking.

Leanne Catchpole referred to the comprehensive approach needed to address smoking, as highlighted by the Select Committee dealing with the issue, including taxes, packaging, smoke free policies and providing an environment which supported people attempting to give up smoking.

Allison Roe advised that she had a couple of conversations with Ian Potter, Chief Executive of the Health Sponsorship Council, and had been told that 4-5% of the smoking population quit spontaneously, but that if a health professional initiates an interaction on this, that rate tends to double.

There was a discussion of the quit smoking pilot in West Auckland involving pharmacies. It was noted that pharmacists are highly trusted by the public and that most people visit pharmacies more often than their general practitioner. Leanne Catchpole advised that the preliminary results from the pilot would be received at the end of July and they would then consider the ongoing approach to the use of pharmacies.

Sandra Coney advised the Committee that Auckland City was considering measures to restrict smoking in public places.

Information was requested on the support being given to Waitemata DHB staff to quit and on monitoring of the no smoking policy in Waitemata DHB facilities and any difficulties being experienced. In response, the Chief Executive advised that following recent NZ Herald articles concerning the approach Auckland DHB was taking to smoking in and around its facilities, contact had been made with ADHB, to look at possible alignment of the approach being taken by the two DHBs. A report will be prepared for the Hospital Advisory Committee providing an update on the support given to staff to quit smoking and how enforcement of WDHB's "no smoking" policy on hospital grounds and other sites is going, and on the ADHB approach and how we might align where appropriate.

The Committee also noted that despite the overall reduction in smoking in the general population, the inequality with Maori has actually grown, and there is a need to think strategically around this issue.

Resolution (Moved Warren Flaunty / Seconded James Le Fevre)

(a) That the report be received.
(b) That CPHAC endorse actioning the clawback clauses in the contract by Planning and Funding, if a PHO has not met the deliverables in their PHO Smokefree contract.

Carried

4.3 Bowel Screening Pilot (agenda pages 27 - 32)

Gaye Tozer, Project Manager, Bowel Screening Pilot, Mike Hulme-Moir, Clinical Director, Moira McLeod, Programme Manager Breast and Bowel Screening Programmes, and Mhairi Porteous, Manager, Bowel Cancer Team, Ministry of Health were present for this item.

Answers to questions included:

- Any screening programme will normally have an upper and lower age limit, based on assessment of costs and benefits and international best practice.
- The successful tender was a bid by Waitemata DHB on behalf of the whole Auckland Region. It involves using some services from outside the Waitemata DHB, for example colonoscopy, and it is also extremely important to involve general practitioners. The Register, located at the Breast Screen Coordination Centre, will act as a fail save device for the programme.
- For people who had questions when they received their pre-invitation letters or test kits, both a summary pamphlet and a comprehensive booklet are being developed. They would also be encouraged to ring the information line or their GP if they had concerns, and a website address would be provided.
- The programme would be independently monitored and evaluated, including for cost effectiveness.
- A first round of Focus Group meetings had been held to look at the look and feel of the programme, letters and pamphlets. Another round of meetings was currently under way, drawing on people from the community and invited stakeholders to provide an input.
- The approach being taken is to direct resources and energy towards to those parts of the population which are known to be low responders to health initiatives, and to put comparatively less effort into the rest of the population. A working group led by Moira McLeod is designing a detailed programme expected to meet as many people in the high needs population as possible.
- The issue of how the first year invitees will be selected is currently being looked at, with a number of options for the invitation strategy being considered. One possibility would simply be to use date of birth, with those with an even number invited in the first year, and with an odd number in the second year.
- It is correct that the programme will identify false positives, but not false negatives, although it may be possible to identify those long tem through the cancer register.
- Overseas screening programmes had achieved screening rates of about 40%. Based on an assumption of 60% uptake, and expected positive results of 6% of those screened, there should be sufficient capacity to cope with the number of colonoscopies that would be required as a result. This calculation could only be based on assumptions.
- The maximum waiting time for colonoscopies, as set by the Ministry of Health for the pilot, was 50 days. For those with a positive result and waiting for a colonoscopy, there would be two avenues to discuss their concerns; through their general practitioner or through an 0800 number. One of the main reasons for involving general practitioners in the pilot was that there needed to be someone for those with a positive result to talk with. The programme is being designed so that the laboratory results will go both to the register and the GP. The GP will receive the positive result at the same time as the Co-ordination Centre does. In the service delivery model there is an option for the GP to have the conversation by telephone, if that worked for both parties, or in person. Either way the conversation would be funded, but would have to take place within 10 days of the results being known.
- It was hoped that those with a positive result would not opt for private treatment. The philosophy behind the pilot was to set up the best possible system, and proceeding through the public health system would maintain the integrity of the pilot.

The bowel screening pilot team were acknowledged and applauded by the Committee for the long hours they are putting into making the pilot a success, and for the quality of thought being shown in developing the programme.

Resolution (Moved Max Booth / Seconded Gwen Tepania Palmer)

(a) **That CPHAC receives this report describing the key components of the Bowel Screening Pilot.**
(b) **That CPHAC notes progress towards the implementation of the Bowel Screening Pilot.**

Carried

The above resolution was carried unanimously, with acclamation.

5. STANDARD MONTHLY REPORTS

5.1 Funder Services Update (agenda pages 71-72)

Janine Pratt, Group Planning Manager, Tim Wood, Acting Group Funding and Primary Care Manager, Andrew Coe, Manager of PHOs and Primary Care, Stuart Jenkins, Clinical Director Primary Care and Cliff La Grange, Finance Manager were present for this item.

Janine Pratt advised that work was starting to be done around Auckland Council's "Auckland Unleashed Plan", with a view to a draft submission being presented to the Board, probably in September. It was noted that many of the things the Council does have health impacts and it is important to have an input into this process.

With regard to the Business Case Update – GAIHN, it was noted that what is allowed for in the District Annual Plan is what goes in the funding envelope. The critical issue is that when the Board consents to a business case, it needs to go through due process. Andrew Coe advised that projected costs for GAIHN are changing weekly as more detail is received.

The amendment to PHARMAC's Exceptional Circumstances Scheme was welcomed, as the previous restriction on funding under the scheme to medications where there were ten or less patients nationally had caused distress.

Resolution (Moved Pat Booth / Seconded Max Abbott)

That the report be received.

Carried

On the occasion of his last meeting as Chair of CPHAC, Warren Flaunty thanked Committee members, the Chief Executive, management and staff, and the health link representatives for their support.

On behalf of the Health Links, Deborah Dalliessi thanked the Board for acknowledging the importance of their Committees. They looked forward to strengthened resources and ongoing engagement with the Board and the Chief Executive Officer.

Dale Bramley thanked Warren Flaunty on behalf of management, for providing great chairmanship and a steady hand when difficult issues arose.

The Chair thanked members for their attendance and attention to business.

The meeting concluded at 2.54p.m.

SIGNED AS A CORRECT RECORD OF THE WAITEMATA DISTRICT HEALTH BOARD COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING OF 13 JULY 2011

____CHAIR

Actions Arising and Carried Forward from Meetings of the Community & Public Health Advisory Committee (CPHAC) as at 15 July 2011

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 8/12/10 9/2/11	4.4	Healthlink Reports: Shortage of GPs in West Auckland - arrange for Health Workforce NZ to brief Board.	Peta Molloy	Board 31/8/11	Presentation will be made by Health Workforce NZ covering this and other health workforce issues.
CPHAC 13/4/11	4.3	Interpreter Service – Next Asian Health Service Update to include information on level of service provided, number of times used and cost.	Sue Lim	CPHAC 12/10/11	
CPHAC 11/5/11	4.1	Pharmaceuticals – information to be provided on what percentage of the increase in number of items dispensed relates to close control items.	Tim Wood	CPHAC 10/08/11	
CPHAC 11/5/11	4.5	Cancer Control – Ministry of Health to be asked to send a representative to a meeting of HAC to report on how they are intending to improve cervical cancer screening rates and remove inequalities in delivery of that service.	Tim Wood	HAC 31/8/11	Confirmed with Ministry for August HAC.
CPHAC 13/7/11	3.1	Correlations of health needs by linking data - a report to be prepared for CPHAC on other possible approaches that would assist in progressing understanding of family health needs based on linkages.	Peter Sandiford	CPHAC 12/10/11	
CPHAC 13/7/11	4.2	Smoking - a report to be provided for HAC on the support being given to staff to quit smoking and how enforcement of the Board's non-smoking policy in hospital grounds and other sites is proceeding, and on the ADHB approach and how we might align where appropriate.	Alan Wilson	HAC 31/8/11	

2.2 Confirmation of the Minutes of the Auckland District Health Board Community and Public Health Advisory Committee Meeting held on 20 July 2011

Recommendation:

That the Minutes of the Auckland District Health Board Community and Public Health Advisory Committee Meeting held on 20 July 2011 be approved.

Community and Public Health Advisory Committee
Minutes

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

1	**KARAKIA**
	The Chair declared the meeting open at 2:01 pm. Kerry Hiini led the meeting with the karakia.
2	**ATTENDANCE AND APOLOGIES**
	Committee Members Dr Lee Mathias (Chair) Judith Bassett Dr Chris Chambers Peter Aitken Susan Buckland Ian Ward **Management in Attendance** Dr Denis Jury – Acting Chief Executive Hilda Fa'asalele – General Manager Pacific Health Aroha Haggie – Maori Health Gain Manager Kerry Hiini – Planning and Funding Manager Janice Mueller – Director Allied Health Andrew Old – Public Health Physician Ian Bell – Board Administrator **Apologies** Apologies had been received from Dr Lester Levy, Jo Agnew, Rob Cooper, Robyn Northey, Gwen Tepania-Palmer, Garry Smith and Taima Campbell. Judith Bassett advised that she would be leaving at 3:30pm. <u>Moved Peter Aitken; seconded Susan Buckland</u> *That the apologies be sustained.* <u>Carried</u>
9.2	**GAIHN Proposed Work Plan 2011 – 2013**
	Dr Ray Naden, Chair of GAIHN and David Tucker were in attendance. Since the last meeting, where there had been an update, a paper on the direction and approach had been developed. There was still work to be done on timelines and implementation. The first quarter of the work programme is to be funded through current available funds noting that the indicative budget requirement in 2011 - 2012 for ADHB is $450k. GAIHN was looking at an integrated approach across the sector focused on patients who have acute events. The purpose of the project is to maximise benefit for the patients and their families and reduce the flow of acutes admissions. Auckland, as a region, has a higher rate of hospital admissions. The approach is to identify the patients in order to prevent acute events. Secondly, if there is an event, to initiate the response at primary care level and if hospitalisation is required to shorten that as much as possible through such programmes as "making time to care".

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

	Issues were communication with primary care, difficulties in joining the network and determining what lesions were sensible to be done.
	After Hours Proposal for Auckland Metro Region
	Andrew Coe, Manager PHOs and Primary Care and Dr Stewart Jenkins, Clinical Director Primary Care were in attendance. The Auckland After Hours Network proposal had been distributed noting that the indicative funding was $10m with approximately $5m already committed by DHBs with the remaining funding proposed to be shared between DHBs and PHOs with the DHB contribution on a population based funding equivalent basis rather than the historically contributions. Target groups would be defined as high need, rather than Maori and Pacific and deprivation, identified by NHI. After Hours should not be cheaper than day visits to GPs. Funding for over night of $2.8m would be removed as this may be undertaken in the hospital EDs. There were links with St Johns to get the right place for right care. While the proposed model was not ideal, and will need to be managed carefully so as not to move patients from their medical home for longer term management, there was a need to work with primary care on what is proposed. There was a need to model the effect on individual practices. The committee asked that contractual obligations be limited to a maximum of one year. An indication was given that the proposal was for 10 months in the first instance. Judith Bassett left the meeting at 3:30pm. Specifications would be waiting times less than one hour and other quality and performance measures. PBF allocation was important, involvement of primary care and ED clinicians as well as an evaluation of what would change from 1 September although it may not be in final form, the stages and dollars. It was essential that the bundle of services were only paid for once and it needed to link to the GAIHN projects to change acute demand. There was concern at the short timeframe with issues to be resolved such as the definition of high needs and noting that A&M clinical governance did not sit under PHOs or DHBs. There was also concern to ensure medical home retention. Moved Chris Chambers; seconded Peter Aitken *That the CPHAC recommends that the Auckland DHB Board:* 1. ***Receives** the Auckland Region After Hours Proposal to Metro Auckland DHBs June 2011 prepared by the After-Hours Alliance, noting that the Proposal is currently being updated to include further operational detail and specificity* 2. ***Endorses** the redesign of after-hours services in the Auckland region over the next year in line with the After-Hours Alliance Proposal, subject to sufficient funding being approved by Metro Auckland DHBs and PHOs* 3. ***Notes** that indicative funding for the total Proposal is $10M; approximately $5M of which is already committed by DHBs in existing services and the remaining funding of $5M is proposed to be shared by DHBs and PHOs* 4. ***Endorses** that the DHB contribution across the region is on a population based funding equivalent basis* 5. ***Approves** that management proceed to work through the required implementation detail with the After-Hours Alliance, and provide a report by the end of August 2011 that includes specific funding recommendations* 6. ***Notes** that a phased implementation approach is proposed, and a review of overnight service options will be completed in phase two and prior to 31 December 2011, in order to inform service arrangements and funding from 1 April 2012* 7. ***Notes** the current rural after hours services will continue as now and be unaffected by the changes proposed in Phase 1and 2 (to March 2012)* Carried

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

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

3.1 Proposed Approach to the Combined Auckland DHB and Waitemata DHB Community and Public Health Advisory Committee Meetings

Recommendation:

That it be recommended to the Auckland and Waitemata District Health Boards:

1. **That the proposed approach to the management of the combined Community and Public Health Advisory Committee Meetings is supported.**
2. **That the function and benefits of the combined advisory committees be reviewed at the time that meetings move onto the proposed six weekly cycle.**

Prepared by: Dr Debbie Holdsworth (WDHB – Acting Chief Planning & Funding Officer) and Dr Denis Jury – (ADHB - Chief Planning & Funding Officer)

Glossary

CPHAC - Community and Public Health Advisory Committees
DHB - District Health Board

1. Executive Summary

The move to combine Community and Public Health Advisory Committee meetings for Auckland and Waitemata DHBs provides a unique opportunity to consider the role of the committees and the most beneficial way to ensure the committees are well informed and supported in their decision-making. An overview of the benefits and a proposed approached to the management of these committees is described to assist the committees and determine how best to provide advice to their respective Boards under this new model.

2. Introduction/Background

The Boards of Auckland District Health Board and Waitemata District Health Board have sought approval from the Minister of Health to combine the functions and membership of the Community and Public Health Advisory Committees. The Minister of Health supports this collaborative initiative, noting that to remain compliant with the New Zealand Public Health and Disability Act, they must be separately identifiable.

2.1 Benefits of a joint approach

The joint approach to these committees enables greater collaboration at a governance level where there are issues in common, particularly:

- Making sure that patients come first and that any barriers for them are reduced across our boundaries
- Achievement of common Board priorities
- Global view of the health needs / burden of disease for the district populations
- Service development and health services to be provided
- Approaches to prioritisation, including principles and framework
- Maori interests and the Maori health plan/s

- Manawhenua interests
- Initiatives to reduce inequalities for specific populations: Pacific, disabled people, new New Zealanders
- Community / patient views and preferences
- Local implications of national and sector-wide health goals and performance expectations e.g. overseeing progress on national health targets and indicators
- Strategic direction as per our regional health plan
- Planning for the next financial year (annual plan and statement of intent)
- Oversight and monitoring of contract processes
- Risk management
- Improving collaboration between the two DHBs
- Improving the use of resources across boundaries and reducing bureaucracy.

While the committees will share the same agenda and information, they will still need to report back to their respective Boards with their recommendations and advice in order to meet the legislative requirements within the Act.

3. Proposed Approach

In order to progress this initiative, the overall approach and management of these committees needs to be agreed by both organisations. The success of the combined advisory committees should also be reviewed at the time that meetings move onto the proposed six weekly cycle.

3.1 Development of the Agenda

The scope of the committees' advice is broad; therefore it is proposed that the main focus of each agenda is on the achievement of Auckland and Waitemata DHB's Board priorities, and those areas identified by both Boards as opportunities for collaboration as per the terms of reference (Attachment 1). The Committees will also be asked to consider elements of the various accountability documents, reporting requirements, service development approvals and other work within the responsibility of the Chief Planning and Funding Managers.

A schedule of future papers will be agreed by the Committee Chair to enable preparation of more substantive papers. This will assist the committees to discuss complex issues more thoroughly. It is expected that primary care will feature on each meeting's agenda. Similarly an overarching status report of planning and funding activity will be provided.

It is also proposed that the committees' agenda be split into two key sections; decision papers and performance update papers. The former focused on the key decisions within the remit of the committees, and the latter focused on a status update and performance report (including relevant health targets and annual plan performance as appropriate).

Wherever possible, each paper included in the agenda shall be a joint paper, including performance and key performance indicator reporting. Decision papers should consider the implications for both DHBs, even where the recommendation has been initiated and involves only one DHB. In some cases, there may be papers submitted by one DHB but these will be by exception and approved by the Chief Planning and Funding Officers.

Where possible, papers requested as updates only, may in future be circulated to members for their information. These 'for your information' papers will not necessarily be part of the agenda.

3.2 Logistics

As previously agreed, the host DHB of the combined committees will prepare the agenda documentation, including the format. Therefore, for CPHAC, Waitemata DHB will undertake this role.

In order to get the agenda papers to CPHAC members in a timely way, the agenda for each meeting will be agreed with the Chair a minimum of three weeks prior to the meeting, enabling two weeks for the papers to be written with one week for collation and distribution.

It is also expected that the writers of the papers will be available at meetings as required, to respond to questions. The Chief Executive and Chief Planning and Funding Officer, and appropriate clinicians from each DHB will also attend meetings.

3.3 Review of Committee

It is proposed that the function and benefits of the combined advisory committees be reviewed at the time that meetings move onto the proposed six weekly cycle, i.e. February 2012. This review should consider the topics discussed by the committees compared with other Board committees, the style and form of the papers provided, the key performance information reported and opportunities for streamlining the approach to the committees.

4. Risks/Issues

There are a number of risks and issues which have been identified while considering the combined approach to the management of the combined CPHACs. These include:

- Managing the logistics of preparing papers across two organisations with a short turnaround between meetings
- Ensuring the implications of decisions for both DHBs are considered
- Managing the scope of the committee
- Managing stakeholder expectations
- Aligning the focus of the committees with the relevant Board to ensure the same approach to decisions, functions or activities is implemented e.g. Auckland DHB manages the annual plan process through CPHAC, whereas Waitemata DHB utilises the Board and Audit and Finance Committee.

Much of these can be successfully managed through good communication between the CPHAC Chair and the Chief Planning and Funding Officers who support the committees.

5. Conclusion

The joint approach to these committees enables greater collaboration where there are issues in common. The proposed approach attempts to support this goal with increased collaboration in advice provided to the committees and greater opportunity for more detailed discussion on the complex issues within the key functions of the committees.

Attachment 1
Terms of Reference

AUCKLAND and WAITEMATA DISTRICT HEALTH BOARDS

Community and Public Health Advisory Committees
Terms of Reference

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1. Establishment

The Community and Public Health Advisory Committees (CPHAC) are established by the Boards of the Auckland District Health Board ("ADHB") and Waitemata District Health Board ("WDHB") under section 34 of the New Zealand Public Health and Disability Act 2000 ("Act"). The Boards may amend the terms of reference for the Committees from time to time. While constituted as each Board's separated CPHAC they will meet and act as one committee.

2. Functions of Committees

The functions of the CPHACs of the ADHB and WDHB are to:

- Give the Boards advice on:
  a) the needs of the resident populations of the ADHB and WDHB districts
  b) any factors that the committees believe may enhance or degrade the health status of the resident populations of the ADHB and WDHB districts; and
  c) priorities for use of the health funding available to either or both ADHB and WDHB
- The aim of CPHACs' advice will be to ensure that service delivery provided for the ADHB and WDHB populations maximises the overall health gain for the populations through:
  a) all service interventions the ADHB and WDHB have provided or funded or could provide or fund for the populations;
  b) all policies the DHBs have adopted or could adopt for their populations
- The Committees' advice must not be inconsistent with the New Zealand Health Strategy

3. Responsibilities

(a) The Committees will be responsible for review and advice to the Boards on:

- Ensuring that the Committees and Boards have a global view of the health needs of the Auckland and Waitemata district populations.
- Recommendations from management concerning health services to be provided by the ADHB and WDHB to their respective resident population.
- The needs of the populations and developing principles on which to determine priorities for using finite health funding.
- Establishing and maintaining processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement.
- Continuing to foster the development of Maori capacity for participating in the health and disability sector and providing for the needs of Maori.
- Establishing and maintaining processes to enable Pacific people to participate in, and contribute to, strategies for Pacific health improvement.
- Continuing to foster the development of Pacific capacity for participating in the health and disability sector and providing for the needs of Pacific people.
- Interpreting the local implications of the nation-wide and sector-wide health goals and performance expectations.
- The prioritisation framework used by the ADHB and WDHB to achieve an equitable and efficient funding mix between services and population groups.

- the effectiveness of the Northern Region's Health Plan and ADHB's and WDHB's annual plans and advise the Boards on the plans' effectiveness in meeting district health needs and meeting Government health goals.
- Oversight and monitoring of the contracting processes relating to service agreements with other providers of health and disability support services. This will include:
  - ensuring appropriate systems, policies and procedures are in place for auditing and monitoring the performance, capacity and sustainability of contracted providers.
  - reviewing and providing advice on associated legal, service and financial risks.
- Improving collaboration and coordination of services between the ADHB and WDHB to effectively and efficiently provide for the needs of the populations served.

(b) The Committees will identify issues and opportunities in relation to the provision of health services that the Committees considers may warrant further investigation and advise the Boards accordingly.

4. Relationship with Boards and Management

(a) The Committees are established by and accountable to the Boards. The Committees' role is advisory only, and unless specifically delegated by a Board from time to time in accordance with clause 39(4) of Schedule 3 of the Act, no decision-making powers are delegated to the Committees.

(b) The Committees shall receive all material and information for review or consideration through the respective Chief Executive Officers.

(c) The Committees shall provide advice and make recommendations to the Boards only.

(d) The Committees are to comply with the standing orders of the ADHB and WDHB based on the model standard standing orders.

5. Membership

(a) The membership of the CPHACs will comprise of:
- ____ Board members from ADHB
- ____ Board members from WDHB
- ____ appointed members

(b) The Chairperson(s) of both ADHB and WDHB will mutually agree upon the appointment of the Chairperson of the CPHACs.

(c) The Boards will endeavour to appoint, as members of the Committees, persons who together will provide a balance of skills, experience, diversity and knowledge to enable the Committees to carry out their functions.

(d) The Boards will ensure that the Committees include representation for Maori in accordance with section 34 of the Act and for Pacific people.

(e) The Boards will appoint any external appointees as members in accordance with the following process:
- The Chair and Deputy Chair of each Board together with the respective Chief Executive Officer will evaluate potential members in accordance with the criteria determined by the Boards and make recommendations to the Boards as to the proposed appointments.
- The Boards will make the final appointments (if any) to the Committees.

6. Meeting Procedure

(a) The Committees shall meet in a combined forum every six weeks. Meetings shall be conducted in accordance with:
- The requirements of the Act
- The Standing Orders of ADHB and WDHB

(b) ADHB and WDHB CEOs will ensure adequate provision of management and administrative support to the CPHACs' function including attendance of the CEOs and Chief Planning and Funding Officers.

(c) The venue for the meeting will normally alternate between an agreed ADHB and WDHB site, with technology (e.g. video or teleconferencing) aiding from remote locations where appropriate.

(d) The quorum of each meeting shall be, if the total number of members of the Committees is an even number, half that number; but if the total number of members is an odd number, a majority of the members.

5.1 Planning and Funding Update

Recommendation:

That the report be received.

Prepared by: Denis Jury (ADHB – Chief Planning and Funding Officer), Debbie Holdsworth (WDHB – Acting Chief Planning and Funding Officer), Julie Helean (ADHB – Manager Planning and Service Development), Janine Pratt (WDHB – Group Planning Manager), Tim Wood (WDHB - Group Funding Manager), Andrew Coe (ADHB and WDHB – Planning and Funding Manager, PHOs and Primary Care) and Cliff La Grange (WDHB – Finance Manager)

Glossary

ALT - Alliance Leadership Team
BSMC - Better Sooner More Convenient Primary Health Care
DHB - District Health Board
GAIHN - Greater Auckland Integrated Network
IDF - Inter District Flow
MOH - Ministry of Health
NGO - Non Government Organisation
NHC - National Hauora Coalition
PHO - Primary Healthcare Organisation
POAC - Primary Options Acute Care

1. Executive Summary

The purpose of this report is to update the Committees on Auckland DHB and Waitemata DHB's Planning and Funding activity over the last month. Note, the format and content of this report is in transition, as each DHB approaches Board Committee reporting in a slightly different way. A common approach needs to be developed for future reports.

2. Summary of activities in common

2.1 Planning

As previously advised, the annual plan and statement of intent for both Boards were approved by the Minister of Health and are now available on the respective DHB's websites. Once the Northern Regional Health Plan budget has been finalised, this will also be made available on the websites. Hard copies are available from the DHB offices. The suite of accountability documents from Auckland and Waitemata DHBs were well received by the Minister of Health.

DHBs have been provided an opportunity to advise the Ministry of Health / National Health Board on lessons learned and ways to improve the process in preparation for the 2012/13 planning round. Key feedback includes the difficulties in creating a useful statement of intent from the annual plan modules, changes to the financial templates at the last minute (and errors) and ongoing lack of alignment between the Office of the Auditor-General and the Ministry of Health. There was also considerable National Health Board interest in primary care activity, the specific detail of which proved difficult to confirm across the region and across the three business cases.

From a positive perspective, the process resulted in great improvements for the statement of forecast service performance, which was developed between the metro-Auckland DHBs with advice from Audit NZ. There was also a streamlined approach to the key actions to be delivered by the DHB and an improved relationship with the National Health Board through the relationship manager and via our early involvement in the preparation of the planning package guidance.

The focus is now on preparing the annual reports for the end of the financial year reporting to Parliament. A proposed approach for Waitemata DHB is being discussed at the August Audit and Finance meeting.

The metro-Auckland DHBs' planning teams are working with the Auckland Regional Public Health Service to develop a proposed approach to working with Auckland Council in a more proactive way. A briefing paper for Boards is being prepared for September to ensure DHB Boards are provided an opportunity to input into the submission on the draft Auckland Plan. This work is also linked to the asset and spatial planning activity included in the Northern Region Health Plan implementation.

In preparation for locality planning, Waitemata DHB has prepared a health needs assessment for the five Auckland Council wards and eight local boards of its district. This is available on the DHB's website. Auckland DHB is in the process of preparing a similar health needs assessment for its district.

2.2 Primary Care

2.2.1 Implementation of Government's Better Sooner More Convenient Primary Care Strategy

Regional Progress to Date
The Metro Auckland DHBs collectively continue to make progress with implementation of the regional components of Government's Better Sooner More Convenient Primary Health Care (BSMC).

Progress with PHO Consolidation
The National Hauora Coalition and Waitemata PHO are two new PHOs that came into effect on 1 July 2011. When BSMC was released during October 2009, there were 19 PHOs across Metro Auckland. By 1 July 2011, the Metro Auckland region had reduced its PHOs by over two thirds to seven PHOs:

1. ProCare Networks Ltd (Regional)
2. Waitemata PHO (WDHB)
3. Auckland PHO (ADHB)
4. Alliance Health + (ADHB and CMDHB)
5. National Hauora Coalition (National)
6. East Health Trust (CMDHB)
7. North Waikato (CMDHB)

There are now three cross DHB boundary PHOs; ProCare operates across the entire metro region; Alliance Health + and National Hauora Coalition operate across Auckland and Counties Manukau DHB. North Waikato actually operates outside the Auckland Metro region and into CMDHB but it is expected to join the NHC by 1 October 2011. The remaining three PHOs operate within their respective DHB boundaries.

The National Hauora Coalition replaces Te Hononga PHO (which Total Healthcare Otara rolled into in April) which will continue as an NGO as an interim transition arrangement. There has

been a slight delay in North Waikato in joining National Hauora Coalition and this is expected to be completed by October 2011.

Contracts are still being processed for the two Waitemata DHB PHOs, ProCare Networks and Waitemata PHO. Discussions are still continuing around the allocation and split of contracts where they have involved practice moves and old geographical boundaries.

Auckland DHB Specific Progress to Date
In addition to active involvement in the above regional work programmes, Auckland DHB PHO and Primary Care team work plan progress includes:

Progress with the Auckland DHB PHO Alliance
The last of the alliance workshops will be completed in early August. At this point a decision will be made whether to continue this alliance particularly in regard to its function within a locality approach for primary care.

2.2.2 Improve Primary – Secondary System Efficiency: The Regional Annual Plan projects

Access to Diagnostics
This project achieved the annual plan 2010-2011 targets. General practice utilisation of the ProExtra tool continues to increase for Auckland DHB. 701 mores requests generated through ProExtra in Q4 over the previous quarter; this is a 158% increase. Customisation of the ProExtra Radiology tool for CMDHB is complete and pre-implementation pilot testing has occurred at eight Counties Manukau DHB practices and three Auckland DHB practices since May. Roll out is scheduled to launch on 3 August 2011. Waitemata DHB continues to manually triage all referrals using the ATD-Radiology Clinical Triage Criteria. Review by the Project's Clinical Governance Group of the Clinical Triage Criteria is almost complete and will be forwarded onto the Regional Radiology Forum for endorsement and adoption.

Minor Skin Surgery – Skin Lesions
The number of minor surgery referrals sent to accredited general practitioners is steadily increasing across the region. The key focus for July was on the remedial strategies including raising the awareness and confidence in the initiative. Details about the skin surgery scheme including the pathway, frequently asked questions, a list of the contracted general practitioners, and a general practitioner opinion survey, was advertised in the primary care newsletter and distributed across the Metro Auckland region. A satisfaction survey is being sent to all patients who are referred to the general practitioner scheme from 1 July 2011 to 30 September 2011.

Clinical Pathways
Annual plan targets for 2011-12 have been set. The Project Plan and Resourcing Plan for development and implementation of pathways has been signed off by the Steering Group and will be submitted to GAIHN Alliance Leadership Team for sign off in August. The key focus this year is on operational implementation. The mechanism for operational management and business integration is being developed and will be a significant success factor for this year.

Acute Demand / Primary Options for Acute Care
The 2011/2012 contract and volumes have not been formally confirmed at this stage but will be finalised by the end of August 2011.

- Preliminary figures for July 2011 show a total of 1425 referrals
- 88% of all referrals were managed in primary care without admission

After Hours
The primary care After Hours Alliance has developed an alternative proposal for a "whole system" afterhours service, and this was presented to DHBs in early July 2011. The Alliance

and DHBs are now considering the service and funding implications of this proposal. PHOs initially agreed to match additional DHB funding, but have since withdrawn this offer which has left a shortfall of $1.0m. Further modelling is being undertaken on high-needs populations to determine the reduction in co-payments. An implementation plan is being developed with a view to commence the new service from 1 September. This assumes that agreement on the final model can be reached in the next 2-3 weeks.

Optimal Prescribing Project
The region is using a multi-focused approach to address a wide range of identified improvement needs. Counties Manukau DHB and Auckland DHB are jointly addressing pharmacy services and budgets. The clinical pharmacists' poly pharmacy audits have continued in general practices. There have been no cell groups in July.

The importance of dose reduction of digabatran in patients with renal impairment was highlighted in a bulletin following a number of cases of bleeding that resulted in hospital admissions.

The steering group membership is being reviewed along with discussion of the project governance in line with GAIHN oversight and the contract is still under discussion for 2011/12.

Maori Service Devolvement
This project has now been closed off for 2010/11.

Auckland Metro Health Targets
This month targets have been met for immunisation, diabetes detection, and cardiovascular disease risk assessment.

2.2.2 Summary of Annual Plan Targets

Initiative		**Auckland Metro Volumes**		**Auckland Metro target to end June 2011**
		Month (June)	**Full year 2010-11**	
Acute Demand / POAC		1,568	16,492 (provisional figure)	15,000 cases
Access to Diagnostics	**DAP Target 1** *Measures elective plain x-ray and ultrasound referrals by GPs for diagnostic radiology to Non DHB Providers*	885	9,453 Includes diagnostic radiology procedures via POAC	4,500
	DAP Target 2	2,694 (referred via Clinical Triage Criteria) 2,154 (referred via "old" forms)	27,718 34,829 **Total= 62,547**	16,000+
Skin Lesions		113	871	1,200

Progress on Health Targets

Target (Auckland Metro)	Target	Achieved
Immunisations	90%	91%
Diabetes Get Checked	55%	84%
Diabetes Management	70%	72%
CVD Risk Assessment*	80%	81%

*=Estimated from Quarter Three 2010/11 MoH data

2.2.4 Business Case Update

All three business cases contributed to the revision of Auckland and Waitemata DHBs' Annual Plans and have been working on finalising their implementation plans for 2011/12.

Greater Auckland Integrated Network (GAIHN)
A paper from GAIHN recommending endorsement of the work programme should be received this month, advising that funding approvals will be sought at the end of the first quarter. Further work is needed on the work programme project budgets – which will reduce the quantum of 'new money' to be sought from DHBs.

It is proposed that GAIHN take over four current regional projects: POAC (Primary Options Acute Care), Access to Diagnostics, Clinical Pathways, and Optimising Prescription Pharmaceuticals (Auckland DHB and Counties Manukau DHB Pharmaceutical project). Primary Care Planning and Funding representatives are meeting with GAIHN executives to progress the project transition.

Although the GAIHN Alliance Agreement and PHO Variation have been agreed by the DHBs and PHOs, and were expected to be signed off at the Alliance Leadership Team meeting on 26 July 2011, all PHO partners have now requested that they go to each PHO's Board before they can be signed. Planning and Funding representatives are taking around the documents after the respective board meetings to the delegated representative to sign. This process should be completed within the next few weeks. Care Plus maximisation will be achieved after the signing of the PHO Variation. Start date for this is 1 July 2011 and therefore back payments may be required.

National Hauora Coalition (NHC)
The Alliance Agreement and PHO Variation have been agreed by the DHBs and are now back with the NHC for review. The DHBs have agreed the Collaborative Agreement and this is due to be circulated to the DHBs for signing shortly.

The NHC are keeping two Alliance Leadership Teams up to the end of the calendar year when they will be reviewed along with the transition of locally retained contracts. There is an Auckland and a Midlands Alliance Leadership Team. Membership is being reviewed as these were originally due to be dissolved at the end of June.

The details are still being worked out on the logistics of a national PHO within the PHO Performance Programme (PPP). Potentially there will be national targets collated from the locality level ones. There is a desire by the DHBs to keep locality level targets and visibility of performance and progress. This is being worked through by NHC, the PHO Performance Programme (PPP) team and the Ministry of Health.

The NHC has developed a draft implementation plan for year 2 which is being reviewed by DHBs and the Ministry of Health. A meeting has been held between the NHC and the host and partner DHBs (Counties Manukau, Auckland, Waikato, Taranaki and Whanganui) to discuss the deliverables in the implementation plan and the collection of baseline data from which to set targets. The DHBs are supporting the NHC through the collection of baseline data wherever possible.

There has been discussion about the creation of Support Alliance Leadership Teams (SALTs) to progress the collection of data, setting of targets and PPP discussion to support NHC. It is envisioned that a number of these groups will be set up utilising expertise from the DHBs around specific targets.

Alliance Health + (AH+) (Note: This section pertains to ADHB and CMDHB only)
AH+ have met with whanau to develop an outcomes framework underpinned by Results Based Accountability. AH+ are organising Results Based Accountability training for providers under AH+; in attendance will be National Hauora Coalition and some DHB planners and funders. The objective is to familiarise key stakeholders with outcomes development and promote radical efficiency.

The Clinical Governance Committee has met and established an internal clinical work performance programme, currently going through an internal review. The Clinical Governance Committee is preparing papers for the Alliance Leadership Team to help inform prioritisation.

The Mt Wellington Integrated Family Health Centre is on track to be completed by August 2011.

Southseas Nurse led services specialising in chronic obstructive pulmonary disorder has been initiated. AH+ is working with Bader Drive on nurse-led clinic development. The Nurse-Led Clinic will be open In October 2011. The nurse leader is currently liaising with Mt Wellington and Onehunga about their nurse-led initiatives.

AH+ Year 2 Implementation plan is currently working through its internal processes.

2.3 Community Pharmacy

The National Pharmacy Working Group has decided with the support of DHBs to extend the existing Pharmacy Services Agreement (PSA) for a period of eight months to allow the working groups to develop more detail for the long term conditions and aged residential care patient groups. The new agreement is due to come into effect on 1 April 2012.

The northern region pharmacy mangers are discussing how they may be able to continue to support the national process to ensure the desired outcomes are achieved on 1 April.

Consultation meetings are scheduled for the week beginning 15 August and there will be one evening meeting in each of the DHBs with an open invitation to pharmacists to attend any of the sessions.

As a roll over will not address the current growth issues in the community pharmacy budget, the northern region is developing an agreed course of action to manage outliers. This will be implemented on a local basis to try and curb some growth, and to change sector perceptions around the use of close control in preparation for the likely changes to the rules in April.

2.4 Youth Health project

Both Auckland and Waitemata DHBs are funding the Collaborative Trust to lead a series of training sessions for primary care. The Collaborative Trust has adapted a programme and

associated manual that was developed by the New South Wales Centre for Advancement of Adolescent Health for the New Zealand context. Topics covered by the training include; (i) Violence & Abuse, (ii) Eating Disorders, (iii) Traumatic Stress, (iv) Grief & Depression, and (v) Anxiety. Additionally, the programme looks at how to make general practices welcoming to youth. Barriers to youth accessing health services are: (i) a fear of embarrassment, (ii) fear of confidentiality being broken, (iii) cost, and (iv) lack of knowledge about what is available. Training sessions will run for General Practitioners, Practice Nurses and Receptionists.

3. Auckland DHB update

3.1 Child, Youth and Women's Health

Immunisation
Provisional NIR data as at 1 August 2011 shows 92% overall all ethnicities coverage of 2 year olds fully immunised at age 2 has been maintained. Maori coverage however has now increased to 92%, a 4% increase over last month. Auckland DHB now has no equity gap for immunisation at age 2 for Maori and Pacific children. This is a significant achievement. Coverage of other ethnicities at age 2 are Pacific 94%, Asian 94%, NZE 92% and Other 85%. It is intended to examine the 'Other' group, which is a similar volume to Pacific, in order to identify trends and opportunities.

The national immunisation target for 2011/12 is 95% of all 2 year olds fully immunised. This will be challenging. Auckland DHB has a current decline rate at 2 years of 3.4% (53 children), so achieving 95% will mean locating almost all of the non-immunised, non-declined children.

Well Child Tamariki Ora Services
It was reported previously that the Ministry of Health has decided to 'repatriate' Well Child Tamariki Ora funding from DHBs and contract back with them at the same levels for these services via the Crown Funding Agreement (CFA). After the first year it is then intended to roll this funding into DHB baseline funding. Auckland DHB has 4 Well Child Tamariki Ora providers (Health Star Pacific, Ngati Whatua O Orakei Health Centre and Tongan Health Society and a provider arm service, Community Child Health & Disability Service (CCHADS)).

The service provided by CCHADS has been significantly enhanced by Auckland DHB over the years to better meet the needs of its client group. It is now a multi disciplinary service working with highly deprived population groups with complex social and other needs. Accurately identifying the costs associated with providing just the standard Well Child service to this group is a challenge and poses a degree of risk. Auckland DHB is working with the Ministry of Health on a way to do this.

Health Services for Children and Young People in Care
Auckland DHB Planning and Funding continues as the DHB representative on the national multi-sector working group developing and now implementing this programme. CYF will contract directly with DHBs for services. Comment is currently being sought on draft contract documents.

Other Activity
Work continues on developing a new Health Service Group Child Health Plan and developing an implementation plan for the Youth Health Plan 2010 – 2014. Work to facilitate implementation of the Healthcare Service Group structure for child health and for women's health is ongoing. Auckland DHB child health team members participated in recent BSMC workshops to design an integrated community child health model. Regular meetings with child and youth health planning and funding and clinical colleagues at Waitemata and Counties

Manukau DHBs continue to be held to share information on issues and initiatives and to collaborate on joint projects where appropriate.

3.2 Mental Health

Secure Rehabilitation
The application to the Ministry to move operational funds to capital in order to build the new facility has required further information and will cause some delay before a decision about preparing a full business case can be made.

Alternative to Admissions
This service is now fully operational. The NGO provider has secured new long term premises that will be refurbished, based in Onehunga. This unit will likely be open in late October depending on council processes.

The provider will present to both inpatient and community team about the new premises and the service over the next three months.
Online therapy
This online CBT option is now available. Initially access will be through GP surgeries for mild to moderate mental health problems, although we are investigating options for a mechanism for cancer services to access this service. There is also a need to investigate direct access from community mental health teams so that they can use the service as an adjunct to specialist care.

3.3 Performance Improvement

Oral Health
The key activity in the oral health portfolio is the implementation of the Child and Adolescent Oral Health Business Case which is progressing according to plan. Avondale Intermediate was completed in mid-July, and inspection is underway at Royal Oak, Wesley and Blockhouse Bay Intermediates. Services will commence from the Avondale Clinic by the end of August.

3.4 Live Within Our Means

Month's Funding Issues
A verbal update on any developing funding issues will be given.

4. Waitemata DHB Update

4.1 Funding

Waitemata DHB's funding team is in the middle of reconfiguring the majority of the youth health related contracts. An Expression of Interest and Tender process is underway. Further advice on the outcome will be reported at a later meeting.

While this is progressing, two other youth related activities have been progressed. The first is discussed in section 2. The second involves sponsorship from:

1. Brookfield Multiplex – Major Sponsor
2. Russell Group of Companies (Dominion Constructors and Acrow)
3. Smith & Davies
4. Jasmax
5. Bassett Plumbing and Drainage Limited
6. Designer Stainless Limited
7. Reoco
8. MSC Consulting
9. Coffey Geotechnics.

The sponsorship is to enable Cut Collective (http://cutcollective.co.nz) to develop and paint a mural on the western hording of the car park development at the North Shore campus. The mural is being developed in conjunction with the Youth Advisory Group and will present positive health messages for youth. At the completion of the car park build, the mural will be cut into sections and framed for hanging within the DHB's facilities. The Youth Advisory Group was set up in 2009 to obtain youth input in to health topics and service development.

4.2 Funder Finance

Funder Non Government Organisations (NGO)
The June core result for Funder NGOs was $1.6M unfavourable to budget for the month and $3.5M favourable to budget for the year. The unfavourable June month variance includes adjustments resulting from the year end review process and ensuring contractual liabilities are fully accounted for. It also includes neutral adjustments for changes between Funder NGO and Funder IDF (as resulting from the ProCare merger).

Funder Inter District Flows (IDFs)
The June core result for IDFs was $1.3M favourable for the month and $3.2M unfavourable for the year. The June result includes adjustments resulting from the year end review process and accounting for the forecast final IDF position across a number of demands based services. This includes the forecast IDF wash-up position for hospital based medical and surgical services as well as community based pharmacy, laboratory and primary care services.

Funder Consolidated
The June consolidated core result for Funder was $250K adverse for the month and $280K favourable for the year. In 2010/11 the responsibility for IDF Services was taken over by the Funder (subsequent to the budget being set). The Funder now includes both NGOs and IDFs giving the Funder greater resource and opportunity to more fully understand and mitigate demand growth and other risk factors across all of these services.

6 Resolution to Exclude the Public

Recommendation:

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Pharmaceuticals	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Maintenance of the Law** The disclosure of information would be likely to prejudice the maintenance of the law, including the prevention of, investigation of, and detection of offences, or prejudice the right to a fair trial. [Official Information Act 1982 S.6 (c)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information. [Official Information Act 1982 S.9 (2) (b)]

AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING – 10 August 2011

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

COMMITTEE MEMBERS
Lee Matthias - Committee Chair (ADHB Deputy Chair)
Warren Flaunty - Committee Deputy Chair (WDHB Board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Deputy Chair
Jo Agnew - ADHB Board member
Peter Aitken - ADHB Board member
Pat Booth - WDHB Board member
Susan Buckland - ADHB Board member
Chris Chambers – ADHB Board member
Sandra Coney - WDHB Board member
Rob Cooper – ADHB and WDHB Board member
Robyn Northey - ADHB Board member
Christine Rankin - WDHB Board member
Allison Roe - WDHB Board member
Tim Jelleyman - Co-opted member
Eru Lyndon – Co-opted member
Alfred Ngaro – Co-opted member

MANAGEMENT
Dale Bramley – WDHB, Chief Executive
Garry Smith – ADHB, Chief Executive
Debbie Holdsworth - WDHB, Acting Chief Planning and Funding Officer
Denis Jury - ADHB, Chief Planning and Funding Officer
Taima Campbell - ADHB, Executive Director of Nursing
Hilda Fa'asalele - ADHB, General Manager, Pacific Health
Paul Garbett – WDHB, Board Secretary
Naida Glavish - ADHB, Chief Advisor, Tikanga & General Manager Maori Health
Janice Mueller - ADHB, Director Allied Health – Scientific & Technical
Andrew Old - ADHB, Medical Advisor – Funding Division

Apologies:

AGENDA

DISCLOSURE OF INTERESTS

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

PART I – Items to be considered in public meeting

All recommendations/resolutions are subject to approval of the ADHB and WDHB Boards.

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

PRESENTATION:
2.00pm Primary Care Strategic Direction

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES
2.30pm 2.1 Confirmation of Minutes of the Meeting of the Waitemata DHB Community and Public Health Advisory Committee held on 13/07/11 1
2.2 Confirmation of the Minutes of the Meeting of the Auckland DHB Community and Public Health Advisory Committee held on 20/07/11 11

3 ITEMS FOR CONSIDERATION AND RECOMMENDATION TO BOARD
2.40 pm 3.1 Approach to combined Community and Public Health Advisory Committee Meetings 19

4 ITEMS FOR INFORMATION
(No information items)

5 STANDARD MONTHLY REPORTS
3.00pm 5.1 Auckland and Waitemata DHB Planning and Funding Update 27

3.15pm **6 RESOLUTION TO EXCLUDE THE PUBLIC** 37

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Professor of Leadership – University of Auckland Business School Chief Executive – New Zealand Leadership Institute Deputy Chair – Health Benefits Limited Independent Chairman – Tonkin & Taylor Chair – Auckland District Health Board Chair – Waitemata District Health Board Trustee, A+ Trust	25/05/11
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Board Member – Health Workforce New Zealand Board Member, AUT Millennium Ownership Trust	25/05/11
Jo Agnew	Senior Lecturer Nursing - University of Auckland Casual Staff Nurse – Auckland District Health Board	21/04/10
Peter Aitken	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd	10/12/10
Pat Booth	Consulting Editor – Fairfax Suburban Papers in Auckland	24/06/09
Susan Buckland	Self employed – Writing, editing and public relations services Professional Conduct Committee member – Medical Council of New Zealand Professional Conduct Committee member – Occupational Therapy Board	7/08/09
Chris Chambers	Employee – Auckland District Health Board (wife employed by Starship Trauma Service) Clinical Senior Lecturer – Anaesthesia Auckland Clinical School Associate – Epsom Anaesthetic Group Member – ASMS Shareholder – Ormiston Surgical	20/04/11
Sandra Coney	Elected Member – Chair, Parks Committee, Auckland Council	02/05/11
Rob Cooper	Board Member – Auckland District Health Board Board Member – Waitemata District Health Board Chief Executive - Ngati Hine Health Trust Advisory Board Member – James Henare Research Centre, University of Auckland Member – National Health Board Chair – Whanau Ora Governance Group	19/01/11
Warren Flaunty	Member of Henderson – Massey, Rodney and Upper Harbour Local Boards, Auckland Council Trustee - West Auckland Hospice Chair - Waitakere Licensing Trust Shareholder - Metlifecare Shareholder - EBOS Group Shareholder – Pharmacy Brands Ltd Shareholder – Westgate Pharmacy Ltd Chair – Three Harbours Health Foundation	01/02/11
Lee Mathias	Managing Director – Lee Mathias Ltd Director – Iris Limited Director – Midwifery and Maternity Providers Organisation Ltd Shareholder/Director – Pictor Ltd Director – John Seabrook Governance Advisor – AuPairlink Ltd Council member – NZ Council of Midwives Chair – Tamaki Transformation Transitional Board	31/05/11
Robyn Northey	Project management, service review, planning etc. – Self employed Contractor Board member – Hope Foundation Northern Region Member – Ethics Committee	16/12/10
Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Member - The Families Commission Director - The Transformational Leadership Company	02/02/11
Allison Roe	Shareholder – Optimisewellbeing.com Founding member – Breast Health Foundation Director – Spiritus NZ Trustee – Allison Roe Trust Founder – Takapuna 2020 Community Group Board member – North Shore Hospital Foundation	28/03/11

Co-opted Members

Dr Tim Jelleyman	Clinical Director, Paediatrics (Child Health Service) Member, Active Clinical Network (ACN) for the Greater Auckland Integrated Health Network (GAIHN) Project	08/09/10

Board/Committee Member	Involvements with other organisations	Last Updated
Eru Lyndon	To be advised.	
Alfred Ngaro	Consultant – 4pm Group Ltd Chair – Pacific Advisory Committee Task Force Member – National Task Force for Family Violence MSD Advisory Member – Family and Community Services National Advisory Group Executive Member – Auckland Safer Communities Chair – Tamaki Achievement Pathways Schooling Improvement Elected Trustee – Tamaki College Board of Trustees Member – Tamaki Community Development Trust	11/05/09

Auckland and Waitemata District Health Board

Community and Public Health Committee Member Attendance Schedule 2011

Note: Combined Auckland and Waitemata DHB Committees meeting commenced 1st August 2011.

NAME	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Lee Mathias (ADHB Committee Chair , Feb – July 2011 and ADHB / WDHB combined Committees Chair from Aug 2011)	ü	ü	ü	ü	ü	ü					
Warren Flaunty (WDHB Committee Chair, Feb – July 2011 and ADHB / WDHB combined Committees Deputy Chair from Aug 2011)	ü	ü	ü	ü	ü	ü					
Dr Lester Levy (Chair)	ü	ü	ü	ü WDHB # ADHB	ü	û					
Max Abbott (Deputy Chair)	ü	ü	ü	ü	ü	ü					
Jo Agnew	ü	ü	ü	ü	ü	û					
Peter Aitken	û	ü	ü	ü	û	ü					
Pat Booth	ü	ü	ü	ü	û	ü					
Susan Buckland	ü	ü	ü	ü	ü	ü					
Chris Chambers	ü	ü	ü	û	ü	ü					
Sandra Coney	û	ü	û	ü	ü	ü					
Rob Cooper	ü	^	^	^	^	^					
Wendy Lai	ü	û	ü	ü	ü	û					
James Le Fevre	ü	ü	ü	ü	ü	ü					
Robyn Northey	ü	ü	ü	ü	ü	û					
Christine Rankin	ü	ü	ü	ü	ü	ü					
Allison Roe	ü	û	ü	ü	ü	ü					
Gwen Tepania - Palmer	ü	ü	ü	ü	ü	ü					
Co-opted members											
Dr Tim Jelleyman	ü	ü	ü	ü	ü	ü					
Eru Lyndon (member from 1 August 2011)											
Alfred Ngaro (member from 1 August 2011)											
Lyvia Marsden	ü	ü	û	û	ü	ü					
Tereki Stewart	û	û	û	û	û	û					
Tracy McIntyre	ü	ü	*n/a*	*n/a*	*n/a*	*n/a*					
Deborah Dalliessi	*n/a*	*n/a*	ü	ü	ü	ü					

û *absent*
^ *leave of absence*
* *attended part of the meeting only*
# *absent on Board business*