



*Waitemata*  
District Health Board  
*Te Wai Awhina*

## **Community and Public Health Advisory Committees Meeting**

**Wednesday, 14<sup>th</sup> September 2011**

**2.00pm**

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**Venue**

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



## AGENDA ORDER AND TIMING



**AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS  
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING –  
14 September 2011**

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

**Time: 2.00pm**

COMMITTEE MEMBERS

Lee Mathias - Committee Chair (ADHB Deputy Chair)  
Warren Flaunty - Committee Deputy Chair (WDHB Board member)  
Lester Levy - ADHB and WDHB Board Chair  
Max Abbott - WDHB Deputy Chair  
Jo Agnew - ADHB Board member  
Peter Aitken - ADHB Board member  
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)

	<b>1</b>	<b>AGENDA ORDER AND TIMING</b>	
	<b>2</b>	<b>CONFIRMATION OF MINUTES</b>	
2.00pm	2.1	Confirmation of Minutes of the Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting held on 10/08/11 .....	1
	<b>3</b>	<b>DECISION ITEMS</b>	
2.05pm	3.1	GAIHN Workplan and Investment Proposals for 2011/12.....	21
2.25pm	3.2	Primary Care an Integrated Strategic Approach – Mergent Health Care.....	65
2.40pm	3.3	Auckland Council – Draft Auckland Plan and Potential Future Relationships .....	75
	<b>4</b>	<b>ITEMS FOR INFORMATION</b>	
2.55pm	4.1	Immunisation.....	81
	<b>5</b>	<b>STANDARD MONTHLY REPORTS</b>	
3.10pm	5.1	Auckland and Waitemata DHB Planning and Funding Update.....	87
3.30pm	<b>6</b>	<b>GENERAL BUSINESS</b>	
3.35pm	<b>7</b>	<b>RESOLUTION TO EXCLUDE THE PUBLIC</b> .....	101

## REGISTER OF INTERESTS

<b>Board/Committee Member</b>	<b>Involvements with other organisations</b>	<b>Last Updated</b>
<b>Lester Levy</b>	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
<b>Max Abbott</b>	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
<b>Jo Agnew</b>	Senior Lecturer Nursing - University of Auckland Casual Staff Nurse – Auckland District Health Board	21/04/10
<b>Peter Aitken</b>	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd	10/12/10
<b>Pat Booth</b>	Consulting Editor – Fairfax Suburban Papers in Auckland	24/06/09
<b>Susan Buckland</b>	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
<b>Chris Chambers</b>	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
<b>Sandra Coney</b>	Elected Member – Chair, Parks Committee, Auckland Council	02/05/11
<b>Rob Cooper</b>	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
<b>Warren Flaunty</b>	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
<b>Lee Mathias</b>	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
<b>Robyn Northey</b>	Project management, service review, planning etc. – Self employed Contractor Board member – Hope Foundation Northern Region Member – Ethics Committee	16/12/10
<b>Christine Rankin</b>	Member - Upper Harbour Local Board, Auckland Council Member - The Families Commission Director - The Transformational Leadership Company	02/02/11
<b>Allison Roe</b>	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
<b>Co-opted Members</b>		
<b>Dr Tim Jelleyman</b>	Clinical Director, Paediatrics (Child Health Service) Member, Active Clinical Network (ACN) for the Greater Auckland Integrated Health Network (GAIHN) Project	08/09/10

*Register of Interests continued...*

<b>Board/Committee Member</b>	<b>Involvements with other organisations</b>	<b>Last Updated</b>
<b>Eru Lyndon</b>	Ngati Whatua o Orakei Corporate Ltd Honorary Research Fellow – Auckland University Member – AUT Business School Industry Advisory Committee Te Mata a Maui Law	12/08/11
<b>Alfred Ngaro</b>	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 1<sup>st</sup> 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)	✓	✓	✓	✓	✓	✓	✓				
Warren Flaunty (WDHB Committee Chair, Feb – July 2011 and ADHB / WDHB combined Committees Deputy Chair from Aug 2011)	✓	✓	✓	✓	✓	✓	✓				
Dr Lester Levy (Chair)	✓	✓	✓	✓ WDHB # ADHB	✓	✗	✓				
Max Abbott (Deputy Chair)	✓	✓	✓	✓	✓	✓	✓				
Jo Agnew	✓	✓	✓	✓	✓	✗	✗				
Peter Aitken	✗	✓	✓	✓	✗	✓	✓				
Pat Booth	✓	✓	✓	✓	✗	✓	✓				
Susan Buckland	✓	✓	✓	✓	✓	✓	✓				
Chris Chambers	✓	✓	✓	✗	✓	✓	✓				
Sandra Coney	✗	✓	✗	✓	✓	✓	✓				
Rob Cooper	✓	^	^	^	^	^	✗				
Wendy Lai	✓	✗	✓	✓	✓	✗					
James Le Fevre	✓	✓	✓	✓	✓	✓					
Robyn Northey	✓	✓	✓	✓	✓	✗	✓				
Christine Rankin	✓	✓	✓	✓	✓	✓	✓				
Allison Roe	✓	✗	✓	✓	✓	✓	✓				
Gwen Tepania - Palmer	✓	✓	✓	✓	✓	✓					
<b>Co-opted members</b>											
Dr Tim Jelleyman	✓	✓	✓	✓	✓	✓	✓				
Eru Lyndon (member from 1 August 2011)							✓				
Alfred Ngaro (member from 1 August 2011)							✗				
Lyvia Marsden	✓	✓	✗	✗	✓	✓					
Tereki Stewart	✗	✗	✗	✗	✗	✗					
Tracy McIntyre	✓	✓	n/a	n/a	n/a	n/a					
Deborah Dalliesi	n/a	n/a	✓	✓	✓	✓					

✗ *absent*

^ *leave of absence*

\* *attended part of the meeting only*

# *absent on Board business*

CONFIRMATION OF MINUTES  
- 10 August 2011



## **2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 10 August 2011**

### **Recommendation:**

**That the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 10 August 2011 be approved.**



Minutes of the meeting of the Auckland DHB and Waitemata DHB

**Community & Public Health Advisory Committees**

**Wednesday 10 August 2011**

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna  
commencing at 2.03p.m

**COMMITTEE MEMBERS PRESENT:**

Lee Mathias (Committee Chair) (ADHB Deputy Chair)  
Warren Flaunty (Committee Deputy Chair) (WDHB Board Member)  
Lester Levy (ADHB and WDHB Board Chair)  
Max Abbott (WDHB Deputy Chair)  
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) (present from 2.10p.m)  
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)

**ALSO PRESENT:** 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)  
Aroha Haggie (ADHB, Health Gain Manager Maori)  
Alan Greenslade (Project Manager, Primary Care)  
Stuart Jenkins (Clinical Director, Primary Care)  
Cliff La Grange (WDHB, Finance Manager)  
Janice Mueller (ADHB, Director Allied Health – Scientific and Technical)  
Andrew Old (ADHB, Medical Advisor – Funding Division)  
Janine Pratt (WDHB, Group Planning Manager)  
Imelda Quilty-King (WDHB Community Engagement Co-ordinator)  
Tim Wood (WDHB Manager Funder NGO)

**PUBLIC AND MEDIA REPRESENTATIVES:**

Deborah Dalliessi, North Shore Community Health Voice  
Tracy McIntyre, Waitakere Health Link  
Margaret Willoughby, Rodney Health Link  
Lynda Williams, Auckland Women's Health Council  
Lorelle George, Waitemata PHO  
Nick Swain, ProCare

**APOLOGIES:** Apologies were received from Jo Agnew, Rob Cooper, Alfred Ngaro and Naida Glavish.

## **PART I – Items considered in public meeting.**

### **WELCOME**

The Chair, Lee Mathias, welcomed all to the first combined meeting of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees. She commented that many of those present had a history of involvement with both organisations.

### **PRESENTATION – Primary Care Strategic Direction**

Stuart Jenkins, Clinical Director Primary Care, provided this presentation, a copy of which is attached to these minutes as Appendix 1.

In answer to a question relating to after hours care, Stuart Jenkins advised that this is a good example of an issue that needs to be managed on a locality basis. The process involved literally taking a map of an area, for example West Auckland, understanding the data relating to existing services and who is accessing them, planning, and then engaging with providers.

The Boards' Chair, Lester Levy, noted that “after hours” is an example of terminology that is no longer relevant. What is wanted is access and continuity of service. It would make sense for example for some general practitioners and other primary care providers to operate say from 2p.m to 10p.m. He suggested that out dated terminology may be reflected in discussion being old fashioned compared to where it needs to be.

With regard to the presentation, Denis Jury noted that what is being undertaken is an important piece of work, which is starting to bring some sense around primary care. The presentation had been designed to give a taste of what is involved. Next month two more detailed papers would be provided around how we make this work and how we develop and manage localities. These would be very important papers in terms of how we operate in future with primary care.

### **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 the open part of this agenda.

### **SETTING THE SCENE FOR COMBINED COMMITTEE MEETINGS – LESTER LEVY**

Lee Mathias again welcomed those present and invited the Chair of the two Boards, Lester Levy, to say a few words.

Lester Levy welcomed everyone present. He stated that the process of collaboration across the region and particularly between Auckland DHB and Waitemata DHB is not to be viewed as a “little trial”, but as the way forward. It would be extremely important that Board members and managers provided a model of working together collaboratively. He took this process extremely seriously and had a strong expectation that Board members and senior executives would make a real effort to overcome any obstacles to it. He said that no one should underestimate his commitment to patients and what they needed. People shared in that, but sometimes got distracted by particular issues.

Lester Levy noted the general expectation that on most matters to come to the combined committee meetings, the management of the two Boards would speak as one voice, although at times there would be exceptions with issues particular to one Board only. An overall objective is to seek better outcomes in terms of resources allocated. This is a serious and deliberate move towards collaboration in the best interests of our population and patients.

## 1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed in the agenda.

## 2. COMMITTEE MINUTES

### 2.1 Confirmation of the Minutes of the Meeting of the Waitemata DHB Community and Public Health Advisory Committee held on 13 July 2011 (agenda pages 1-10)

**Resolution** (Moved Pat Booth / Seconded Sandra Coney)

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

#### Carried

#### Matters Arising:

No issues were raised.

### 2.2 Confirmation of the Minutes of the Meeting of the Auckland DHB Community and Public Health Advisory Committee held on 20 July 2011 (agenda pages 11-18)

**Resolution** (Moved Lee Mathias / Seconded Peter Aitken)

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

#### Carried

#### Matters Arising

No issues were raised.

## 3. DECISION ITEMS

### 3.1 Proposed Approach to the Combined Auckland DHB and Waitemata DHB Community and Public Health Advisory Committee Meetings (agenda pages 19-26)

In the course of consideration of this report, the following matters were noted or confirmed:

- Meetings to be monthly for the remainder of 2011, moving to six weekly for 2012.
- The meeting venue for 2011 is to be 15 Shea Terrace, Takapuna, but with the expectation that meeting venues alternate between Auckland DHB and Waitemata DHB in 2012.
- With regard to Section 2 of the agenda report, Susan Buckland asked that it be noted that in her view the two Boards had agreed to the proposal for combined committees, rather than initiated it.
- Any decisions made will need to be recommendations to the respective Boards.
- A review of the functions and benefits of the combined advisory committee meetings is to be carried out at the time meetings move to the six weekly cycle.
- Historically, the two CPHAC Committees have been run very differently. This is an opportunity to start with a fresh approach.
- The default position is that agenda papers will be joint papers from ADHB and WDHB.

- While each Board had developed its own set of performance indicators, the intention will be to avoid presenting CPHAC with totally different sets of indicators for the two Boards.
- The Board Chair noted that he would like to see more challenge of the status quo, in the context of considering different ways of achieving the objectives in the District Annual Plans.
- The decision to move to a six monthly cycle for 2012 had been a decision of both Boards. Regular monthly updates (for example, financial reporting) would still occur, e-mailed to Board members as soon as available.
- With regard to the relationship between Waitemata DHB and its Health Links, the intention is to continue and improve the existing relationships. There will be regular meetings with the Chief Executive to try and expedite the solution of any issues they had. In response to a request that the relationship at a political level not be lost sight of, Dale Bramley offered to discuss options with the Health Links over what would work best and come back to CPHAC on that.
- Garry Smith advised that Auckland DHB would be keen to learn from the Health Links experience. In addition to that, ADHB has been developing an electronic means of connecting with the population, called Healthvoice, inviting comment and posing questions for feedback. A third avenue for connecting with the community is through community networks.
- Committee terms of reference - Chris Chambers provided some suggested wording changes, including moving from passive to active voice, for consideration by Denis Jury and Debbie Holdsworth. It was also noted that the last line of Section 1 of the Terms of Reference needs to be corrected to read: "While constituted as each Board's separate CPHAC, they will meet and act as one committee."

**Resolution** (Moved Warren Flaunty / Seconded Chris Chambers)

**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.**

**Carried**

#### **4 INFORMATION ITEMS**

There were no information items.

#### **5. STANDARD MONTHLY REPORTS**

##### **5.1 Planning and Funding Update** (agenda pages 27-36)

With regard to Community Pharmacy, the Committee was advised that a pharmacist in Mt Albert had been convicted and was awaiting sentencing for dispensing prescribed generic drugs but claiming for far higher priced brand name drugs. There was a discussion around how such offences are detected. Tim Wood (WDHB-Group Funding Manager) advised that comparison of prescribing patterns nationally can help identify issues, but detection of offences relied heavily on audit and on individuals reporting their concerns. In discussion it was noted that alertness and sophistication are being enhanced in internal audit and there are benefits from applying enhanced audit techniques in this area.

The Committee Chair noted the importance that introducing electronic pricing linked with the claims system would have in preventing fraud. Tim Wood advised that a small scale pilot is taking place in South Auckland, with a larger pilot due to be rolled out. There are a number of issues to be worked through, but he hoped that the system could be in place nationally within two years.

Progress on the regional after hours service solution - it was agreed that the weekly updates being provided to the Auckland DHB Board members would also be provided to Waitemata DHB Board members.

Eru Lyndon made the suggestion that reporting round BSMC (Better Sooner More Convenient Primary Health Care) could be an opportunity to incorporate some reporting from Whanau Ora providers.

Mental health patients living in the community – it was agreed that a joint paper be prepared for CPHAC on mental health residential facilities located in local communities covering location, who is providing, issues and risks, safety and how crises are handled.

Child and Adolescent Oral Health Business Case – while there had been some positive feedback about increased volumes at school dental clinics, the building programme was not yet complete by any measure. At this stage it would be premature to start reporting on outcomes, but in two to three months it would be timely to start looking at changes in numbers receiving dental care.

Fluoridation – Robyn Northey advised that she had raised the issue of the absence of fluoridation in Onehunga at the Local Board meeting for that area, but had not received the support of the Local Board. It was noted that there are very divergent views around fluoridation. Allison Roe offered to provide information on concerns regarding fluoridation to any Committee members who would like to receive that.

Mural at North Shore Hospital car park development – in answer to a question, the meeting was advised that this had been designed so that it can be cut up into sections, refreshed and repainted and framed for hanging.

POAC (Primary Options Acute Care) - there was a discussion around the question of the evidence to show whether or not POAC is making a difference. There was general agreement that as with any change project, there should be a proper evaluation. It was agreed that there should be robust regular reporting on POAC to CPHAC.

Health target reporting – Eru Lyndon suggested that it would be useful to receive with these reports information relating to Maori and Pacific populations in terms of the targets. Denis Jury advised that health target reporting was being considered as part of the review of the framework for these reports in future.

The Planning and Funding Update report was received by the Committee.

## **6. RESOLUTION TO EXCLUDE THE PUBLIC** (agenda page 37)

**Resolution** (Moved Warren Flaunty /Seconded Max Abbott)

**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	<p>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</p> <p>[NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</p>	<p><b>Maintenance of the Law</b> 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.</p> <p>[Official Information Act 1982 S.6 (c)]</p> <p><b>Confidence</b> The disclosure of information would not be in the public interest because of the greater need to protect information which if made available:</p> <ul style="list-style-type: none"> <li>i) would disclose a trade secret; or</li> <li>ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information.</li> </ul> <p>[Official Information Act 1982 S.9 (2) (b)]</p>

**Carried**

3.28p.m to 3.57p.m - public excluded session.

The meeting in open session resumed at 3.57p.m.

There was no general business.

The Committee Chair thanked members for their participation in the first combined meeting.

The meeting concluded at 4.00p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND  
WAITEMATA DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH  
ADVISORY COMMITTEES HELD ON 10 AUGUST 2011

\_\_\_\_\_  
CHAIR

**Actions Arising and Carried Forward from Meetings of the  
Community & Public Health Advisory Committees  
as at 7<sup>th</sup> September 2011**

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
WDHB CPHAC 13/4/11	4.3	<u>Interpreter Service</u> – 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	Information will be included in the October Planning and Funding Update.
WDHB CPHAC 13/7/11	3.1	<u>Correlations of health needs by linking data</u> - 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	
WDHB CPHAC 13/7/11	4.2	<u>Smoking</u> - 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 28/09/11	
CPHAC 10/8/11	3.1	<u>Relationship Waitemata DHB and its Health Links</u> – options to maintain relationships at a political level to be discussed with Health Links and recommendation made to CPHAC.	Dale Bramley		Recommended solution agreed with Health Links – refer comments in Sept CPHAC Planning and Funding Update.
CPHAC 10/8/11	3.1	<u>CPHAC Terms of Reference</u> – suggested improvements from Chris Chambers to be considered.	Denis Jury, Debbie Holdsworth		Will be incorporated in review of CPHAC in early 2012.
CPHAC 10/8/11	5.1	<u>Regional After Hours Services Solution</u> – weekly updates to ADHB Board Members also to be provided to WDHB Board members.	Denis Jury, Debbie Holdsworth		Actioned.
CPHAC 10/8/11	5.1	<u>Reporting from Whanau Ora Providers</u> – suggestion that this might be included with reporting around BSMC to be looked at.	Denis Jury, Debbie Holdsworth		
CPHAC 10/8/11	5.1	<u>Mental Health</u> – joint paper to be prepared for CPHAC on mental health residential facilities located in local communities covering location, who is providing, issues and risks, safety and how crises are handled.	Howard Dawson, Clive Benseman	CPHAC 12/10/11	
CPHAC 10/8/11	5.1	<u>Child and Adolescent Oral Health</u> – joint paper to be prepared for CPHAC covering statistics for the last 2-3 years.	Vicki Scott, Rachel Mattison	CPHAC 12/10/11	
CPHAC 10/8/11	5.1	<u>POAC</u> – robust regular reporting on this to CPHAC.			Noted. Will be included in BSMC reporting.



DECISION ITEMS



3.1 GAIHN Workplan and Investment Proposals for 2011/12



## 3.1 GAIHN Workplan and Investment Proposals for 2011/12

### Recommendation:

- a) That the report be received.
- b) That CPHAC notes the investment requested and that the request will be considered by the Audit and Finance Committee and the Board for Auckland and Waitemata DHBs in support of the continued development and implementation of the work streams and associated projects as summarised in this report.
- c) That CPHAC notes that this funding request represents 60% of the agreed funding limit for 2011/12 and that a further funding request will be received in December 2011.
- d) That it be noted that confirmation will be sought on whether the Clinical Pathways work stream will need to go to the National Health IT Board due to the amount requested.
- e) That it be noted that Waitemata DHB and Auckland DHB will work in a collaborative way with GAIHN to ensure there is no duplication between the GAIHN work and the DHBs' contracts with community and primary care providers, the provider arm and the Northern Region Health Plan.

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**Prepared by:** *Andrew Coe, Group Manager Primary Care & PHOs, Auckland & Waitemata DHBs (based on information provided by David Tucker, Project Director GAIHN)*

**Note:** *Ray Naeden, Chair of GAIHN will be in attendance for this item.*

### Glossary

ADHB – Auckland District Health Board  
ALT – Alliance Leadership Team  
BFG – Better Sooner More Convenient Group  
CCP - Contribution to cost pressure  
CPHAC – Community Public Health Advisory Committee  
DHB – District Health Board  
FFT – Future Funding Track  
GAIHN – Greater Auckland Integrated Health Network  
MOH – Ministry of Health  
PHO – Primary Healthcare Organisation  
WDHB – Waitemata District Health Board

## 1. Executive Summary & Background

The GAIHN Alliance Leadership Team (ALT) has previously agreed to a comprehensive programme of activity for 2011 – 2013. It has also been agreed to resource this programme through equitable partner contributions based on enrolled population. The District Health Board (DHB) partners have agreed to match the contribution of Primary Health Organisation partners. Contributions can be made up of financial support, in-kind support, or a mixture of both depending on the preference of the organisation. ALT agreed to an indicative resourcing ceiling up to an equivalent of \$3.00 per enrolled/domiciled population over two years.

ALT determined that “bulk funding” of the GAIHN programme is not an option for 2011/12. A stage-gate process was agreed whereby specific funding requests are submitted for approval at key milestones. Subject to ALT sign off, these funding requests would then be submitted to

partners for approval using the population based formula. Partners will then release funds to the GAIHN resourcing pool for management by the Programme Director under the governance of ALT.

Upon receipt of partner funding, projects can be advanced to the next stage of development or implementation. GAIHN operations and programme development are currently being funded from money carried forward from 2010/11.

The purpose of this report is to present CPHAC with the current GAIHN work plan which identifies the first tranche of funding for the 2011/12 financial year. There is a mix of full year funding for parts of the programme and staged funding for others. A formal request for funding will be presented to the Audit and Finance Committees of both boards in October. There will be a second resourcing request in December 2011. This current request represents approximately 60 % of the agreed funding limit for 2011/12.

## 2. GAIHN Projects & Requested funding

The GAIHN Alliance Leadership Team has agreed a focus for 2011/12 on the goal:

‘Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions’

In order to align, manage and mobilise effort across Auckland Metro, the GAIHN programme has been organised into seven discrete but interrelated work streams. From 1 July 2011 the GAIHN Office became responsible for the development and management of this programme under the governance of ALT. Some of the projects are still in the hand over process which may be influenced by the outcome of this resourcing/funding process.

Whilst each of the seven work streams will contribute directly or indirectly towards the achievement of the GAIHN goal, work streams 1 & 2 form the core of the programme, namely:

- Better management of targeted individuals in primary care
- Better primary response to acute events when they occur.

The remaining work streams all support the above two work streams as well as better primary care generally.

The table below details the requested GAIHN project/work stream funding allocations and whether the funding request is for the full or part year. The full plan is found in Appendix One.

	<b>Work Stream/Project</b>	<b>Funding Request</b>	<b>Funding Period</b>	<b>Project Key Deliverables</b>
1	Better management of targeted individuals	\$440,250	To 30 June 2012	<ul style="list-style-type: none"> <li>○ Development and implementation of a predictive risk algorithm risk stratification tool to identify the risk scores of individual patients for hospital admission and re-admission associated with enrolled patients within the GAIHN population</li> <li>○ Begin the process of re-orientating clinician focus and behaviour towards the prevention of unplanned hospitalisations by transparently assisting practices in targeting their resources to patients most likely to benefit.</li> </ul>

	Work Stream/Project	Funding Request	Funding Period	Project Key Deliverables
2	Better response to acute events	\$185,000	Further resourcing requests, Dec. 2011	<ul style="list-style-type: none"> <li>○ Reshaping, realignment and expansion of existing services responding to acute events aimed at achieving a reduction of unplanned hospitalisations, focussing initially on: St John Ambulance Services; Primary Options of Acute Care</li> <li>○ Stock take and planning for re-orientated services including (to be reported back): Triage; Aged residential care; Non medical home care; St John urgent community care service.</li> </ul>
3	Enablers of better primary care - e-Practice  - Access to Diagnostics  - Reg. Clinical Pathways  - Optimising Prescribing	\$ 10,000  \$25,000  \$705,000  \$ nil	1/9/11 – 30/11/11  1/9/11 – 30/12/11  To 30 June 2012  New request Dec. 2011	<ul style="list-style-type: none"> <li>○ Continued development and delivery of existing regional enabler programmes, including: <ul style="list-style-type: none"> <li>▪ Electronic-Practice Support Systems</li> <li>▪ Access to Diagnostics</li> <li>▪ Regional Clinical Pathways</li> <li>▪ Optimising Prescribing</li> </ul> </li> <li>○ Strategy agreed and funding secured for 12/13 for the development and implementation of e-Practice enablers across all work streams.</li> <li>○ Closer alignment and integration of enablers with GAIHN Programme.</li> <li>○ e-Practice strategy agreed and funding secured for 12/13 for the development and implementation of high priority e-Practice enablers across all work streams</li> </ul>
4	Population prevention programmes	\$90,000	1/9/11 – 13/12/11	<ul style="list-style-type: none"> <li>○ Targeted population prevention interventions aimed at supporting and enhancing the GAIHN programme particularly work streams 1 &amp; 2.</li> <li>○ An analysis of current programmes with a view to incorporating, adapting and improving them to compliment the GAIHN Programme</li> <li>○ An initial focus on the following; Smoking cessation; Cellulitis; Stroke; Fall prevention; Preventable child medical illness.</li> <li>○ Other programmes may be considered following the outcome of the risk stratification process in work stream one</li> </ul>
5	Alliance support & development	\$622,000	To 30 June 2012	<ul style="list-style-type: none"> <li>○ Programme leadership including strategy, project development and delivery to targets</li> <li>○ Effective communications &amp; stakeholder engagement</li> <li>○ Programme logistics and support</li> <li>○ Governance support</li> <li>○ Administrative support</li> <li>○ Advocacy.</li> </ul>

	Work Stream/Project	Funding Request	Funding Period	Project Key Deliverables
6	Systems improvement	\$135,000	1/9/11 – 30/11/11	<ul style="list-style-type: none"> <li>○ Definitive principles on which to base changes in the incentives and contracting environment</li> <li>○ New incentives and contracting regimen in place for selected areas by 30 June 2012.</li> <li>○ Information gathering hub established</li> <li>○ GAIHN programme indicators operational.</li> </ul>
7	Child health improvement	\$ nil	Resourcing request December 2011	For the period to 30 December 2011 the main focus will be via other work streams including work stream four, addressing preventable child health medical illness.
	Total funding request #1 for 2011/12	\$2,212,250		

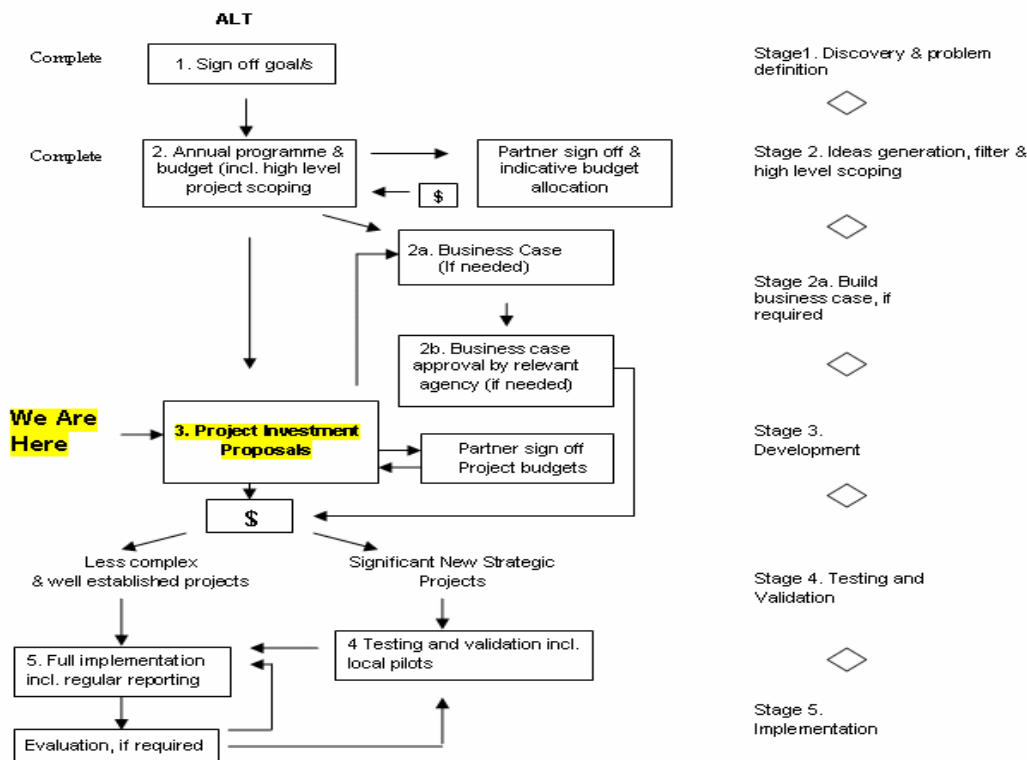
The requested funding total amount split on the percentage of the GAIHN population, results in the following costs being requested from each GAIHN partner organisation:

Partner Organisation	Contribution # 1 for 2011/12	% of GAIHN Population
<b>ADHB</b>	<b>\$309,715</b>	28.0%
CMDHB	\$320,776	29.0%
<b>WDHB</b>	<b>\$475,634</b>	43.0%
Total DHB contribution #1	\$1,106,125	
APHO	\$50,881	4.6%
East Health Trust	\$81,853	7.4%
ProCare Networks Ltd.	\$774,288	70.0%
Waitemata PHO	\$199,103	18.0%
Total PHO contribution #1	\$1,106,125	
<b>Total</b>	<b>\$2,212,250</b>	

### 3. Stage Gate approval process for release of funding

The 'stage-gate' concept is that ALT will receive a request for approval of each main stage of project work and the release of funding to meet the staged work resource requirement. ALT will sign-off the funding for specific work streams or project stages on receipt of an appropriate case for funding.

The figure below illustrates the current states of the programme in relation to the stage gate approval process.



#### 4. Risks/Issues

There are a number of risks and issues associated with the GAIHN business case, which require further investigation.

From a governance perspective, concern has been raised with regard to regular reporting through to member organisations. Discussions are taking place with the Chair of GAIHN, to ensure appropriate governance arrangements moving forward are put into place. It should be noted that at the time of writing, that a formal alliance agreement including charter, although agreed, has not been signed by the parties.

A number of historical annual plan projects, have been transitioned into GAIHN. It will be important to ensure that these projects continue to be effectively managed and progressed against key variables reported via the ALT.

The current projects as detailed in the 2011-2012 Project Investment Proposal will require additional analysis to ensure clarity with regard to project deliverables, timeframes, accountabilities and budgets. A review of these projects will need to take place to ensure that there is no duplication between these projects, current funded PHO activity or DHB Provider Arm functions and further clarity is being sought with regard to linkages between GAIHN, the National Hoaura Coalition and Alliance Health+.

It is expected that many of these risks and issues will be resolved or an appropriate mitigation strategy will be developed before a more detailed plan and budget is submitted to the Audit and Finance and DHB Boards for approval and sign-off.

## 5. Indicative DHB budget allocations

The Better Sooner More Convenient strategies are congruent with the DHB's 'Living Within Our Means' commitment and new and ongoing initiatives in this regard are expected to endorse and augment this commitment.

The ongoing implementation of Better Sooner More Convenient strategies and initiatives (as outlined in the Annual Plan and as approved in the Northern Regional Health Plan for commencing in 2011/12) is resourced at 2010/11 spend plus growth in line with Funding Envelope expectations.

It should be noted that the methodology for funding allocation using enrolled population may need to be reviewed in the light of PHO membership to GAIHN and changes to enrolment registered that are currently in train.

### Waitemata DHB Funder

The formal budget for 2011/12 as per the annual plan for BSMC is the amount expended for BSMC for 2010/11 plus growth increase as per funding envelope (CCP/FFT).

For GAIHN, the amount expended was \$95,950 relating to the first tranche at 25c, which was invoiced and paid plus \$99,175 relating to the second tranche at 23c that was invoiced but is not yet paid (awaiting confirmation). The total 2011/12 budget specifically allocated for this particular initiative therefore amounts to \$195,125 plus CCP/FFT or rounded to \$200,000.

### Auckland DHB Funder

Auckland DHB has structured its indicative funding allocation for Primary Care initiatives using a project framework as detailed below:

*For Projects*

Project	Comment	Value
New primary care projects	GAIHN budget \$6.5m funded 50% GAIHN and 1/3rd each DHB	500,000*
Managing service Change	Managing service change 2° to 1°	250,000
BFG mandated activities		125,000
Total		875,000

*For the GAIHN initiative in particular, the following allocation has been identified:*

#### GAIHN office

- PHO register 817k at 0.25c per enrolled person total for the year \$204,358 (\*This figure is part of the New Primary care projects value in the table above)

#### Access to Radiology

- \$802,116 budgeted

## **Appendix One: GAIHN 2011-13 Project Investment Proposals**



# Greater Auckland Integrated Health Network

## 2011 – 2012 Project Investment Proposals

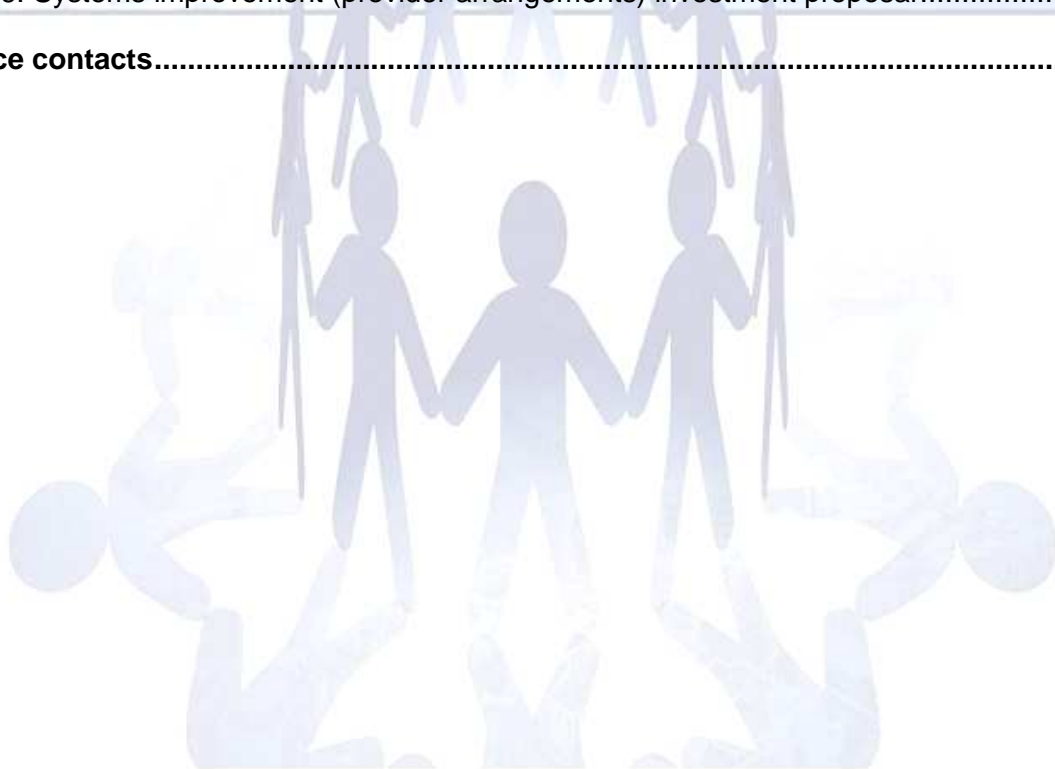


‘Better primary care  
to reduce acute episodes  
which result in unplanned  
hospital admissions’

24 August 2011

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## Introduction

The GAIHN Alliance Leadership Team (ALT) has previously agreed to a comprehensive programme of activity for 2011 – 2013. It has also agreed to resource this programme through equitable partner contributions based on enrolled population. The District Health Board (DHB) partners have agreed to match the contribution of Primary Health Organisation partners. Contributions can be made up of financial support, in-kind support or a mixture of both depending on the preference of the organisation. ALT agreed to an indicative resourcing ceiling up to an equivalent of \$3.00 per enrolled/domiciled population over 2 years.

ALT determined that “bulk funding” of the GAIHN programme is not an option for 2011/12. A stage-gate process was agreed whereby specific funding requests are submitted for approval at key milestones. Subject to ALT sign off, these funding requests would then be submitted to partners for approval using the population based formula. Partners will then release funds to the GAIHN resourcing pool for management by the Programme Director under the governance of ALT.

Upon receipt of partner funding, projects can be advanced to the next stage of development or implementation. GAIHN operations and programme development are currently being funded from money carried forward from 2010/11.

The purpose of this report is to seek approval for the first tranche of funding for the 2011/12 financial year. The report recommends a mix of full year funding for parts of the programme and staged funding for others. There will be a second resourcing request in December 2011. This current request represents approximately 60 % of the agreed funding limit for 2011/12.

## Recommendations

1. That ALT endorses the continued development and implementation of the suite of projects outlined in this report.
2. That ALT approve an initial funding allocation for 2011/12 of \$2,212,250 in support of the continued development and implementation of the work streams and associated projects as outlined in this report and summarised in the table below.

	Work Stream/Project	Funding Request	Funding Period
1	Better management of targeted individuals	\$440,250	To 30 June 2012
2	Better response to acute events	\$185,000	Further resourcing requests, Dec. 2011
3	Enablers of better primary care - e-Practice - Access to Diagnostics - Reg. Clinical Pathways - Optimising Prescribing	\$ 10,000 \$25,000 \$705,000 \$ nil	1/9/11 – 30/11/11 1/9/11 – 30/12/11 To 30 June 2012 New request Dec. 2011
4	Population prevention programmes	\$90,000	1/9/11 – 13/12/11
5	Alliance support & development	\$622,000	To 30 June 2012
6	Systems improvement	\$135,000	1/9/11 – 30/11/11
7	Child health improvement	\$ nil	Resourcing request December 2011
	<b>Total funding request #1 for 2011/12</b>	<b>\$2,212,250</b>	

3. That ALT partner representatives report to the next meeting of the relevant committee within their respective organisations seeking approval to release the first GAIHN funding contributions for 2011/12 for the amounts identified in the table below.

Partner Organisation	Contribution # 1 for 2011/12	% of GAIHN Population
ADHB	\$309,715	28.0%
CMDHB	\$320,776	29.0%
WDHB	\$475,634	43.0%
Total DHB contribution #1	\$1,106,125	
APHO	\$50,881	4.6%
East Health Trust	\$81,853	7.4%
ProCare Networks Ltd.	\$774,288	70.0%
Waitemata PHO	\$199,103	18.0%
Total PHO contribution #1	\$1,106,125	
<b>Total</b>	<b>\$2,212,250</b>	

4. That partner representatives confirm approval from their respective organisations at the earliest possible date before the 27 September ALT meeting thereby enabling GAIHN to invoice for the payments.
5. That the next funding request be reported to ALT at its 14 December 2011 meeting.

## Programme and Projects

The GAIHN Alliance Leadership Team has agreed a focus for 2011/12 on the goal:

‘Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions’

In order to align, manage and mobilise effort across Auckland metro, the GAIHN programme has been organised into seven discrete but interrelated work streams. (Refer to figure one below). From 1 July 2011 the GAIHN Office became responsible for the development and management of this programme under the governance of ALT. Some of the projects are still in the hand over process which may be influenced by the outcome of this resourcing/funding process. Whilst each of the seven work streams will contribute directly or indirectly towards the achievement of the GAIHN goal, work streams 1 & 2 form the core of the programme, namely:

- Better management of targeted individuals in primary care
- Better primary response to acute events when they occur.

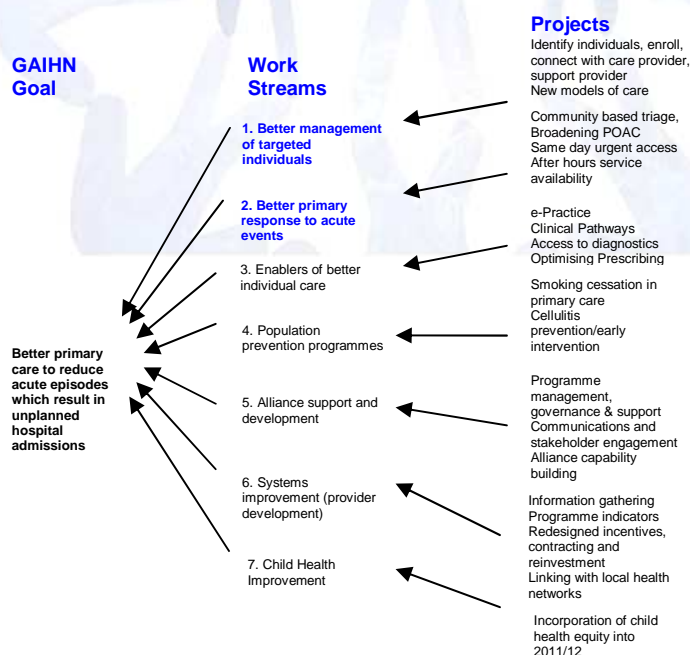
The remaining work streams all support the above two work streams as well as better primary care generally.

The GAIHN programme consists of a mixture of newly forming and already established initiatives. Several of the existing initiatives have a history that precedes the establishment of the GAIHN alliance but because they are important to the achievement of its goal, they are considered to be best managed by the alliance and have been incorporated into the GAIHN programme. It is suggested that where possible, established projects be given approval to continue with their planned implementation programme (stage 5) for the remainder of the 2011/12 financial year.

Other initiatives, still under development, will be the subject of follow up reports and funding requests in December.

The GAIHN programme office aims to have all projects to a point in their planning where they are able to identify their resourcing requirements for the remainder of the financial year by 13 December 2011. This will reduce the need for further funding requests for 2011/12.

**Figure one: GAIHN Programme and Projects**

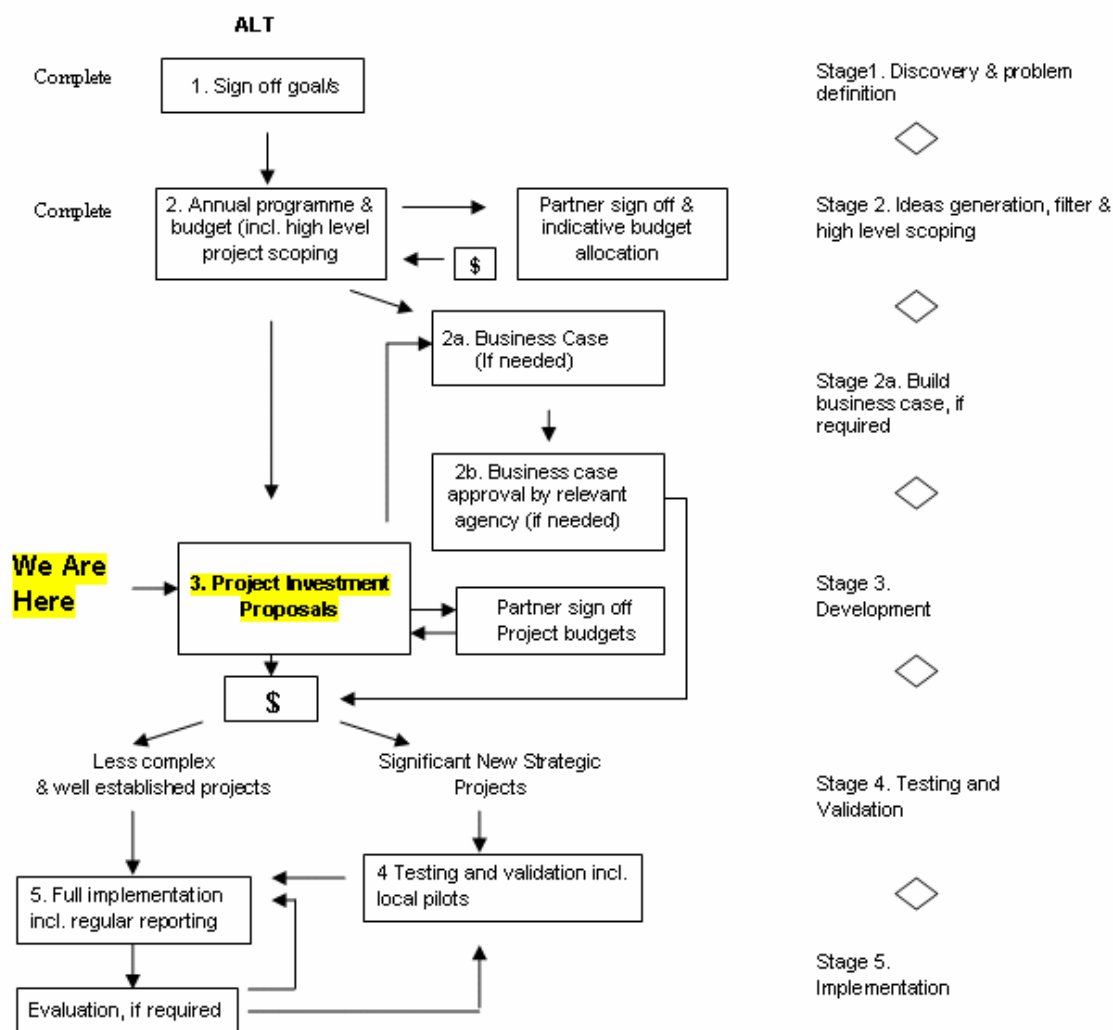


## Project Investment Proposals

Figure two illustrates the current status of the programme in relation to the stage gate approval process. In order to establish a common understanding, each of the GAIHN Project Leads has prepared a Project Investment Proposal using the same format. The purpose of the proposals is to outline each project in sufficient detail to give ALT confidence to invest in its continued development and implementation.

As mentioned previously, well established or less complex projects can be given approval for the full year's funding where appropriate. For strategic and complex new initiatives, there are likely to be additional steps required in the approval process.

**Figure two: Stage Gate Approval Process:**



## Existing Projects

As outlined above, four existing projects have now been incorporated into the GAIHN-accountable programme. These projects are:

- Access to Diagnostics
- Regional Clinical Pathways
- Optimising Prescribing
- Primary Options for Acute Care (POAC).

Each of these projects has had business case approval in previous years. Several (e.g. POAC) also have existing payer-provider contracts for service delivery. These contracts will remain outside of the GAIHN accountability structure and will retain their normal payer-provider accountability relationships.

Within the new GAIHN context, the focus for consideration is as follows:

- What is the potential of this initiative to contribute to the delivery of the GAIHN goal and what resourcing/funding is required to achieve this?
- Which component of the project should remain accountable through existing payer-provider relationships?
- How can GAIHN enhance the potential of this project to deliver its current and potential future outputs?
- How can this initiative enhance other GAIHN initiatives and vice versa?

### New Projects

Work streams one, two, three, four and six include new initiatives that are still under development. In considering the proposals for new initiatives, the primary considerations are:

- How does the initiative support the GAIHN goal either directly or indirectly?
- Is there sufficient confidence in, or potential return on investment demonstrated to warrant continued funding of this initiative?
- If not, how should the proposal be modified or improved?

In order to assist ALT in its decision making, Project Investment Proposals have been prepared utilising the same format as follows:

- **Situation:** A brief description of the current situation with respect to the particular initiative.
- **Opportunities:** The opportunities presented by the current situation
- **Strategy:** A programme of action to deliver on the opportunities
- **Impact:** On the system, patients and costs
- **Resourcing required:** including budget and human resource
- **Risks:**

**Table one: Work stream & project investment proposal summary table**  
(Refer to appendices for more detail)

#### Work stream 1 – Better management of targeted individuals (Appendix 1)

**Key deliverables:**

- Development and implementation of a predictive risk algorithm risk stratification tool to identify the risk scores of individual patients for hospital admission and re-admission associated with enrolled patients within the GAIHN population
- Begin the process of reorientating clinician focus and behaviour towards the prevention of unplanned hospitalisations by transparently assisting practices in targeting their resources to patients most likely to benefit.

**Resourcing required to 30 June 2012:** \$440,250

**Situation:** There is significant potential to increase the capability of primary care to take a greater role in people’s health care. This work stream will focus on identifying and managing high risk/high gain individuals in the community. Once identified, patient interventions can be applied in order to improve the quality of care and reduce the likelihood of events which lead to hospital admission.

**Impact:** Better targeting of system resources to patients with greatest return (health gain), which will also lower requirements for additional capital and operational investment over coming years.  
Refer to Appendix 1 for further detail including risks

#### Work stream 2 - Better response to acute events (Appendix 2)

**Key deliverables:**

- Reshaping, realignment and expansion of existing services responding to acute events aimed at achieving a reduction of unplanned hospitalisations, focussing initially on:
  - St John Ambulance Services
  - Primary Options of Acute Care
- Stock take and planning for reorientated services including (to be reported back):
  - Triage
  - Aged residential care
  - Non medical home care
  - St John urgent community care service.

**Initial resourcing required:** \$185,000. (A second request will be forthcoming in December 2011).

**Situation:** A large range of existing services are available for improvement and further development in furtherance of the GAIHN goal. The Project Advisory Group has been established to prioritise options that warrant further consideration. These are outlined below.

**Opportunities:** Work stream 2 provides the alliance with opportunities for immediate wins that should be capitalised on. Five projects have been identified for investigation and further development through the year. These are:

1. Alternative St John Transport options
2. St John Urgent Community Care Service
3. Triage Standardisation

<p>4. Aged Residential Care Support 5. Non Medical Home Care (In association with work stream 1) The St John project is a first priority for action.</p>
<p><b>Strategy:</b> A key strategy is to build on the capability of existing well run projects where potential exist for further gains in relation to the goal with limited lead time. This will require collaboration with other work streams and external stakeholders. In the regard, POAC has considerable potential and St John is a willing partner and ready to go. Prioritisation of effort is another key strategy so that return on investment is maximised given the limited resource available. Collaboration with other work streams is critical.</p>
<p><b>Impact:</b> Potential exists for immediate impact:</p> <ul style="list-style-type: none"> <li>▪ For patients (more convenient care centred around the medical home or related community facilities)</li> <li>▪ On the system (reduced ED presentations, improved community triage, increased capability for existing well run projects with limited lead time required)</li> <li>▪ On costs, by directly reducing the number of days patients use in unplanned hospital admission.</li> </ul>
<p><b>Resourcing Required:</b></p> <ul style="list-style-type: none"> <li>▪ Immediate requirement from 1 September to 30 June 2012, \$185,000</li> <li>▪ Anticipated future resourcing requirements during 2011/12 \$800,000.</li> </ul>
<p><b>Risks:</b> Lack of willingness by partners to further invest in existing programmes.</p> <ul style="list-style-type: none"> <li>▪ Mitigation: strong, robust return on investment (ROI) demonstrated.</li> </ul>
<p><b>Work stream 3 - Enablers of better primary care (appendix 3)</b></p>
<p><b>Key deliverables:</b></p> <ul style="list-style-type: none"> <li>▪ Continued development and delivery of existing regional enabler programmes, including: <ul style="list-style-type: none"> <li>○ Electronic-Practice Support Systems</li> <li>○ Access to Diagnostics</li> <li>○ Regional Clinical Pathways</li> <li>○ Optimising Prescribing</li> </ul> </li> <li>▪ Strategy agreed and funding secured for 12/13 for the development and implementation of e-Practice enablers across all work streams.</li> <li>▪ Closer alignment and integration of enablers with GAIHN Programme.</li> <li>▪ e-Practice strategy agreed and funding secured for 12/13 for the development and implementation of high priority e-Practice enablers across all work streams. (Appendix 3a).</li> </ul>
<p><b>Resourcing required:</b> 30 December 2011: \$10,000</p>
<p><b>Situation/Opportunity:</b> A work stream advisory group has met to consider the range of initiatives that are either planned or underway in the e-Practice area. This group is in the process of analysing the material and developing a prioritised program and approach aimed at maximising the benefit to the GAIHN programme over the medium term. e-Practice is one of the threads that have the potential to unify the GAIHN programme and integrate it with other initiatives across Auckland metro. A common knowledge base coupled with a shared understanding and use of information for better integrated care of individual patients and planning development and implementation across the region is a baseline for collaborative action and true shared care.</p>
<p><b>Work stream 3 Project - Access to Diagnostics (appendix 3b)</b></p>
<p><b>Key deliverables:</b></p> <ul style="list-style-type: none"> <li>▪ On-going analysis and feedback during the roll out so far indicates that a number of modifications and additions to the initial access to radiology clinical triage criteria are required. These improvements will ensure maximum utilisation of the tool by GP's by presenting a comprehensive decision support tool and user interface which is readily incorporated into their current work flow. The clinical triage criteria will be developed further in the future when the system transfers to Regional e-Referrals Phase 2.</li> </ul> <p>The initial investment will pay for the programming required to update the triage criteria.</p>
<p><b>Resourcing required</b> 1 September - 30 December 2011, \$25,000. Further development of clinical triage criteria in ProExtra.</p>
<p><b>Situation:</b> The Access to Diagnostics-Radiology project was originally an ADHB and ProCare initiated project and dates back to May 2008. In early 2010 it transitioned into a regional DAP project. It is currently in the regional rollout phase and the majority of the activity is funded under the contract that ADHB holds with ProCare for the implementation and management of ProExtra on behalf of ADHB &amp; CMDHB. The roll out of 100 ADHB practices was completed in February 2011. The CMDHB roll out has now begun and is scheduled to be completed in December 2011.</p>
<p><b>Opportunities:</b> General practices face barriers in accessing timely, convenient diagnostic investigations. Both GP's and DHB radiology providers share a desire to improve the journey for patients. "Better access" includes not only improved access for patients who need diagnostics but also more appropriate use of the resource so that diagnostics are not used where there is little value. A number of improvement opportunities have been identified and are being actioned. This project has demonstrated that successful collaboration across the primary/secondary boundary is achievable and has the potential to be replicated in many other areas. Integration with e-Referrals within the next 2 -3 years.</p>
<p><b>Strategy:</b> To reduce the rate of referrals being submitted to DHB radiology providers that do not meet clinical triage criteria by supporting GP decision making to determine patient eligibility. This will expedite the availability of the diagnostic resource to those patients who do meet appropriate criteria.</p>
<p><b>Impact</b> On patients:</p>

- Provision of services closer to home in particular for high needs patients who are the most disadvantaged through having the farthest to travel.
- Improved clinical care due to more timely diagnosis
- Regional improvements in:
  - Access to radiology
  - Understanding of service utilisation
  - Appropriateness of GP referrals for radiology investigations through the use of robust evidence based guidelines
  - Reduction of inequalities due to more convenient options for diagnosis.

On costs:

- Current experience indicates that better use of diagnostics (where the patient situation meets criteria for appropriateness) not only speeds up access but often reduces utilisation overall. This programme will definitely improve value for money from the diagnostic resource and may well reduce absolute costs in some areas.

### Work stream 3 Project - Regional Clinical Pathways (appendix 3c)

#### Key deliverables:

- Operationally implement the following pathways  
TIA COPD DVT Community Acquired Pneumonia.
- Select and develop up to five additional pathways during 2011/12
- Clinical Benefits
  - Standardised integrated care across the region
  - Improved patient outcomes
  - Improved evidence base through tracking process and outcomes
  - Improved safety for patients and clinicians in a complex environment.

Indicative Economic Benefits:

	COPD	TIA	Dyspepsia
Investment	\$5.7m	\$1.7m	100k
Savings	\$11.3m	\$4.0m	\$1.8
Regional Benefit (ROI)	\$5.7m (98%)	\$2.3m (135%)	\$1.7m (1700%)

**Resourcing required** to 30 June 2012: \$705,000.

**Situation:** Clinical pathways development has been occurring over many years with a resurgence of focused and organised activity during the last 2 years. A lack of agreed clinical pathways in the Auckland metro area has resulted in inefficiencies and poor coordination between primary and secondary care at multiple points on the patient journey leading to unnecessary delays, inconvenience and potential harm for patients.

**Opportunities:** Clinical pathways set out maps of best practice that guide clinicians to treat their patients in the right way at the right time in the right place. There are significant benefits to be derived from early, standardised best practice as evidenced in the pathways that have been implemented to date. There is a significant opportunity to enhance the GAIHN Programme through careful selection and implementation of further pathways over the coming years. Significant opportunities exist for integration with e-Practice initiatives especially e-Referrals.

#### Strategy:

- Focus on implementation of pathways already developed in order to identify and resolve issues and to replicate and systematise success factors.
- Utilise the best available expertise on development and implementation teams to ensure robust and workable pathways.
- Develop a selected range of new pathways which evidence suggests will positively contribute to the GAIHN goal.

#### Impact on the system:

Widespread implementation of standardised best practice is a fundamental to good health care. It will also contribute to significant system wide improvements in effectiveness and efficiency.

Impact on patients:

- Improved safety, consistency of care, timeliness, and overall service quality.

Impact on costs:

- Significant return on investment potential is possible and beginning to be demonstrated. Refer to Table 1: COPD, TIA and Dyspepsia, (Appendix 3b)
- Resourcing required
- For the period 1 September 2011 to 30 June 2012, \$705,000
- For pathway development, project management, implementation planning and operationalisation.

#### Risks

Clinical pathways are a risk minimisation mechanism when developed and implemented effectively.

### Work stream 3 Project - Optimising Prescribing (appendix 3d)

- Key deliverables:** Continued focus on the appropriate use of medicines in terms of quality and resource allocation using multiple staged interventions including
- Electronic bulletins

<ul style="list-style-type: none"> <li>▪ GP and Practice nurse education sessions</li> <li>▪ Practice prescribing audits.</li> </ul>
<p><b>Resourcing required:</b> Currently covered under the existing contractual arrangements with ADHB/CMDHB and ProCare.</p>
<p><b>Situation:</b> There is a desire to roll out this programme within the WDHB area which will be the subject of a further investment proposal in December 2011.</p>
<p><b>Work stream 4 - Population prevention programmes (appendix 4)</b></p>
<p><b>Key deliverables:</b></p> <ul style="list-style-type: none"> <li>▪ Targeted population prevention interventions aimed at supporting and enhancing the GAIHN programme particularly work streams 1 &amp; 2.</li> <li>▪ An analysis of current programmes with a view to incorporating, adapting and improving them to compliment the GAIHN Programme</li> <li>▪ An initial focus on the following <ul style="list-style-type: none"> <li>Smoking cessation                      Cellulitis                      Stroke</li> <li>Fall prevention                              Preventable child medical illness.</li> </ul> </li> </ul> <p>Other programmes may be considered following the outcome of the risk stratification process in work stream one.</p>
<p><b>Resourcing required to 30 December 2011:</b> \$90,000 A second request will follow in December 2011</p>
<p><b>Situation:</b> GAIHN is focusing considerable effort on better primary care for targeted individuals. There will be occasions when this model of care will need to be supported by broader campaigns aimed at specific groups to reinforce prevention messages.</p>
<p><b>Opportunities:</b> There is an opportunity to design targeted prevention programmes in association with work stream one to compliment the activity in that area and increase the impact of the messages.</p>
<p><b>Strategy:</b> Focus on five areas initially:</p> <ol style="list-style-type: none"> <li>1. Smoking cessation/smoke free</li> <li>2. Cellulitis</li> <li>3. Stroke</li> <li>4. Falls prevention</li> <li>5. Preventable child health medical illness.</li> </ol>
<p><b>Impact on patients</b> Population prevention programmes when utilised in conjunction with individualised targeted interventions will provide a more powerful combination than either would achieve in isolation. <b>On system &amp; costs</b> Existing programmes and pathways will be enhanced and modified rather than designing new initiatives tailored to the GAIHN programme in order to make greater use of limited health promotion resources.</p>
<p><b>Resourcing/funding required to 30 December 2011</b> \$90,000 Project leadership, clinical release time and community engagement. Short assessment of current delivery and to prioritise action</p>
<p><b>Risks:</b></p> <ul style="list-style-type: none"> <li>▪ Perception of limited value in this activity as many current programmes exist.</li> <li>▪ Mitigation: close integration of programmes with work stream one to ensure maximum impact and targeting.</li> </ul>
<p><b>Work stream 5 - Alliance support &amp; development (Appendix 5)</b></p>
<p><b>Key deliverables:</b></p> <ul style="list-style-type: none"> <li>▪ Programme leadership including strategy, project development and delivery to targets</li> <li>▪ Effective communications &amp; stakeholder engagement</li> <li>▪ Programme logistics and support</li> <li>▪ Governance support</li> <li>▪ Administrative support</li> <li>▪ Advocacy.</li> </ul>
<p><b>Situation:</b> The GAIHN Office provides programme leadership as well as a support hub for the governance structure and work streams to improve the capability of the alliance to deliver the programme to time, cost and quality. Currently this function is resourced by a team of two people plus the Independent Chair.</p>
<p><b>Opportunities:</b> There is an immediate opportunity to create better value for the Alliance through the creation of a Master Scheduler function to manage the meeting schedules and data bases for the entire programme. This will enable the project and clinical leads to better focus on delivering project outputs and for the communications and stakeholder engagement function to be maximised to its true potential. Other opportunities will be presented as the programme evolves.</p>
<p><b>Strategy:</b></p> <ul style="list-style-type: none"> <li>▪ Rapid transition from ideas to collaborative, focused, goal orientated action. Integration of activity and best practice across Auckland metro.</li> <li>▪ Lean operating structure to maximise project resourcing capability.</li> </ul>
<p><b>Impact on system:</b></p> <ul style="list-style-type: none"> <li>▪ Increased likelihood that GAIHN will achieve its goal which is a regional priority namely</li> <li>▪ Improved capability of primary care to better manage high risk/high gain individuals and acute events in the community thereby reducing demand on hospital ED's</li> </ul> <p><b>Impact on patients</b></p>

<ul style="list-style-type: none"> <li>▪ Improved care pathways for patients and clinicians with a focus on community based care and practice innovation</li> </ul>
<p><b>Resourcing/funding</b> from 1 September 2011 to 30 June 2012, \$622,000</p> <p>Three full time functions suggested:</p> <ul style="list-style-type: none"> <li>▪ Programme Director</li> <li>▪ Communications &amp; Stake Holder Engagement</li> <li>▪ Master Scheduler</li> </ul> <p>Overall operational costs are significantly less than original business case estimates.</p>
<p><b>Work stream 6 - Systems improvement (appendix 6)</b></p>
<p><b>Key deliverables</b> 2011/12</p> <ul style="list-style-type: none"> <li>▪ Definitive principles on which to base changes in the incentives and contracting environment</li> <li>▪ New incentives and contracting regimen in place for selected areas by 30 June 2012.</li> <li>▪ Information gathering hub established</li> <li>▪ GAIHN programme indicators operational.</li> </ul>
<p><b>Resourcing required</b> to 30 November:</p> <p>Contracting and Incentives 2011, \$135,000</p> <p>Indicators operation &amp; maintenance to 30 June 2012, \$25,000</p>
<p><b>Situation:</b> GAIHN is a regional initiative aimed at addressing significant regional issues. It has set itself an ambitious 3 -5 year goal. Achievement of the goal will require sustainable changes in clinician and patient behaviours. Some of the key drivers for change will be through modifications to the incentives and contracting environment and the way information is gathered, shared and utilised for planning reporting and evaluation.</p>
<p><b>Opportunities:</b> GAIHN is an integrator, innovator and developer. The alliance will share and disseminates best practice and build on the capabilities of its partner organisations and other stake holders to achieve more than they would acting in isolation. It is recognised that the alliance functions within a wider context and wherever possible, it aims to contribute to systems improvements at the regional and national level.</p> <p>Achieving changes in the incentives, contracting and information environments is potentially one of the most challenging and yet most rewarding aspects of the GAIHN Programme.</p>
<p><b>Strategy:</b> An influential team of opinion leaders to develop change principles in September. These principles will be used as a framework for design and development of proposed changes in incentives and contracting areas. This process will dovetail with the DHB planning cycle.</p>
<p><b>Impact</b> on system</p> <p>These principles will provide a reference framework for action and innovative arrangements within the GAIHN programme and elsewhere including other business cases an potentially the entire health system</p> <p><b>Impact</b> on patients</p> <p>Primary care should have improved capability to deliver customised services aimed at maximising the benefit at the practice and locality level. Both clinicians and patients will be appropriately recognised and rewarded for behavioural changes that deliver the goal.</p> <p><b>Impact</b> on costs</p> <p>The report indicates significant savings that can be realised through implementation of a comprehensive programme. It is anticipated that some of the savings, once realised, will flow through to primary care to further develop and implement the programme.</p>
<p><b>Resourcing/funding required</b> from 1 September to 30 December 2011 \$115,000 for independent expert advice, clinical release time and partner staff time.</p>
<p><b>Risks:</b></p> <ul style="list-style-type: none"> <li>▪ Delays cause by partner resistance to change</li> <li>▪ Mitigation: Clear and decisive Board &amp; Senior Management direction from the outset to define the scope of the change required.</li> </ul>
<p><b>Work stream 7 – Child Health Improvement</b></p>
<p><b>Situation:</b> For the period to 30 December 2011 the main focus will be via other work streams including work stream four, addressing preventable child health medical illness.</p>

# Appendices – GAIHN Investment Proposals

## Appendix 1: Better management of targeted individuals investment proposal

Work stream 1 Clinical Lead	Work stream 1 Project Lead
Harley Aish	Kylie Ormrod

### Situation

The Northern Region Health Plan provides evidence and convincingly states that continuing to deliver health services as we do now is not sustainable<sup>1</sup>. The region plan emphasises the fact that we need to build a foundation now that will enable us to progressively deliver services in a fundamentally different way over the next five years.

Key issues supporting this conclusion are that:

1. Over the next 20 years the population in the Northern region will grow by around 500,000 which exceeds the current population of any other DHB and will account for two out of every three additional people in New Zealand (NZ).
2. Our population is getting older and the burden of chronic diseases is increasing – in diabetes alone we estimate that an additional 40,000 people will be diagnosed with diabetes over the next 10 years.
3. Our projections show that if we continue to deliver services as we currently do, each year we will need an additional 75-100 beds just to accommodate demographic growth. We will add an additional \$20m in operating costs to our cost base from 2011, which will grow to an additional \$100m per annum from 2015. An additional \$300m of capital will also be required to build further hospital facilities to accommodate the growth.

### Opportunity

The majority of our health resources are currently being consumed by older patients and those who have a long-term condition. These patients are often classified as 'high risk' patients and once identified a series of patient interventions can be applied in order to improve the quality of care and reduce the likelihood of being (re)admitted to hospital.

### Strategy

The purpose of this project is to choose and apply a risk assessment model to segment the population in order to target resources within the health system to those patients where the biggest health gain (health outcome, improved resource usage etc.) can be made. It is anticipated that a risk stratification model will be agreed by the end of September 2011 and the first reports will be distributed to practices by the end of November 2011.

### Impact

The key benefits to this stream of work to the system will be better targeting of limited health system resources to those patients where a greater return on investment is predicted and thereby lowering the requirements for additional capital and operational investment over the coming years.

### On Patients

By identifying patients who are most at risk of being re-admitted or admitted to hospital we can better target a set of preventative patient centred interventions to reduce to their risk. The benefits to the patient of avoiding an admission include iatrogenic harm, disruption to life, confidence reduction, etc.

There is evidence to support the use of self-management programmes, rehabilitation, regular nurse follow up and discharge planning to improve the health outcomes for patients with a long-term condition. There are a range of existing programmes to support patients and by stratifying the population more intensive case management can be applied to those who have a high risk score. This is in alignment with the Chronic Disease Management Pyramid. Patients who are highly complex often require a key worker who actively manages and co-ordinates their care.

### Requirements

We propose to develop and implement a predictive risk algorithm type risk stratification tool to ultimately identify the risk scores associated with all the enrolled patients within the GAIHN population.

This is initially planned to be an adaptation of an internationally renowned Kings Fund "Patient's At Risk of Readmission" (PARR) Tool which will produce monthly lists of patients to practices based initially on their hospital data with associated percentage 'risk scores'.

<sup>1</sup> Refer Northern Region Health Plan for context and drivers of change in the Northern Region.

We aim to develop and refine the predictive power of the predictive risk algorithm and have this driven from the data that resides in primary care in order to a) apply a risk score the whole population; b) focus on prevention of 'index' admissions as well as re-admissions and c) compare the risk profile of a population over time.

The second area of focus was around the mechanical aspects of presenting practices with 'lists' of patients, and around the key behaviour changes we were expecting providers to make (e.g. reaching out to those patients who may require assistance from the health system rather than just responding to those that ask for it). Primary Health Organisations (PHO) currently have this practice-engagement responsibility for other programmes (e.g. PHO Performance Programme, Optimising Prescribing) so these existing systems and methodologies would be leveraged.

The consensus is that the first step with regard to the above two pieces of work is that we would 'spread' the work that has been done for WDHB (NZ version of the PARR tool) across the ADHB and CMDHB areas (recognising that the result would only include the data from patients that have been admitted to hospital previously), and use these results as a way of testing methods for communicating the lists to Practices as well as beginning the change process with providers.

The next step would be to develop the risk algorithm to be driven off primary care data, so that it could be applied to the whole enrolled population, and then reinforce further behaviour change through the most effective methodologies. Implementation of this tool is based on the assumption that unplanned admissions to hospitals represent poor patient outcomes. The tool is not designed to apportion 'blame' in any sense but to transparently assist practices in targeting their resources to patients most likely to benefit.

The risk stratification tool is part of an overall suite of interventions and performance measures designed to improve the overall quality of care provided to our patients in the community and thereby improving their quality of care and quality of life whilst also reducing unplanned use of hospitals.

### Project Budget

The budget for this work stream is \$440,250 for the 2011 / 2012 year. Costs beyond this financial year depend on the scope of the requirements in future years, particularly around improving the sophistication and accuracy of the risk prediction through incorporation of additional data sets, or research into the impact of new variables on the algorithm or through newer and faster methods of accessing and reporting data and risks scores to the patient's medical home.

Budget Item	2011 / 2012 Total	Description
Clinical Release Time	\$20,000	Clinical Leadership for the work stream, and maintaining linkages to other GAIHN work streams, Active Clinical Network, Alliance Leadership team as appropriate. Working with the project team and university to ensure suitability of output for frontline clinician. Working with peers to ensure clinician buy-in to the approach continues, and any risks / issues are mitigated / addressed.
Project Management	\$80,000	Managing the project including project reporting, managing deliverables (especially from the University), developing the educational materials, and managing risks and issues identified in the project.
Programme Management	\$80,000	Managing/monitoring the programme for the identified group of patients to ensure that an appropriate care plan and interventions are in place to prevent future admissions/re-admissions.
Project Administration	\$36,000	Supporting the Project Manager initially, and then running the monthly process of obtaining the risk data from the University of Auckland and preparing the reports for distribution to practices.
Data Analyst	\$21,250	We expect to utilise data analyst skills and time at the beginning to review the hospital data and support data extractions related to our enrolled patient register. We also expect to require significantly more data analyst time in the second phase supporting the extraction and manipulation of primary care data for use by the University in developing and running the second version of the algorithm.
Printing & Report Distribution	\$12,000	Printing and distributing the monthly lists of patients by practice with their risk scores.
Business Analyst	\$16,000	Two short phases of work to: <ul style="list-style-type: none"> <li>Develop the requirements for initial reporting (Sep 2011)</li> <li>Develop requirements and specification for primary care data extracts (Jan 2012)</li> </ul>
Risk Stratification Operation (Auckland University)	\$90,000	Gathering the hospital data, matching it to GAIHN's enrolled patient register, running the risk algorithm and providing the risk stratification files on a monthly basis.
Risk Stratification Development (Auckland University)	\$60,000	Two phases of work to: <ul style="list-style-type: none"> <li>Develop the process for running the risk stratification algorithm for our enrolled patients across all three DHBs (already trialed with WDHB)</li> </ul>

		<ul style="list-style-type: none"> <li>Develop the expanded risk stratification algorithm and associated primary care data set.</li> </ul>
PMS Vendor Payments for Primary Care Data Extract Development	\$25,000	Provision for anticipated costs of changes to practice management systems to enable the primary care data extract to support the enhanced phase two risk algorithm.
Total	\$440,250	

## Project Phasing

The project is planned to be undertaken in two major phases over the first year.

Phase one is to utilise hospital data to create risk scores for our enrolled patients across all three DHBs. It is likely therefore that only patients with previous hospital events will be scored in this phase. The risk scores will be translated into paper-based or electronic reports and provided back to practices to assist practices in targeting care to these patients. Phase one will include educational materials and cell group presentations describing the nature of the risk scores and also reminding practices of the existing suite of programmes and services that they can employ to support these at risk patients. We anticipate this reporting of monthly risk scores to practices will be established in the second quarter of the 2011 / 2012 year and will be monitored closely through the third quarter of the year.

Phase two is to expand the risk algorithm to include data derived from practice management systems. This is already undertaken in different iterations of the Kings Fund PARR tool, but has not yet been undertaken in New Zealand. The inclusion of this data is expected to enable risk scores to be produced for all enrolled patients in the network and also to improve the sensitivity and specificity of the algorithm in predicting risk. We anticipate this phase will commence in the third quarter of the 2011 / 2012 year and would hope to be able to produce risk scores based on a combination of primary and secondary care data in the fourth quarter of the year.

## Project Scope

This project is specifically about undertaking risk stratification of our enrolled population. It is to identify patients who are most at risk of hospital admission (or readmission) and therefore enable practices / PHOs and others to target their resources. This project is not specifically a clinical service or intervention. However the education programme associated with the risk lists will emphasise the range of existing services available to help practices better support the needs of the high risk patient group.

## Risk Assessment

Major risks associated with the project have been identified:

1. Access to hospital data about patients enrolled with Primary Care (being managed through GAIHN)
2. Understanding and application of a NZ version of the risk algorithm based on hospital data (developed and piloted already by Auckland University, our partners in this project)
3. Understanding and application of a NZ version of the risk algorithm based on Primary Care data (some local initiatives are underway with PHOs to improve data consistency).
4. GAIHN incentives and contracting work not delivering a change to the current environment, whereby practitioners are not incentivized/supported/ encouraged to change focus/behaviour toward reducing unplanned hospitalisations (to be addressed by incentives and contracting work-stream).
5. Availability of resources within practices to support new models of care to reduce unplanned admissions in high risk patients (intended to be addressed through the wider GAIHN programme and other local initiatives).

## Situation

Our projections show that if we continue to deliver services as we currently do, each year we will need an additional 75-100 beds just to accommodate demographic growth. We will add an additional \$20m in operating costs to our cost base from 2011, which will grow to an additional \$100m per annum from 2015. An additional \$300m of capital will also be required to build further hospital facilities to accommodate the growth.

## Opportunity and Strategy

The purpose of this project is to choose and apply a risk assessment model to segment the population in order to target resources within the health system to those patients where the biggest health gain (health outcome, improved resource usage etc.) can be made. It is anticipated that a risk stratification model will be agreed by the end of September 2011 and the first reports will be distributed to practices by the end of November 2011.

## Benefits

The key benefits to this stream of work to the system will be better targeting of limited health system resources to those patients where a greater return on investment is predicted.

## Return on Investment

It is difficult to calculate a specific return on investment attributable to this project in isolation, rather this project should be viewed as a marginal increase in investment in reducing unplanned hospital admissions leading to a larger than otherwise achieved reduction in acute demand through the suite of current initiatives implemented and new initiatives being planned. This premise is based on the assumption that we both have and are planning highly effective interventions, but are not systematically applying them to the patients with the greatest need (or greatest capacity to benefit).

This is an assumption, but completion of the project (ironically) will tell us the degree to which the project was worth doing. Whilst many current initiatives have selection criteria which may take the form of some type of risk assessment, international literature suggests that algorithm based approaches are better than other forms such as clinical judgement or threshold methods.



## Appendix 2: Better response to acute events investment proposal

Work stream 2 Clinical Lead	Work stream 2 Project Lead
Campbell Brebner	Under negotiation

### Situation

This work stream will focus on developing better primary response in the community to acute events and building the capability of the primary/community sector through planning and improving a range of existing programmes to enhance their potential to contribute to the goal.

Examples of these programmes include:

- St John Ambulance Services
- Triage, in all its permutations
- Broadening of POAC
- Same day and urgent access to medical home and outside hours availability
- Aged residential care management.

An essential component is that all patients should have access to their usual practice or deputising agency and a significant emphasis will be placed on this principle.

At present response to acute illness varies considerably. This occurs for numerous reasons related to variability in:

- Patient behaviour, knowledge and expectation
- Medical Home processes, priorities and capacity
- Other Primary Care provider options and capabilities
- Secondary care processes, priorities, and capacity
- Variability in access to health information by providers.

The POAC service which has been available to Primary Care for 10 years has gone some way in enhancing Primary Care ability to respond to acute illness. General practitioner referrals to hospital acute medical services have not increased for several years whereas self referrals have grown steadily.

### Opportunity

Work stream two provides the GAIHN alliance with significant opportunities for relatively immediate wins. With this in mind there is potential to work with St John to intervene in and modify a percentage of ambulance transportations. A substantial number of Emergency Department (ED) attendances brought in by ambulance are managed by and discharged from ED. Evidence suggests that there is potential to make safe changes to this practice. Owing to the limitations of data collected by EDs, it is difficult to obtain a good understanding clinically of these patients, but the assumption is that a substantial number could be equally as well managed in a Primary Care setting. A separate thought piece on this initiative is appended with this report.

A better, sooner, more convenient process to develop and fund a network of After Hours clinics in Auckland is currently underway. Whether it will provide a long term sustainable solution to the after hours needs of Auckland is yet to be determined. This work stream will develop sustainable medium term options for consideration at a later date.

Telephone triage is utilised inconsistently throughout Auckland. This applies to both patients and providers. Triage service providers vary in the functionality they offer and the degree to which they integrate with the Medical Home. Practices vary in the triage processes they adopt and the messages they give. Face to face triage is undertaken by St John and in Emergency Departments but subsequent utilisation of a community located management options is inconsistent.

Aged Residential Care facilities are reported to be high referrers to EDs thought to be related to skill set and clinical support deficiencies. A CMDHB initiative to address this has seen a noticeable reduction in unplanned admissions. There is potential for region wide improvements in this area.

Patients often present for care at locations and times that are convenient and affordable for them. Consequences of this are that their care is frequently frustrated by limited availability of health information, and will lack continuity. The ability of non medical home providers to access and communicate health information can only serve to improve care. Likewise, fostering the concept of all such providers working on behalf of and being an extension of the medical home is fundamental.

At present options available to community located providers when managing acute illness are limited: treat where possible, or send to hospital. Making available additional services locally is a viable course of action

## Strategy

A key strategy is to build on the capability of existing well run programmes where the potential exists to further improve their effectiveness. This will require collaboration with other GAIHN work streams as well as external stakeholders. The St John organisation is a willing partner and has already made contact with GAIHNN and others.

As highlighted above, there are many and varied possibilities for development as part of this work stream. Prioritisation of effort will be important to ensure that GAIHN achieves maximum return for its limited investment capability. The Project Advisory Group has met and discussed priorities as outlined below.

### 2011/12 Projects

1. St John Transport - refer to attached paper.
  - Estimated resource requirement, \$50,000
2. St John Urgent Community Care Service
  - Based on Horowhenua UCC pilot - 28% reduction in transfers to Emergency Department
  - Paramedic visits and manages lower priority calls
  - Liaison with GP, DN, Pharmacy as needed
  - Potential for 10,000 avoided transfers by 2 x 5-person teams phased over 2 years
  - Opportunity to develop into a Medical Home-designated Home Visit service
  - Estimated cost per team: \$700,000.
3. Triage Standardisation
  - This requires scoping to determine baseline, direction and ideal outcome.
  - Estimated resource requirement: \$25,000
4. Aged Residential Care Support
  - Provide education and immediate support for management of acute illness
  - Provide alternatives to hospital referral for facilities such as referring to an alternative accredited facility (e.g. IFHC, A&M, other Residential Care provider)
  - Estimated resource requirement: Scoping and development \$100,000
5. Non Medical Home Care (Initial scoping in association with work stream 1)
  - a. Develop a sustainable system to better manage patients who present to locations other than their medical home (including hospital ED) whether in hours or after hours.
  - b. Develop additional options for medical home directed care at an alternative site such as community located observation units and acute/semi-acute medical clinics.

## Impact

On system - Through working closely with the GAIHN Incentives and Contracting work, there is potential to expand and improve a range of existing initiatives as outlined above.

The Ambulance Transportation project has good potential to make an immediate impact on the number of ED presentations and subsequent admissions based on the attached report and the results obtained elsewhere.

On Patients - Community based care, preferably in association with the medical home, is more convenient for patients especially for high need patients for whom transportation is an issue.

It is an aim that every patient that presents to an ED has had some form of triage in the community prior to presentation.

On Costs - Most of the costs identified for 2011/12 are development costs. Further reports will be presented to ALT as they are developed. And return on investment (ROI) opportunities are established.

## Resourcing Requirements

There is an immediate requirement for a project lead for this work stream. An internal advertising process was carried out amongst partner organisations to secure an in house person for this role. No internal candidates put their name forward. Negotiations are now nearing completion with a suitable person, formerly from a partner organisation, initially for 24 hours per week. East HealthTrust has offered to provide the employment facility for this person on behalf of the Alliance. The person will be seconded to GAIHN for 100% of their time.

### Estimated Costs 2011/12

## Immediate Resourcing Requirement (from 1 September 2011 to 30 June 2012)

Project Lead	\$60,000 (to 30 June 2012)
Clinical Lead	\$20,000 (to 30 June 2012)
Project 1: St John Transport	\$50,000 scoping and development
Project 2: St John Urgent Community Care Service	\$10,000 scoping and ROI analysis for reporting to ALT
Project 3: Triage Standardisation	\$25,000 for triage analysis
Project 5: Non Medical Home Care	\$20,000 scoping and reporting to Dec ALT
<b>Total</b>	<b>\$185,000</b>

Anticipated future resourcing requests during 2011/12 subject to ALT approval

Project 2: \$700,000, for an initial deployment of one team

Project 4: \$100,000 (CMDHB only).

### Project 1 - Community based management of Ambulance transported patients

A project to support better sooner more convenient patient care

#### Background

The POAC service was established in 2001 and enables general practitioners to manage patients in the community, as an alternative to referring acutely to a public hospital. Nevertheless growth in acute demand continues to increase, particularly self-referred patients, which includes those brought in by ambulance.

At present the vast majority of ambulance call-outs result in the transporting of a patient to a public hospital ED. A significant proportion of these cases could be equally as well managed in the community, either by the patients GP, an Integrate Family Health Centre or an A&M clinic.

In 2010 approximately 8700 non-ACC patients were transported to and discharged from Middlemore Hospital (MMH) ED. Potentially many of these patients would be suitable for management in the community. ACC cases will not be excluded.

An unfunded pilot has been running in Howick whereby qualifying patients are transported to Eastcare A&M as opposed to MMH ED, and receive reduced cost of care. Over 90% of these patients were successfully managed without referral to hospital.

Verbal approval has been provided by the Funding and Planning departments of all three Auckland metro DHBs to proceed with this project.

#### Proposal

- We propose expansion of the POAC referrer base to include St John Ambulance officers.
- Upon identification of an eligible case (refer to Appendices 1 and 2), the paramedic will transport the patient to either the patient's medical home, or to the nearest POAC Approved A&M.
- POAC Approved A&Ms will include only those A&M clinics that are members of the Auckland region After Hours Network.
- The standard St John transport fee will continue to be applied.
- POAC will fund all aspects of the patient's care upon arrival at the site of treatment.

#### Costs

Based on the Eastcare pilot experience, cases are likely to be managed for an average of \$80 – 100. It is difficult to accurately predict volumes but based on the MMH data a conservative estimate would be 15,000 regionally in the medium term.

#### Roll out

There will be staged roll out over the Auckland region, commencing with the CMDHB region, followed by WDH then ADHB:

September 1 2011: Commence project in CMDHB

January 1 2012: Commence project in ADHB

April 1 2012: Commence project in WDH.

## Reporting

St John:

- Date and time of attendance
- Demographic and clinical details of patients transported for community based care
- Demographic and clinical details of patients declined for community based care
- Place transported to for community based care
- Ratio of Non-transported : Community Transported : Hospital Transported

POAC:

- No of Patients transferred to and declined by Medical Home
- No of patients transferred to POAC Approved A&M
- No of patients subsequently transferred to ED
- Costs for Ambulance transported cases.

### Clinical Eligibility Criteria (to be ratified)

The patient is assessed as status three or four and has one of the following medical conditions:

- Respiratory: asthma / croup / CORD responsive to nebulised medications
- CHF
- Non cardiac chest pain
- Chest infection
- Fever
- Allergic reaction (not including respiratory / systemic symptoms)
- Abdominal pain (including renal colic but excluding pregnancy with bleeding) Skin infections (cellulitis, abscess)
- Loss of consciousness with completely normal recovery (i.e. simple syncope only)
- Diarrhoea and vomiting
- Urinary tract infection
- Non accident related musculoskeletal pain
- Migraine
- Hyperemesis Gravidarum.

### General POAC Eligibility Criteria

- Patients who would otherwise require an acute hospital referral
- Patients who reside within the Counties Manukau, Auckland or Waitemata DHB area. This includes those who are on holiday or have temporary residence with friends/family in these regions
- NZ Citizens, including visitors from UK and Australia (refer to the MOH eligibility criteria online or in this manual)
- Patients whose safety is not compromised (if in any doubt over safety of treatment, always refer to the Clinical Director, Medical Registrar or Consultant for advice)
- Patients whose treatment is not covered by another funding stream such as ACC or Maternity (with the exception of Hyperemesis treatment).

### Stakeholders

- DHB Planning & Funding
- A&M Clinics
- St John
- Hospital Emergency Departments
- After Hours Network
- Primary Health Organisations.

## Appendix 3: Enablers of better primary care investment proposal

Work stream 3 Clinical Lead	Work stream 3 Project Lead
TBD	Sarah Tibby

The Enablers of Better Primary Care work stream consists largely of existing initiatives which have been incorporated into the GAIHN programme because they will have a marked impact on the achievement of the goal and are considered to be better managed under the GAIHN umbrella. They include:

- e-Practice (new)
- Access to Diagnostics (existing)
- Regional clinical Pathways (existing)
- Optimising Prescribing (existing).

The project leads of the above initiatives have prepared project investment proposals below.

### Appendix 3a: e-Practice project investment proposal

Work stream 3 Project a Clinical Lead	Work stream 3 Project a Project Lead
TBD	Sarah Tibby

#### Situation

A project advisory group has met to consider the range of initiatives that are either planned or underway in the e-Practice area. (Approximately 40 initiatives were identified). This group is in the process of analysing the material and developing a prioritised program and approach aimed at maximising the benefit to the GAIHN programme over the medium term.

#### Opportunity

e-Practice is one of the threads that have the potential to unify the GAIHN programme and integrate it with other initiatives across Auckland metro. A common knowledge base coupled with a shared understanding and use of information for planning development and implementation across the region is a baseline for collaborative action and true shared care.

#### Strategy

The findings and preferred approach will be presented to ALT in October 2011.

### Appendix 3b: Access to Diagnostics-Radiology project investment proposal

Work stream 3 Project b Clinical Lead	Work stream Project b Project Lead
	Lara Sedcole

The purpose of this project investment proposal is to request project funding from the GAIHN partners for Q1 2011/12 financial year.

The Access to Diagnostics-Radiology project is currently in the regional rollout phase and the majority of the activity is funded under the contract that ADHB holds with ProCare for the implementation and management of ProExtra on behalf of ADHB and CMDHB. This includes programme management fees, training and installation costs, payment of private radiology procedures ordered via ProExtra, and ProExtra licensing fees. For the purposes of this proposal, these costs and responsibility remain with ADHB and CMDHB for their respective areas.

This proposal covers the costs for required software development and modification costs which are not included in the ADHB/ProCare main contract.

#### Situation

The Access to Diagnostics-Radiology project was originally an ADHB and ProCare initiated project and dates back to May 2008. Then in early 2010, the project transitioned into a Regional District Annual Plan (DAP) project.

The work is lead by a Regional Steering Group and Clinical Governance Group. The Clinical Governance Group developed an initial set of regionally agreed clinical triage criteria, to determine patient eligibility for direct access to

plain x-ray, US, CT and MRI. The clinical triage criteria have been programmed into ProExtra web-based forms which integrate with Medtec and My Practice Patient Management System (PMS). The software tool also includes budget management functionality so GPs are able to track spending or utilisation against assigned community (private practice) budget and DHB Radiology budget.

The project is made up of the following phases:

- Phase 1: Development (May 2008 – 30 June 2010)
- Phase 2: Implementation in ADHB (1 July 2010 – 17 February 2011)
- Phase 3: Regional Rollout (1 January 2011 – 30 June 2011)
- Phase 4: Regional Consolidation of Clinical Triage Criteria (1 July 2011 – 30 June 2012)

The rollout of ProExtra into 100 ADHB general practices was completed in February 2011. The regional rollout to 100 Practices across CMDHB & WDHB was planned for 1 January 2011 – 30 June 2011. However the decision for CMDHB and WDHB to rollout the programme was delayed until February 2011 when CMDHB confirmed it will rollout ProExtra Radiology to 100 Practices and WDHB Radiology Department will continue to manually triage all GP referrals until the long term sustainable end-to-end e-Referrals solution is available. Phase 2 includes Radiology forms with regional access criteria embedded<sup>2</sup>.

CMDHB implementation has now begun and roll out to the 100 CMDHB Practices is scheduled to be completed by December 2011.

For more information about the background of this project please refer to the Implementation plan May 2010 (available upon request).

### **Opportunity**

General Practices face barriers in accessing timely, convenient diagnostic investigations for their patients.

- General Practices should have shared responsibility for use of radiology resources and the ability to track spending or utilisation via visibility of community budgets.
- DHB radiology providers receive a significant number of GP requests for investigations which do not meet clinical triage criteria.
- General Practices and DHB radiology providers share a desire to improve the journey for patients accessing radiology<sup>3</sup>.

### **Strategy**

- To provide GP patients with better, sooner, more convenient access to elective diagnostic radiology via the development and adoption of robust evidence-based clinical criteria, to support GP decision making to determine patient eligibility for triaged access to plain x-ray, US, CT and MRI.
- To reduce the rate of referrals being submitted to DHB radiology providers that do not meet the clinical triage criteria via the clinical triage criteria being loaded on GP desktop Practice Management Systems.
- General Practices having shared responsibility for use of radiology resources and the ability to track spending or utilisation via visibility of community budgets on GP desktops (part of ProExtra Radiology functionality).
- Providing services closer to home in particular for high needs patients who are currently most disadvantaged through having the furthest to travel. GPs will have the ability to refer high need patients to conveniently located Radiology provider (i.e. choose public or private Radiology provider via ProExtra Radiology functionality)<sup>1</sup>.

### **Impact**

On patients - Improve clinical care and outcome due to more timely diagnosis.

Reduce inequalities for high needs patients who are currently most disadvantaged through having the furthest to travel.

On the system - Improved access to Radiology for patients through the use of clinical guidelines and direct referral.

Improved understanding of service utilisation across the region through the ability to monitor referrals and spending against population expectations.

<sup>2</sup> Information taken from the Access to Diagnostics-Radiology power point presentation by Donald Mackie to the GAIHN Summit 3 May 2011.

<sup>3</sup> Access to Diagnostics-Radiology Implementation Plan May 2010, page 3.

Improved clinical appropriateness of GP referrals for radiological investigations through the use of robust evidence-based guidelines

Other advantages/benefits - As more GPs use the ATD-Radiology Clinical Triage Criteria, the volume of referrals that do not meet the clinical triage criteria will decrease coming into the hospital system, which will reduce waiting times.

## Requirements

### Further developing the Clinical Triage Criteria

From initial roll out, the Clinical Governance Group have continually gathered feedback and reviewed the preliminary Access to Radiology Clinical Triage Criteria which underlie the ProExtra tool. Based on this ongoing work, a number of modifications and additions to the initial criteria are required.

Feedback from a number of sources has been considered:

- Feedback from GPs who have been using the ProExtra tool
- GP Liaison practitioners at both ADHB and WDHB who in the course of ongoing weekly manual triage of non-ProExtra requests identify gaps in the existing criteria
- The recently formed Regional Radiology Network has provided another forum to ensure DHB specialist endorsement and consistency of application of the criteria across the region.
- Recent releases from the GAIHN Clinical Pathways project- it is essential the Access to Diagnostics criteria remain aligned with the regional Clinical Pathways.
- Changes in accepted clinical best practice e.g more widespread availability of CT colonography (CTC) replacing barium enemas.

These changes will need to be programmed into ProExtra to take effect. The very rough estimate for the changes that the Clinical Governance Group has requested to the current criteria as well as adding new triage criteria into ProExtra is \$25,000 (provided by ProCare 11.08.2011 and signalled this is likely an overestimate). A final estimate will be provided by ProCare once all changes have been signed off by the Clinical Governance Group (expected by end of August 2011).

Please note it is anticipated as with any such system there will be an ongoing requirement for modifications to the software tool to remain aligned with agreed clinical pathways and current best practice. A significant part of the proposed modifications involves developing criteria for investigations and clinical cases which were omitted from the original criteria that were developed. The Clinical Governance Group are confident that they have now covered all significant areas and it is anticipated that any further modifications required in the future will be relatively minor.

The remainder of the expenses associated with this stage of the project are included in the contract ADHB holds with ProCare for the implementation and management of ProExtra on behalf of ADHB and CMDHB. This includes programme management fees, training and installation costs, payment of private radiology procedures ordered via ProExtra, and ProExtra licensing fees. For the purposes of this proposal, these costs and responsibility remain with ADHB and CMDHB for their respective catchment areas.

## Risk Assessment

A risk register is maintained by the project manager on behalf of the steering group and can be made available upon request.

## Summary

The Access to Diagnostics-Radiology project provides GP patients with better, sooner, more convenient access to elective diagnostic radiology: plain x-rays, ultrasound, CT, and MRI. The project has recently moved into Phase 3: Regional Rollout of the evidence-based clinical criteria; in February 2011 CMDHB confirmed it will rollout ProExtra Radiology to 100 Practices; and WDHB Radiology Department confirmed it will continue to manually triage all GP referrals until the long term sustainable end-to-end e-Referrals solution is available from 2012/2013.

The project improves clinical appropriateness of GP referrals for radiological investigations through the use of robust evidence-based guidelines. It helps facilitate timely diagnosis and provides an opportunity to reduce access inequalities for high needs patients in areas remote from DHB sites.

The majority of the costs associated with this stage of the project are included in the contract ADHB holds with ProCare for the implementation and management of ProExtra on behalf of ADHB and CMDHB. For the purposes of this proposal, these costs and responsibility remain with ADHB and CMDHB for their respective areas

However the main developmental requirements for Q1 2011/12 for the Access to Diagnostics-Radiology project for 2011/12 includes further developing the Clinical Triage Criteria (approximately \$25,000).

### Return on investment

Investment in this further development work of the triage criteria will help ensure ongoing project success and maximal utilisation of the ProExtra tool by GPs – by presenting a comprehensive decision support tool and user interface which is readily incorporated into their current workflow. Keeping the criteria up to date and aligned to other developed guidelines and the clinical pathways, ensures both DHB specialist acceptance and support and optimised utilisation of available imaging resources. The clinical triage criteria will be used in the future when the system transfers to Regional e Referrals Phase 2.

### Appendix 3c: Auckland Regional Clinical Pathways project investment proposal

<b>Work stream 3 Project c Clinical Lead</b>	<b>Work stream Project c Project Lead</b>
	Kris Vette

### Situation

The lack of agreed clinical pathways in the Auckland metro area leads to inefficiencies and poor co-ordination between primary and secondary care, which occurs at multiple points in the patient journey leading to unnecessary delays, inconvenience and potential harm for patients, with unnecessary appointments and frustration for clinicians.

**Clinical pathway definition:**

A clinical pathway is a document outlining a standardised, evidence-based multidisciplinary management plan, which identifies the appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogenous patient group. Variance is defined as any deviation from the proposed standard of care listed within the Clinical Pathway.

### Opportunity

Health trends are such that we must plan and trial new configurations of health delivery with the capability to address the rapidly approaching vastly increased levels of demand. This must be done in a value driven way that reduces overall system cost.

Best practice care and early care is the most cost effective care. The evidence supports this. Clinical pathways set out 'maps' of best practice that guide the clinician to treat their patients in the right way, at the right time, in the right place.

The opportunity is powerfully illustrated with TIA. A person suffering a TIA has a 2 to 40% chance of having a stroke within three months. Half of that risk is in the first 48 hours.

Stroke is a debilitating event for any family/ whanau. It has a dramatic lifetime personal, social and economic effect and is costed at \$80k/stroke in the first year. Early intervention can significantly reduce the risk of stroke.

COPD and respiratory disorders are another example of a disease burden that can be significantly attenuated with early diagnosis and treatment. Twenty per cent of the population suffer from a respiratory disorder. COPD has a 15% incidence in the population over 40 years. There are an estimated 90,000 people with this condition in the Auckland region and only 36,000 are diagnosed. A person needs to lose 50% of their lung capacity before they become symptomatic and yet correct diagnosis and treatment, including smoking cessation can halt the disease.

Apart from the health and societal benefits we know there are significant economic benefits with early, standardised best practise. With just COPD, TIA and Dyspepsia there is an economic case to save \$10 million per annum in the Auckland region. This is conservative and the potential savings quantum in these disease groups is more likely to be double that.

A pathway selection sub-group is running a process that is selecting pathways for this year using a number of metrics, clinical variables and ASH rate data. The potential pathways include;

- CHF
- Chronic Kidney Disease
- Chest Pain
- Respiratory Bundle (Brochiectasis, Asthma, etc)
- Cellulitis
- Syncope
- Depression
- Heavy Menstrual Bleeding.

The clinical pathways project provides a structure to develop standardising, best practice care across the region. As electronic practice develops we will integrate pathways in the workflow of the clinician, with ability to track variance.

The GAIHN focus for this year is on implementation of pathways that;

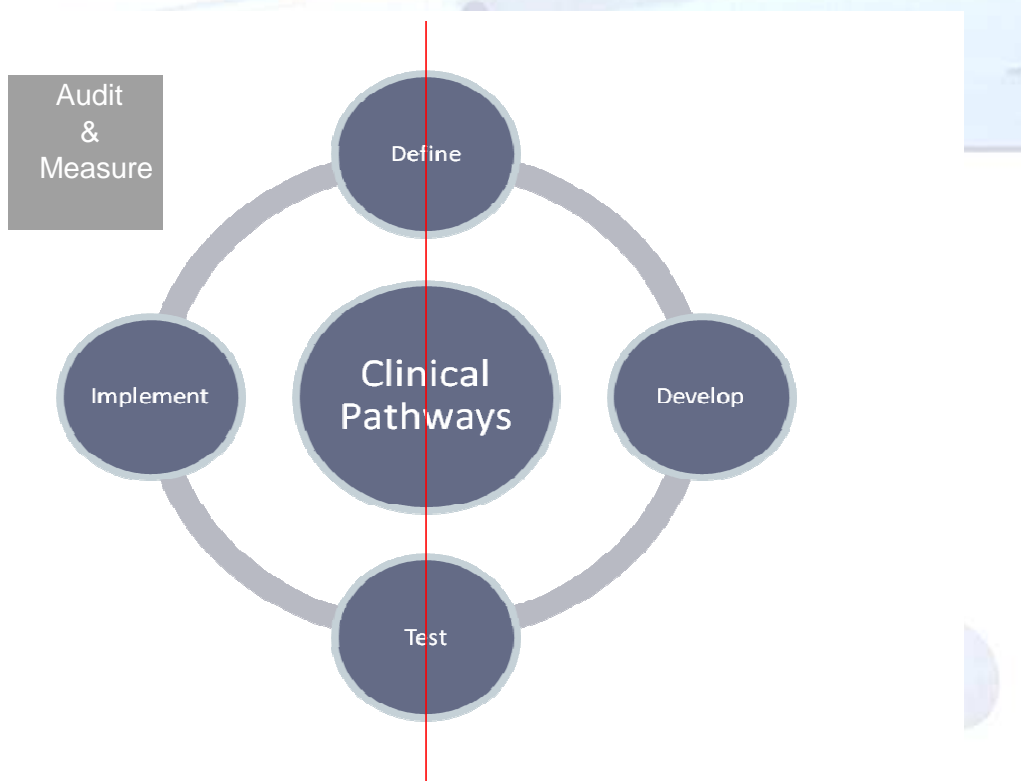
1. Prevent acute episodes which result in unplanned admissions.
2. Identify targeted individuals at high risk of an acute event, particularly poorly controlled cardiovascular and respiratory conditions.

The appropriate project structure and resourcing required to deliver this is set out below.

The existing steering group structure was put in place within the original project scope where the focus was development, clinical engagement and leadership.

The current financial year will require these clinical competencies together with greater business engagement and associated competencies in order to meet the expanded responsibility of implementation and ongoing integration into sustainable business as standard models of care.

The process is illustrated in the figure below:



### Pathway Implementation Teams

To achieve success it is necessary that the appropriate functions are incorporated into the project. These will include operational management, planning and funding, finance, demand-capacity planning, quality improvement, audit & measurement, and communications functions.

Each pathway work stream will develop its own Implementation Team based on the generic composition below;

- Operational Management Lead (primary or secondary care Service Manager)
- Primary Care manager
- Clinical Lead (SMO and/or GP)
- Funding and Planning/ Finance Manager
- Quality Improvement
- Clinical Audit and Measurement
- Decision Support
- Business Analyst
- Admin Support.

## Implementation process and timing schedule

Phase	Process / Action	Milestone	Timings	Resource reference
<b>Development</b>				
	Development meetings	Sign Off by Clinical Working Group	4 months (5x2hr meetings)	Development Working Group
<b>Implementation planning</b>				
	Regional Review	Sign Off by ALT to proceed to implementation	1x ALT mtg	ALT
	Form Pathway Implementation Team	Team membership to ensure planning and implementation	1 week	Implementation Planning
	Service Gap Analysis	Review Pathway. Identify service gaps. Identify potential service reconfigurations.	3 weeks	Implementation Planning
	Demand and Costing Analysis	Identify demand figures and effect on service configuration.	1 week	BA
	Service Planning	Business Case Planning	2 months	Business Implementation Team
	Business Case Development	Completed Business Case	Milestone	BA
	Approval process	Business Case approval process	1 month	ALT
	Communications planning	Communications plan complete	2 months	Comms Team
	Measurement and Audit planning	Metrics&data capture process defined	4 months	Public Health and Decision Support
	Electronic format testing	UAT complete	2 months	UAT
	Electronic Platform loading	Functional e-pathway	2 weeks	IS Implementation
<b>Operationalisation</b>				
	Communication Roll Out	Written articles across all DHB, GP written, e-comms	2 months	Business Implementation Team
	CME and Clinician Peer Group mtgs	All CME, PHO, DHB clinical forums addressed	2 months	Business Implementation Team
	DHB/PHO Governance mtgs	ALL DHB, PHO Governance mtgs addressed	2 months	Business Implementation Team
	IS Cut-Over	Go Live on e-Platform	Milestone	IS Implementation
	Pathway review	Audit Complete	6 month post	Audit

## Impact

### Annualised Reinvestment Potential

Table 1: COPD, TIA and Dyspepsia.

	COPD	TIA	Dyspepsia
Pathway Investment	\$5.7m	\$1.7m	100K
Pathway Savings	\$11.3m	\$4.0m	\$1.8m
<b>Regional Benefit (ROI)</b>	<b>\$5.7m (98%)</b>	<b>\$2.3m (135%)</b>	<b>1.7m (1700%)</b>

## Requirements

The focus of the project in 2011-12 requires implementation of pathways already developed.

At a governance level a revised structure of the steering group is required to facilitate business integration (see Strategy section).

Additionally our User Reference Group has specified the requirements that will enable pathways to be taken up at the clinical interface. The requirement for an electronic platform beyond the current passive hosting on HealthPoint will be developed through integration with the new GAIHN e-Practice work area and existing projects such as e-referrals, Access to Diagnostics, and Shared Care.

The resourcing requirement for 2011-12 is detailed below.

### ARCP Project Resource Plan 2011\_12 Summary

<b>Costs</b>	<b>per pathway</b>	<b>2010_11</b>
Project Management Overhead		420,000
Pathway Development	13,300	66,500
Implementation Planning	26,500	106,000
Operationalisation	22,500	112,500
<b>Total</b>		<b>705,000</b>

### Resource Plan Breakdown (2011-2012) over leaf:



Auckland Regional Clinical Pathways Funding Requirements 2011\_12

Phase	Function Resource	Fte's	Hrs per function	Positions	Hrs per pathway	Cost per hour \$	Cost per function \$	Cost per pathway \$	No of pathways	Total Cost \$
Project Management	Project Management and Reporting	1.5					170,000			420,000
	Clinical Lead	1.2					200,000			
	Project Admin	1.0					50,000			
Development	clinical lead			1	30	150	4,500			66,500
	GP time			3	30	150	4,500			
	Practice RN time			1	10	50	500			
	document writing			1	10	80	800			
	review and test process				20	150	3,000	13,300	5	
Implementation Planning	project management				30	100	3,000			106,000
	funding & planning				20	100	2,000			
	op management (capacity planning)				30	100	3,000			
	business case development				80	100	8,000			
	clinician primary care				10	150	1,500			
	clinician secondary care				10	150	1,500			
	admin support				50	60	3,000			
clinician communications				30	150	4,500	26,500	4		
Operationalisation	project management				30	100	3,000			112,500
	op management (integration mngmt)				30	100	3,000			
	clinician primary care				10	150	1,500			
	clinician secondary care				10	150	1,500			
	admin support				50	60	3,000			
	clinician communications				30	150	4,500			
	economic evaluation				20	150	3,000			
	clinical audit and evaluation				20	150	3,000	22,500	5	
Total									705,000	

Note:

1. IS Integration costing is assumed within the e-Practice project links.
2. Not all costs are new. Existing costs are indicated in colour.

**Risk Assessment**

The risk associated with funding clinical pathways would be that they do not enable timely, best practice, safe, cost effective clinical care. The evidence to date suggests the opposite.

**Summary**

The clinical pathways project will standardise best practice care across the Auckland metro region.

Our strategy is to focus on developing and implementing high demand, high ROI clinical conditions in a clinician led model that integrates primary and secondary working. It is imperative that DHB management are integrated into the implementation process in 2011-12. This will provide the structure for further implementation over the next three years as pathways integrate in the electronic clinical environment.

Early, standardised care will improve quality of care and reduce demand on the secondary system. The pathways chosen for implementation this year could cumulatively save more than \$10 million p.a. in a full year effect. This financial impact is conservative with potential to double that figure.

We require project resourcing that enables a project structure aligned with DHB-PHO business functions including development and implementation teams for each pathway. An investment of \$705k will return in excess of \$10 million net savings.

### Appendix 3d: Optimising Prescribing project investment proposal

Work stream 3 Project d Specialist Advisor	Work stream 3 Project d Project Lead
Paul Roseman	Keith Crump

#### Situation

Targeting pharmaceutical resources in a manner that supports appropriate resource allocation is managed at a national basis by PHARMAC, with support from BPAC but regional interventions within ADHB and CMDHB in collaboration with ProCare and Easthealth have established that prudent use of resources whilst supporting quality and safety in prescribing can be achieved by focused clinical pharmacist interventions.

Key issues supporting this conclusion are that:

- Over the next 20 years the population in the Northern region will grow by around 500,000 which exceeds the current population of any other DHB and will account for two out of every three additional people in New Zealand (NZ).
- Our population is getting older and the burden of chronic diseases is increasing – in diabetes alone we estimate that an additional 40,000 people will be diagnosed with diabetes over the next 10 years, disease screening and medicines management of this population is a wise investment of resource but has significant budgetary implications.

#### Opportunity

Pharmaceutical budgets continue to grow and there remains a significant opportunity to reduce unexplained prescribing variation, improve prescribing quality and to review the value of the investment in medicines in so far as it affects overall quality of healthcare. Closer relationships between prescribers and dispensers will also need to be strengthened as we work towards local health networks and new models of care.

The majority of our health resources are currently being consumed by older patients and those who have a long-term condition. Adherence issues with medicines represent a substantial untapped opportunity to reduce the burden of chronic disease. From a safety perspective there are also clear examples of where optimising prescribing can benefit patients and the health care system., For example currently in ADHB & CMDHB we are focusing on older patients at greater risk of adverse events associated with multiple medicines prescribing (polypharmacy).

#### Strategy

The purpose of this project is to focus on the appropriate use of medicines both in terms of quality and resource allocation using multiple staged interventions such as electronic bulletins, GP and practise nurse education sessions and practise focused prescribing audits.

#### Impact

Changes in prescribing behaviour at a population level and at individual medicines or medicine groupings are analysed to identify potential issues as well as track outcomes.

On Patients - Current prescribing data is accessible by encrypted NHI to a prescriber level and is used to evaluate trends in prescribing behaviour and potential risks that may be associated with individual or combination therapy. Prescribing data will be linked to patients who are most at risk of being re-admitted or admitted to hospital to identify prescribing behaviour that may be linked to reducing admissions or result in increased the risk of readmission.

There is evidence to support the clinical pharmacists are able to provide general practise centric medicines information, audit and prescribing improvement programmes that improve patient outcomes. These programmes are aligned to Chronic Disease Management programmes, clinical pathways and acute demand programmes.

## Requirements

We have developed and implemented a service that includes a prescribing and patient outcome analysis program that has an aligned resource that includes a GP and practise nurse continuing education programme on line bulletins and clinical audits.

## Project Budget

The current project budget for OPP is \$600,000 for 2011 / 2012 with current contractual arrangement with ADHB / CMDHB anticipating the savings in the pharmaceutical budget for this work stream will cover the programme costs. Additional investment of \$300,000 for the 2011 / 2012 year would enable to roll out of the programme to WDHB.

## Risk Assessment

Major risks associated with the project have been identified and mitigated including:

- Access to prescribing and hospital data about patients enrolled with primary care (being managed through GAIHN).



## Appendix 4: Population prevention programmes Investment proposal

Work stream 4 Project a Clinical Lead	Work stream 4 Project Lead
TBD	Nicola Young

### Situation

GAIHN is focusing significant effort on better primary care for targeted individuals through its activities in work streams one and two. However, there will be occasions when it is desirable and pragmatic to communicate en masse with wider target groups to reinforce prevention messages, such as within geographic communities or condition specific groupings for example.

### Opportunity

In order for work stream four to have measurable outcomes it will not only be linked closely with the activities of work stream one and two but also work streams five and six, especially the development and implementation of local health networks and communications and stakeholder engagement. Prevention strategies will be implemented within the families of high risk individuals in order to measure hospitalisations.

### Strategy

Initially, five areas of focus have been identified by GAIHN partners. These include smoking cessation/smoke-free, cellulitis, stroke, falls prevention, and preventable child health medical illnesses.

**Smoking cessation** - This project will include training of health professionals and lay people in smoking cessation using the ABC process (Ask, Brief intervention, Cessation assistance through medication and counselling). Existing smoking cessation community based initiatives will be supported and integrated – smoking cessation and smoke-free champions. Localities will be utilised to ensure spread of champions and messages. Practise will be supported using existing Smoking Cessation Tool Kits already developed. This covers cessation, health education, community links and public policy.

**Cellulitis** - Existing prevention programmes will be examined and linked to primary health care. Patients and their families admitted with cellulitis will be targeted. The Cellulitis Clinical Pathway will be promoted and implemented across practices.

**Falls Prevention** - GAIHN will work with ACC on falls prevention for older people in order to decrease hospitalisations related to falls.

**Stroke Prevention** - Existing community based initiatives will be focused on stroke prevention eg Healthy Village Action Zone for Pacific people and marae based initiatives for Maori.

**Child Health** - The four most significant preventative medical presentations to emergency departments are: asthma, cellulitis, bronchiolitis and gastroenteritis. The clinical pathways for these four conditions have practical assessment and management tools. These will be promoted alongside an education programme for practice teams. This will contribute to early intervention of these conditions to avoid emergency presentations and hospitalisations.

### Impact

**On patients** - The above programmes will provide complimentary support and reinforced messaging for targeted groups. Population prevention programmes, when utilised in conjunction with the individualised targeted interventions will provide a more powerful combination than either would achieve in isolation. The overall impact should be an increase in practice team's capability to manage early presentations of preventable illnesses as well as increased community awareness of the same.

**On System** - The use of targeted prevention messaging in association with individual care programmes should provide a greater focus for the use of limited health promotion resources.

**On costs** - Where possible, it is planned to enhance and refine existing programmes and pathways at limited cost rather than to design new initiatives tailored to the GAIHN programme.

### Requirements

There will be an initial requirement for a 0.5 FTE to undertake a quick assessment of what is already being delivered in the Auckland Region and to develop a scope of work required to be undertaken to support and enhance the GAIHN work streams. To assist with this work, a small project team for each of the five areas of focus will be put together to

asses what is already being delivered and to undertake community and provider engagement. The overall cost to GAIHN for this work stream will then be identified and presented to ALT in December 2011.

**Cost over the next three months**

The estimated cost for the enquiry phase between September and December is \$30,000 to cover Project leadership, clinical release time and community engagement. It is anticipated that a 0.5 FTE will be required to assist this work stream until 30 June 2012 at a cost of \$60,000 (including overheads)

**Risks**

It is difficult to assess the impact of prevention activity unless measures are set in place at the onset. The five areas present a huge scope so this will need to be prioritised and reported in December 2011.



## Appendix 5: Alliance support and development investment proposal

### GAIHN Operations stream

Work stream 5 - Independent Chair	Programme Director
Ray Naden	David Tucker

#### Situation

Each of the GAIHN initiatives has its own project governance structure which is supported through the respective project resourcing streams outlined in this report.

However, in addition to the project-specific funding above, there is also a requirement for overarching programme support and coordination including support to the alliance governance structure. The purpose of this support is to ensure that the programme is well structured, focused, aligned and delivered to time cost and quality.

#### Opportunity

The alliancing methodology offer opportunities to work in new and innovative ways across a broad spectrum of activity. One of the ways that the alliance can align and integrate activity is to utilise in-house expertise to assist with resourcing of its projects and governance. This approach should:

- Reduce the necessity to outsource large amounts of project and governance resource.
- Provide development opportunities for in house staff.
- Minimise the bureaucracy and costs required to secure expertise.
- Foster an inclusive approach amongst alliance partners through sharing expertise and ideas.

#### Strategy

GAIHN's strategy is to achieve its goals through collaborative action based on alliancing methodologies. It values high trust, inclusiveness and responsiveness consensus and action orientation.

The Alliance Leadership team has determined that GAIHN will not build a large organisation of permanent employees. It actively engages as much of the partner resource as is realistically possible given that most people are already busy with business as usual. It will engage external expertise as a back up.

#### Resourcing requirements

With the above strategy in mind, a small operational team of three full time people is proposed. These are:

- Programme Director (already in place)
- Communications and Stakeholder Engagement (already in place)
- Master Scheduler (new function, see following paragraph)

GAIHN achieves its outputs through both the sharing of collective expertise (e.g. advisory groups), as well as through the individual efforts of its project and clinical leads. A significant amount of time can be consumed by project and clinical leads organising and scheduling meetings when all of the players involved are busy people. It is proposed that a centralised scheduling function be made available for use by all of the GAIHN work streams thereby enabling more productive use of time by project personnel.

In addition to the three full time roles above, there are on going costs associated with alliance governance (Chairs of ALT and ACN) clinical leadership, financial management, office overheads, communications and stakeholder engagement and various miscellaneous items identified in the appended budget.

A twelve month operating budget is included in the Appendix. It is recommended that the ALT approves a pro rated operational budget of \$622,000 for the remaining ten months of the financial year in order to ensure continuity of support and stable alliance governance which is essential at this stage of programme development.

**GAIHN Full Year Operating costs 2011/12** (A confidential, detailed break down of operating costs will be available at the meeting)

STAFF		NOTES
Programme Director Comms Project Support Master Scheduler		
<b>Total Salaries &amp; Wages</b>	<b>\$280,000</b>	
Recruitment Costs	\$12,000	
Salary overheads - 15%	\$42,000	ACC, Kiwi Saver, Courses etc
<b>Other Staff Costs</b>	<b>\$54,000</b>	
<b>OUTSOURCED</b>		
Independent Chair		
Chair ACN		
NDSA Finance Support		
Additional admin Support		
Non Project Release time		
<b>Total Outsourced Personnel Costs</b>	<b>\$276,000</b>	
<b>Other Costs</b>		
Mobile Phones	\$5,000	
Travel, local	\$3,000	
Accommodation - IT	\$53,750	5 work stations, all office related costs
Prof Services - consultants	\$50,000	Legal, mentoring, support etc
Summits & Communications	\$24,750	Venue, catering, communications, web site, stakeholder engagement, etc
<b>Total Other Costs</b>	<b>\$136,500</b>	
<b>Total Operating Budget</b>	<b>\$746,500</b>	

## Appendix 6: Systems improvement (provider arrangements) investment proposal

Work stream 6 Project a Clinical Lead	Work stream 6 Project Lead
TBD	David Tucker (interim)

### Situation

GAIHN as an alliance of three DHB's and four PHO's, has a Auckland metro focus. It is an instrument of integration and innovation. It has set itself an ambitious goal that will require sustainable changes in clinician and patient behaviour. Some of the key drivers for change will be through modifications to the incentives and contracting environment and the way information is gathered, shared and utilised for planning reporting and evaluation.

There are three components to this work stream, namely:

- Information for programme development, continuous improvement, evaluation and accountability.
- Programme Indicators
- Redesigned Incentives and Contracting.

### Opportunity

GAIHN is an integrator, innovator and developer. The alliance will share and disseminate best practice and build on the capabilities of its partner organisations and other stake holders to achieve more than they would by acting in isolation. It is recognised that the alliance functions within a wider context and wherever possible, it aims to contribute to systems improvements at the regional and national level.

Achieving changes in the incentives, contracting and information environments is potentially one of the most challenging and yet most rewarding aspects of the GAIHN Programme.

### Strategy

In order to drive change, innovation and system improvement, a small, influential team of opinion leaders will develop change principles during September 2011. These principles will be used as a framework for design and development of proposed changes in incentives and contracting areas.

This process will dovetail with the DHB planning cycle. It is anticipated that the change process commenced here, will be of benefit to other related areas.

The following sections describe in more detail the three areas of activity in this work stream

### Alliance Information Hub

Project Lead: TBD

The way information is gathered reported and utilised for planning, development and evaluation is critical to the success of the programme.

GAIHN has been involved in significant information gathering exercises throughout its evolution to date. Much of this work was undertaken during the early establishment phase in 2010/11. A second round of information gathering was undertaken by the Clinical Alliance Teams (CATS) that were formed to develop DAP bids for the 2011/12 financial year. These teams had an intentionally limited life span and have now been dissolved. The latter was funded by the MOH funding.

The main information needs from this point forward are likely to be generated by project development and system wide requirements. As such, it is recommended that future applied information gathering exercises be managed from an information gathering hub.

The purpose of the hub would be to ensure that information requirements are coordinated and aligned across the alliance as well as with other stakeholder such as the Regional Health Plan teams. Several possibilities are available for the location of this hub and further investigation would be beneficial to recommend the best implementation model. This work will be undertaken between September and November and reported to ALT in December 2011.

Recommended resourcing requirement for the period 1 September to 30 November  
\$10,000, staff time

### Project Indicators

Project Advisor: Paul Roseman. Project Lead: Kylie Ormrod

The design and development of project indicators has been funded by MOH money received in 2010/11. The development phase is nearing completion and GAIHN Programme indicators are now operational. There will be an on going management cost to support this function. It is suggested that this cost be allowed for in the Operational budget and later incorporated into the information hub.

In addition to the overarching GAIHN indicator set, each project will have its own key performance indicators (KPI's) which will need to be integrated to avoid duplication.

Resourcing required \$ 25,000

### **Incentives and Contracting**

Clinical Lead: Ray Naden. Project Lead: David Tucker (interim)

### **Situation**

As mentioned above, GAIHN has set itself an ambitious 3 – 5 year goal. Achievement of the goal will require sustainable changes in clinician and patient behaviour. One of the important drivers of behavioural change will be through modifications to the incentives and contracting environment. These changes include both the creation of positive financial and non financial incentives as well as the removal of perverse incentives that encourage inappropriate and work around behaviour.

### **Opportunity/Strategy**

Achieving changes to the contract and incentive environment is potentially one of the most challenging aspects of the GAIHN Programme. Conversely, it will also be one of the most significant achievements once implemented.

The initial approach during September will be to develop a set of overarching change principles. These will be developed through a two meeting process by a team that includes; Mervyn English, Geraint Martin, Peter Didsbury, Lester Levy, Ray Naden and John Ross.

Once the principles have been agreed, they will provide a framework for a project team to develop new contractual and incentive arrangements in selected areas. These principles will also provide a reference framework for innovative arrangements and other developments within the GAIHN programme.

This process will need to dovetail with the planning cycle of the Auckland metro DHB's, provisionally:

- Draft contract and incentives developed for selected areas by 30 November 2011.
- Final contracts and incentives agreed by 30 March 2012.
- Operational roll out of initial suite of new contracts and incentives commences 1 July 2012.

### **Requirements**

The following cost estimates relate to the period 1/9/11 – 30 /11/11

Independent expert advice:	\$100,000
Clinical release time:	\$15,000
Partner staff time:	\$20,000
Total:	\$135,000

The project costs will be re assessed late November for reporting to the 14 December meeting of the ALT.

### **GAIHN Office contacts**

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www.gaihnhealth.nz



**‘Better primary care  
to reduce acute episodes  
which result in unplanned  
hospital admissions’**



3.2 Primary Care: An Integrated Strategic Approach  
– Mergent Health Care



## **3.2 Primary Care: An Integrated Strategic Approach – Mergent Health Care**

### **Recommendation:**

#### **That the Committee:**

- a) Note that the current and proposed approach to deliver Better, Sooner and more Convenient Primary Care is supported by the sector and will deliver regional consistency.**
- b) Endorse the integrated development approach as being critical in the timely achievement of improved community and public health outcomes**
- c) Endorse the development of a detailed work plan delivered in partnership with the sector.**

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

### **Glossary**

AP	- Annual Plan
BSMC	- Better Sooner More Convenient
CPHAC	- Community and Public Health Advisory Committee
DHB	- District Health Board
IFHC	- Integrated Family Health Centre
IFHN	- Integrated Family Health Network
IHN	- Integrated Health Network
ISG	- Implementation Support Group
MoCRA	- Model of care and revenue agreements
MOH	- Ministry of Health
PHO	- Primary Health Organisation

## **1. Preface**

This paper describes many of the issues facing the primary care sector in the Auckland region and outlines a new direction that should see improved health outcomes for the communities we serve. Over the past two years, there has been significant effort placed on primary care planning. This includes the three Better Sooner More Convenient business cases, with the next challenge being the rollout of these into the community. However, this is not an easy task given the inherent competitive nature of the sector. The key to enabling our primary care strategy is the formation of clinically led but community focused health networks that have access to relevant data.

## **2. Introduction**

### **a) Background**

Auckland and Waitemata DHBs are faced with significant changing demographics, workforce, and disease burden related challenges, resulting in predictions of unaffordable demand on hospital services. For example, recent analysis commissioned by GAIHN has

projected that by 2015 the metro Auckland region will utilise an additional 78,000 hospital bed days. Awareness of such trends is not new; however there is now also a greater sense of urgency in addressing these concerns.

The two DHBs had developed and approved individual Primary Health Care Plans during 2009 in partnership with Primary Care, Community and Iwi stakeholders to deal with such emerging trends. These were widely endorsed, however the implementation of these plans has been limited due to a number of factors:

- Extensive Metro Auckland activity within the three national 'Better Sooner More Convenient' (BSMC) business cases; the Greater Auckland Integrated Health Network (GAIHN), Alliance Health Plus (AH+) and the National Hauora Coalition (NHC)
- Resulting contractual and logistical demands of rapid PHO consolidation within Auckland
- The adoption of a single Primary Care District Annual Plan (DAP) across the metro Auckland DHBs, and more recently
- The merging of Auckland and Waitemata DHB primary care teams.

Many of the common themes, principles, priorities and objectives for primary care development for the next five years were successfully incorporated into the various BSMC business case regional work programmes, or implementation plans, or into the metro Auckland Annual Plan. There has also been significant progress made on Locality Planning, Long Term Conditions Management, Integrated Health Network development and supporting Integrated Family Health Centre (IFHC) development.

#### **b) Regional Consistency**

The degree of connection within the metro Auckland region between the various plans, IFHC developments, locality planning and clinical networks varies across the three BSMC business cases. Over the past two months, a "Metro Auckland" primary care group has been established with the involvement of the three Auckland DHBs and the MoH, as well as the PHOs involved in the Business Cases. Its focus is now on the development and implementation of a single primary care strategy across the region. The framework by which rapidly evolving and diverse change is regulated through planning, clinicians, data and systems under regionally cohesive implementation is **Mergent Health Care** (as illustrated in Appendix 1). This will see effective, accessible and convenient services via integrated and streamlined public services.

#### **c) Competitive Services vs. Patient/Community Centric Networks**

While there are effective and efficient individual business units, centres and services, siloed activity and funding often leads to inadvertent competition both inside and outside of hospitals. This is a significant barrier to the concept of service integration and a sustainable health system starts by acknowledging that regardless of whether care is delivered in a hospital setting or in a community setting, it is the patient's needs and not those of competing providers that should be at the centre. Explicit acknowledgement of this important guiding principal is critical in building trust and facilitating improved partnerships between DHBs and Primary Care.

While there is capacity for planning across the region, there are challenges around the enablers required to deliver sustainable change and increased cooperation. PHOs for example have significantly progressed various network developments, yet the current environment is still hindered by competition, unfortunately often within the same neighbourhood. A single PHO has been suggested by other DHBs, however this is more of a 'band-aid' than the actual solution. What is really needed for region wide improvement is a community centric view informed by the various networks focussing on their unique local populations and contexts.

Such clarity of vision would of necessity include both region wide population mapping intelligence as well as timely understanding and oversight of provider requirements, capabilities and where needed service capacity support and development.

#### **d) Primary Care Facility Development**

Integrated Family Health Centres and Whanau Health Centres are in the process of being established across the region. However, they will initially only service a small percentage of the local population in which they are situated and it is important the whole community has access to their higher level services. Planning around these facility developments needs to be in the context of clinical needs and existing health services. Accident and Medical Centres (A&Ms) provide a valuable service in the community. In the main, these do not currently have clinical governance in the form of DHBs or PHOs. They would also ideally need to be included within the clinical networks.

#### **e) Data as an Enabler of Transformation**

Sharing of data and information within and across the health sector is currently undergoing a significant change. This is a vital enabler of transformation in the health sector. At a national level, prompted by requests from multiple BSMC business cases, the Ministry of Health is reviewing the sharing of data to enable better health planning and importantly to facilitate more efficient and targeted delivery of personal health care.

Locally, this approach is being reflected in the agreement within the BSMC business cases to a set of common indicators to assess the use of hospital emergency departments and unplanned hospital admissions. This shared approach to addressing the unsustainable growth in hospital service utilisation is further augmented by the agreed data specification for sharing of health information about hospital events with primary care in a manner that supports performance monitoring and peer based consideration of unexplained variation in clinical practice as well as enabling new initiatives such as targeting 'high risk' patients for additional health services based on a risk prediction for future hospitalisation.

Primary care has good data that has increasingly shown significant potential to assist groups of clinics, individual practices, and individual clinicians improve their clinical efficacy, however there needs to be more effective use of this data on a regional basis and within the context of rapidly emerging interdisciplinary teams.

#### **f) Aims of the Joint Primary Care Strategy**

Our primary care strategy aims to offer the people of Auckland City a quality primary health care service that achieves wellbeing for everyone and forms part of an integrated total healthcare system. Key functions to deliver this aim include coordinated regional planning, targeted data analysis and effective clinical networks. This simplified approach to integration has broad support from key stakeholders from across the sector.

#### **g) Partnership Model**

It is critical that the Mergent Health Care Framework is further developed in partnership with Primary Care in an agile and responsive manner within a complex and rapidly evolving environment. Given the iterative and interconnected nature of much of the development to date, it must be acknowledged that much of the impetus for change needs to come from within primary care, with the DHBs playing more of a facilitation role.

To date, there has been considerable primary care engagement over this concept, and as the first step, we have achieved significant clinical buy-in across the sector for the development and implementation of integrated clinical networks that use a partnership approach across DHB and primary care. The first network in West Auckland is currently under development.

As the next stage, we plan to partner with Community Care Auckland (CCA) within GAIHN, NHC, and Alliance Health + to develop a set of principles and frameworks that will see consistent and effective implementation of additional networks across both Auckland and Waitemata DHBs.

#### **h) Ministry of Health Statement of Intent**

The recent Ministry of Health (MOH) Statement of Intent calls for a more co-ordinated system with stronger performance management, smarter purchasing, improved prioritisation, and better service and capacity planning.

#### **i) Inter-sectoral approach**

It is important to involve an inter-sectoral approach such as with the Social Sector Forum (Health, Education, Social Development and Justice) which will set and give effect to medium term (3-6 year) strategies for the social sector on Government's priorities where social sector agencies share the need to act. There is also the need to work more closely with Accident Compensation Corporation (ACC) which currently funds 8% of general practice consultations.

### **3. Approach**

#### **Planning**

The planning function sets the strategic direction and occurs at multiple levels in the system from individual localities (locality planning), right through to national level decisions. There is also significant activity across metro Auckland that needs greater alignment so as to ensure the DHBs actually deliver better, sooner, and more convenient healthcare for the populations that they serve. They need to transparently navigate the 'trade-offs' and resource implications associated with intersecting local priorities and wider ranging district, regional and national imperatives.

The Northern Region Health Plan provides a focus on a number of whole of system improvements that are important for all DHBs in the future. The three BSMC business cases, locality planning activity, and a number of Integrated Family Health Centre developments all need to be aligned and coordinated to ensure that the benefits for patients are maximised, duplication is avoided, and that services are integrated and sustainable.

#### **Health Intelligence**

Timely access to quality health information/data is increasingly important in assisting health service providers with a common insight into population health and activity flows at a locality level. For example, locality prioritisation within the planning function will depend on access to sophisticated analytical capabilities (including actuarial) as well as data mining across the continuum of care, across multiple organisations, and across various government agencies so as to provide a genuine whole of system view. The associated benefits are wide ranging and include greater support for improved clinical governance and quality measurement across the Districts.

#### **Health Networks**

##### **a) Integrated Health Networks (IHN)**

IHNs are the clinically led and community focused vehicle for the provision and commissioning of a range of services delivered in the community by networks of clinicians. IHNs will include community based specialists (doctors, nurses, pharmacists, and allied health professionals) and will help facilitate improved patient navigation and service integration between hospital and community care by empowering the primary care workforce. They will facilitate better support and utilisation of our GPs, nurses, pharmacists, allied health

professionals and community based specialists to empower patients and providers to develop practical solutions to the growing demographic demands, increased burden of chronic diseases, and resource limitations that can result in improved service delivery.

The priorities identified in the BSMC business cases will best be addressed in the context of the Integrated Health Network and the form of each network will be determined by its function or goals. Based on international experience, it is likely that:

- It will be clinician-led and owned, supported by an alliance of other stakeholders including DHBs, PHOs and perhaps NGOs. Whether or how they will exist as legal entities in their own right has not been determined.
- It is likely they will have a geographical basis. This is balanced against a patient's right to enrol with a practice outside a geographical community. Details of how this will work need to be determined.
- The networks over time would have a real capitated and risk adjusted budget. They would be both accountable for local health outcomes and able to reinvest surpluses back into services.

There are different levels of integration described by Leutz (1999<sup>1</sup>) ranging from full integration where all resources are pooled in one organisation; coordination of existing organisational units; and linkage via referral to the right service at the right time. It is proposed that IHNs utilise existing integrational leverage across the various clinical networks and that IHNs be built in an iterative manner in the context of a journey and a continuum of service integration. This also allows for the incorporation of the Deming/Shewart 'Plan-Do-Check-Act' (PDCA) quality improvement methodology to ensure responsive changes are improvements, and can be rapidly implemented. Also, rather than limiting integration to disease specific improvements within Health, a whole of person approach with potentially wider economies of scale can be adopted. This will involve working with willing secondary services and may vary across the three proposed networks.

#### **b) Integrated Family Health and Whanau Ora Centres, Integrated Family Health Networks**

IHNs may contain one or more Integrated Family Health Centres (IFHCs) or Whanau Ora Centres (WOCs). They are both a central part of the Government's BSMC policy and function as service delivery hubs that allow access to the expanded suite of integrated services at a more local level. Such integrated services are expected to utilise re-designed pathways that span the traditional primary/secondary care divide. These larger centres will be networked with smaller practices using a hub and spoke model giving rise to an Integrated Family Health Network (IFHN). Critical to their development is greater clarity and explicit agreement regarding the flow of patients, resources, and revenue.

The funding for these centres will be through a Model of Care and Revenue Agreement (MoCRA). The MoCRA will reflect the services and outcomes agreed between the DHB and the IHN, and will form a contractual agreement with the DHB by means of a 'back to back' contract between the DHB and the IHN. Surrounding practices that wish to network with the IFHC will adapt a MoCRA to reflect their utilisation of IFHC services. The MoCRA is a key enabler for transformational change as it allows providers through the network to accept a degree of risk for not achieving agreed targets and for the network to be able to redirect savings into additional services.

The Ministry of Health has provided assistance in the development of IFHN and IFHC/WOC by funding Implementation Support Groups. As IFHNs are rolled out across Waitemata and

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1 Leutz, W. 1999. "Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom." *The Milbank Quarterly* Vol. 77, No. 1: 77-110.

Auckland, the Integrated Primary Care team will build internal capacity to reduce the reliance on external consultants.

#### 4. Risks/Issues

<b>RISKS AND RISK MANAGEMENT</b>			
<b>Risk</b>	<b>Probability</b>	<b>Impact</b>	<b>Risk management strategy</b>
Lack of support by PHOs	Low	Medium	Partner with PHOs and engage directly with Clinicians
Insufficient resources to facilitate process	High	High	Build internal infrastructure based on identified need
Inability to deliver to unrealistic timeframes	Medium	High	Manage expectations and provide clear progress reports
Lack of buy in at a DHB clinician level	Medium	Medium	Develop and implement a clear communication plan
Over saturation of Primary Care plans and policies	Medium	Low	Ensure new planning is built on top of the foundations of existing plans and policies and is an evolution not revolution

#### 5. Linkages/Impact

##### **Annual Plan Priorities**

The key Annual Plan deliverables related to this paper sit under the overarching locality deliverable of

*“A Model of Locality Planning and Funding to be adopted in a minimum of three localities (Maungakiekie-Tamaki, Puketapapa and Whau) by 30 June 2012”.*

Specifically:

1. Engage with the Ministry-funded Consortia to ensure development of the necessary network architecture to support the establishment of Integrated Family Health Centres (IFHCs) that progress the overall approach from July 2011.
2. Local Health Network pilot developed in West Auckland by 30 December 2011.
3. Local health needs assessments and local health improvement plans completed for the three identified localities by 30 June 2012.
4. Learning from the West Auckland Local Health Network pilot informs the development of future networks by 30 June 2012.
5. Connections with other social sector agencies that have a strong influence on health outcomes e.g. Auckland Council and Ministry of Social Development are formalised by 30 December 2011.

#### 6. Costs/Resources/Funding

The Ministry of Health has provided assistance in the development of IFHN and IFHC/WOC by funding Implementation Support Groups (ISGs). Over time, it is envisaged that this capability will be delivered in-house via an integrated resource team that is agnostic to individual organisations, reducing the reliance on external consultants as the IFHN and IFHC/WOC are rolled out across the region. As such, resourcing requirements are likely to need to be increased over time.

## **7. Communications/Marketing**

A communication strategy is currently being developed that is focused on communicating to all stakeholders the changes in delivery of primary care that aligns with those set out under the 'Better Sooner More Convenient' government policy. This will incorporate the communication proposal developed in December 2010 and any associated adjustments of scope and cost assumptions, as well as promoting the new brand 'Mergent Health Care'.

## **8. Implementation**

A more detailed implementation programme plan is currently being developed and will be ready for submission to the CPHAC Boards by November 2011.

## **9. Conclusion**

The next 12 months will see the implementation of the regional health plan, the three business cases, a number of integrated family health centres and a movement in services from a secondary to primary care setting. The proposed mergent health care approach will help facilitate this activity by robust, sustainable integrated clinical networks built upon a partnership approach. This will see the MOH statement of intent outcomes fulfilled and our communities experiencing higher quality services.

What will the patients experience? Higher quality services with less local variations, through an integrated care model that puts the patient in the middle and provides the right care in the right place at the right time.

The challenge is clear, to deliver services within the current funding envelope. However further engagement with clinical leaders across the city will be necessary to ensure this challenge is taken on in a meaningful and sustainable way.

## **10. Reducing Inequalities and Improving Maori Health Gain**

The Public Health and Disability Act 2000 was the first social policy legislation to include reference to the Treaty of Waitangi, and places specific requirements on DHBs consistent with the Treaty. Both the Auckland DHB and Waitemata DHB have made explicit commitments to the Treaty of Waitangi. The Treaty of Waitangi, and specifically the articles of the Treaty, will be used to guide the implementation of the Primary Care Integrated Strategic Approach, as the framework for discussing Māori health priorities for the following reasons:

- First, the importance of a Treaty-based approach to addressing Māori health has been a common feature of feedback from Māori community consultation and both Auckland DHB and Waitemata DHB have made explicit their commitments to the Treaty.
- Second, the purpose of the Treaty, as outlined in the preamble, includes the protection of Maori wellbeing and the notion of equity is central.
- Third, the Māori right to health is derived from three sources – human rights, indigenous rights and Treaty rights as tangata whenua. The Treaty therefore reinforces the Māori right to good health.
- Fourth, the Treaty is a known framework which can be easily understood by the range of Māori health stakeholders.
- Fifth, the Treaty is consistent with Māori models of health in that it takes a broad and holistic approach, seeks to protect Māori custom and therefore cultural integrity and whānau structures, and reinforces Māori control over Māori wellbeing.

Waitemata DHB and Auckland DHB share a common vision to improve health outcomes and reduce health inequalities for Māori through quality prevention, assessment and treatment services for Māori that take a whanau ora approach. This vision is also articulated within the Northern Region Charter mission: “To improve health outcomes and reduce disparities by delivering better, sooner, more convenient services. We will do this in a way that meets future demand whilst living within our means”, and therefore the need to improve health outcomes and reduce disparities has been endorsed by both DHB Boards. It is also derived from the MoH 2010/11 Operational Policy Framework “...improve health outcomes and reduce inequalities”.

It is envisaged that the Primary Care Integrated Strategic Approach will establish local health networks which will facilitate:

- Improving Maori Health and reduce health inequalities
- Working with other Maori organisations to develop a regional approach to primary care delivery for Maori
- Fostering ‘by Maori for Maori’ delivery
- Providing a Kaupapa Maori approach to primary care
- Making Maori models of care available (including Whanau Ora)
- Supporting Maori and community development
- Ensuring non-Maori services are developed in partnership with Maori
- Developing Maori workforce and leadership
- Development of Whanau ora centres and a local network pilot developed in West Auckland

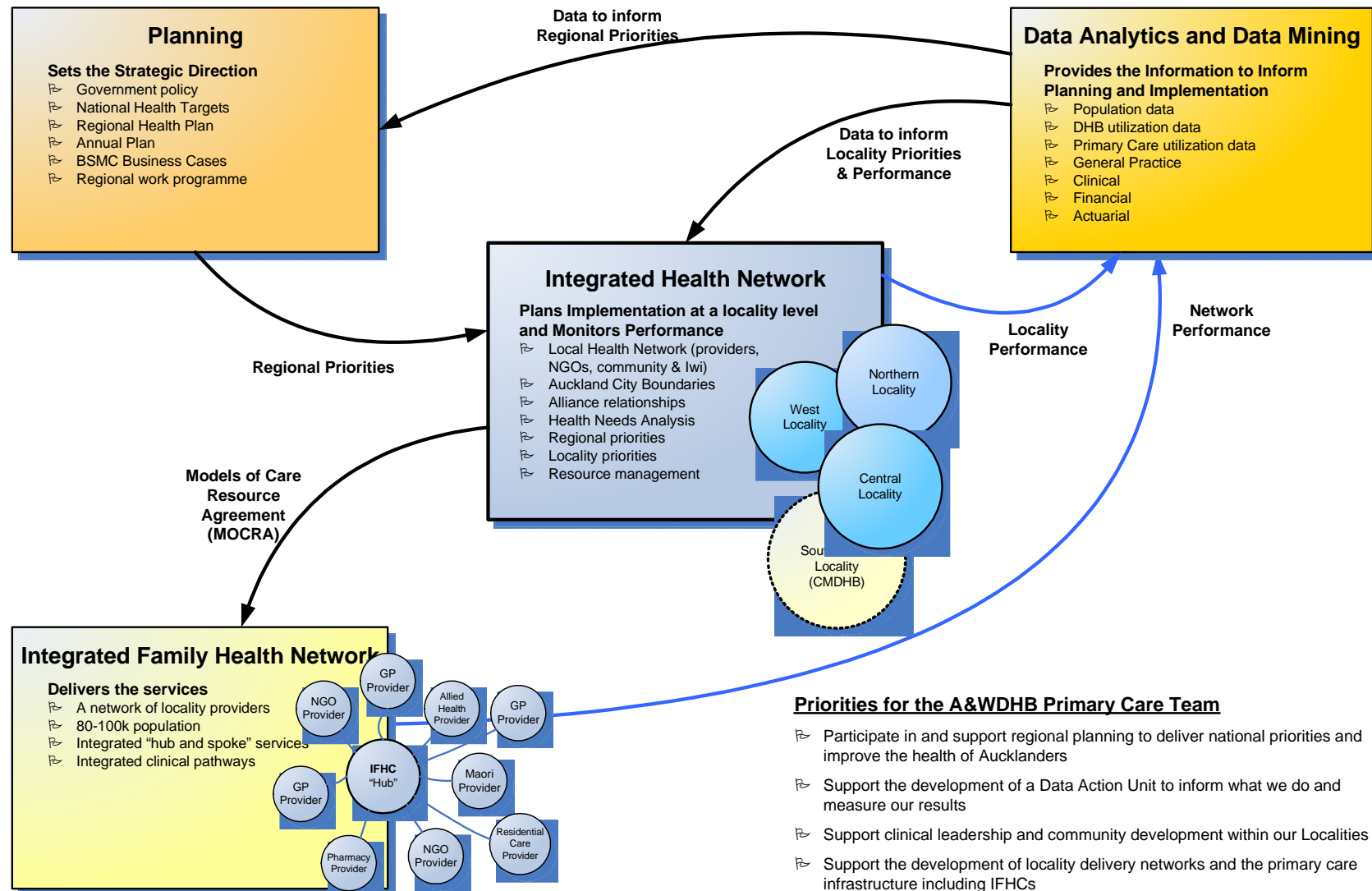
## 11. Next Steps

The Auckland and Waitemata DHB Planning and Funding team will hold a Workshop in the next month where the Outputs will include:

- Configuration of the role of implementation support groups (ISGs)
- Identify learnings from existing IFHC and clinical networks in place or in development
- Carry out a stock take of current facilities, potential IFHCs and current MoH priority sites
- Develop a Network Planning Template which is process orientated and would include how to identify resourcing, populations’ services and handover timelines as well as functions, roles and responsibilities of the Networks
- Create and implement a phased plan to develop the linkages with DHBs and the primary sector /PHOs/ Business cases
- Development of a 12 month work plan including specific resource requirement that will be signed off by the Board
- Create a generic set of potential IFHC services across all areas
- Develop an application and approval process for future IFHCs
- Create a DHB internal Steering group to support the development of local health networks and establishment of IFHCs
- Identify capacity and capability requirements
- Explore opportunities for joint appointments
- Provide CHPAC with a detailed programme update at the November meeting.

**APPENDIX 1:  
Primary Health Care Strategic Framework: ‘Mergent Health Care’**

**Auckland & Waitemata DHBs – Primary Health Care Strategic Framework**





### 3.3 "Auckland Council - Draft Auckland Plan and Potential Future Relationships



### **3.3 Auckland Council - Draft Auckland Plan and Potential Future Relationships**

#### **Recommendations**

- a) **That the information be received.**
- b) **That the Committee endorse the preparation of a joint submission to the Draft Auckland Plan on behalf of Auckland DHB, Counties Manukau DHB, NDSA and Waitemata DHB.**
- c) **That the Committee provide advice on how the proposed joint submission should be signed off on behalf of the participants.**

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Prepared by: Denis Jury (Chief Planning and Funding Officer, Auckland DHB), Julie Helean (Manager Planning and Service Development, Auckland DHB), Janine Pratt (Group Planning Manager, Waitemata DHB), Doone Winnard (Public Health Physician, Counties Manukau DHB), Frank Booth and Andy Roche (Auckland Regional Public Health Service)

#### **Glossary**

- ARPHS – Auckland Regional Public Health Service  
CPHAC – Community and Public Health Advisory Committees  
DHB – District Health Board  
NDSA – Northern Region DHB Support Agency

#### **1. Executive Summary**

Auckland Council is required to prepare a spatial plan for Auckland. Earlier in the year it published the Auckland Unleashed – The Auckland Plan Discussion Document (the Discussion Document). Auckland Regional Public Health Service (ARPHS) led a joint DHB response to the Discussion Document which it is understood has provided valuable input to the Council.

This paper provides an update on how the metropolitan DHBs and ARPHS are responding to the opportunities provided by Auckland Council's preparation of the Auckland Plan.

A small Working Group has been established comprising representatives of Auckland DHB, ARPHS, Counties Manukau DHB, NDSA and Waitemata DHB to consider how the local health sector could work with the Auckland Council to maximise health outcomes, via our participation in the development and implementation of the inaugural Auckland Plan.

The Working Group has now met four times. The Working Group has defined its initial role as being to lead, in the short term, health improvement by:

- Developing clarity for the objectives sought by health from closer engagement with Council.
- Understanding what engagement the DHBs / ARPHS currently have with Council
- Identifying what future engagement is desirable to deliver on the objectives sought
- Managing short term issues such as health's response to the Draft Auckland Plan (September / October) and requests from Council for assistance / collaboration / participation.
- Preparing the 'think piece' sought for the Regional Governance Group.

The Committee's guidance is sought on how it wishes to oversee and approve the proposed joint submission to the Draft Auckland Plan.

## **2. Introduction/Background**

### **2.1 Auckland Plan Status**

The Auckland Plan is not just a Council Plan. While the Plan is prepared and adopted by Council (Sections 79 and 80 Local Government (Auckland Council) Act 2010), the Auckland Plan is a plan for all sectors, including health, in so far as it:

- Sets a strategic direction for Auckland that integrates social, economic, environmental and cultural well-beings.
- Enables coherent and coordinated decision making by Auckland Council and other parties (including health) to determine the future location and timing of critical infrastructure, services and investment.

In the Auckland Plan's preparation Council:

- Must involve central government, infrastructure providers throughout the preparation and development of the plan.
- Endeavour to secure and maintain the support and cooperation of central government, infrastructure providers in the implementation of the plan.

### **2.2 Relevance to Health Sector**

The Northern Region Health Plan has been developed by the four regional DHBs in response to Government requirements and to respond to the collective, predicted challenges, e.g. changes to population numbers, demographic profile, and prevalence of non-communicable diseases.

Council's Inaugural Auckland Plan will influence the success (or otherwise) of the Northern Region Health Plan as follows:

- As a geographic spatial plan it will influence the demand for, and preferred locations of, health sector services and facilities.
- The wider interpretation of spatial planning that Council has chosen to use will mean that the Inaugural Auckland Plan will influence the wider socio-economic determinants of health and other issues such as how attractive the region is to an increasingly mobile and scarce health workforce.

Figure 1 illustrates some of the influences on health that the issue of housing (alone) will have.



- An alternative arrangement could be that the Boards or CPHAC could authorise their respective Chairs to jointly approve a submission.
- Progressing the engagement of the regional asset planning team with Council’s spatial and infrastructure planning team.
  - NDSA will lead this engagement on behalf of the DHBs.

### **Medium and Longer Term**

A range of actions are possible in the medium and longer term. Some of these actions the sector is already undertaking. Refinements to current practices are expected and in some areas new activities are being considered. Possible areas for health sector interaction with Council, which will be enlarged on in a future paper, have been identified as:

- **Determinants of Health**
  - Housing
  - Transport
  - Education
  - Economic Development
  - Risk factor exposure (e.g. smokefree environments, alcohol bylaws)
- **Health Service Delivery**
  - NGO service delivery
  - Primary, Secondary & Tertiary service delivery and locality planning
  - Whānau Ora approaches
- **Design and Planning of Services**
  - Location (and associated transportation issues)
  - Capital development
  - Asset planning (underway)
  - Carbon footprint / sustainability
- **Monitoring the well-being of Aucklanders**
  - work with Council to establish monitoring framework for the Auckland Plan which includes determinants of health
  - coordinate health data to inform Auckland Council planning
- **Health’s Economic Contribution**
  - Employment
  - DHB Investment – capital
  - DHB Investment – operational e.g. telecoms expenditure
  - Businesses involved in the health value chain (providing multiplier benefits from DHB expenditure)
  - Economic and business opportunities resulting from health innovation

## **4. Next Steps**

The Working Group’s intended next steps are to:

1. Lead the short term response to the Draft Auckland Plan.
2. Respond to other short term ad hoc issues.
3. Better understand current inter-actions with Council.
4. Better scope possible future inter-actions with Council.

5. Assess the possible future inter-actions to understand those that will deliver the maximum benefits for the resources invested.
6. Prepare the 'think piece' on the Auckland Plan (and the opportunity and risks it provides) sought for the Regional Governance Group.

## 5. Financial Implications

Influencing the Auckland Plan and building an on going close relationship provides the opportunity to leverage a huge health dividend from the resources that are applied. Specifically it can be expected to:

- Reduce health inequalities through action to address the social determinants of health as foreshadowed in the Discussion Document.
- Increase the value of health service facility investments by allowing better locality planning. Better transport connections to facilities should also impact on levels of DNAs allowing better utilisation of resources.

Better and closer relationships with Auckland Council can be expected to contribute to the future sustainability of the health sector by helping close the predicted gap between service demand and affordable service supply.

There is a short term cost to the Working Group's activities. This short term cost is being covered out of current budgets.

It is expected at this stage that some longer term redirection of resources will be required to maximise the value of the sector's engagement with the Auckland Plan and Auckland Council. This should include more consistent strategic engagement. A planning framework based on the Healthy Cities approach may be of use to support this approach. The optimum level of future DHB commitment and need for dedicated resources is unknown at this stage; however the opportunity cost of not engaging to a greater level has the potential to be considerably greater.

## 6. Conclusion

The Inaugural Auckland Plan is not just a Council plan. The Auckland Plan will be a plan for all sectors, including health, and will shape the future of the Auckland region for the next 30 years.

For health the Auckland Plan will complement the Northern Region Health Plan and directly influence the demand for, and preferred location of health sector facilities and services.

The 'think piece' that the working group will prepare will start to provide clarity around the potential opportunities, costs and risks that differing responses to the medium and longer term opportunities that the implementation of the Auckland Plan will bring.

The 'think piece', although still a high level document, will provide a basis from which the DHBs can start to make informed and robust decisions around the level of engagement and resources that need to be invested to reap the full benefits from the Auckland Plan for health.



ITEMS FOR INFORMATION



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## 4.1 Immunisation

### Recommendation:

**That the report be received.**

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Prepared by: Stacey Strang (Programme Manager Child and Maternity, Waitemata DHB), Tim Jelleyman (Paediatrician, Waitemata DHB), Ann Davis (Immunisation Project Manager, Waitemata DHB), Dr Peter Sandiford (Public Health Physician, Waitemata DHB)

Peer reviewed by: Carol Stott (Planning and Funding Manager, Auckland DHB) and Ruth Bijl (Associate Planning and Funding Manager, Auckland DHB)

### Glossary

IMAC - Immunisation Advisory Centre

MMR - Measles, Mumps and Rubella

## 1. Introduction

This report provides a response to questions raised by the Waitemata Board on:

1. the report of the Health Committee, [“Inquiry into how to improve completion rates of childhood immunisation, and Briefings from the Chief Coroner on the coronial process, from Dr Michael Tatley on the adverse reaction process, and from Professor Sir Peter Gluckman on how to improve completion rates of childhood immunisation”](#),<sup>1</sup>
2. the Measles, Mumps and Rubella (MMR) vaccine
3. the Immunisation Advisory Centre (IMAC).

Email correspondence was received by a Board member raising the following issues:

- a) that the Board be aware of the recommendations in the Health Select Committee report ‘given our role in protecting and promoting the health of our communities, including cultural aspects’;
- b) concern around the Report recommendations that linked education enrolment with proof of immunisation status;
- c) concern that there may be discrimination against specific groups who decide against specific vaccination due to beliefs, and with particular reference to the use of foetal cell lines in the production of the MMR vaccine; and,
- d) a research paper was cited that correlated increased numbers of vaccinations in the first year of life with infant mortality.

In preparing this paper we have taken advice from the Ministry of Health, Medsafe and IMAC.

A number of these questions have been addressed in the government response which this paper discusses.

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<sup>1</sup> [http://www.parliament.nz/NR/rdonlyres/BADCF722-D377-4451-8602-1E00938BFC74/188894/DBSCH\\_SCR\\_5060\\_Inquiryintohowtoimprovecompletionra.pdf](http://www.parliament.nz/NR/rdonlyres/BADCF722-D377-4451-8602-1E00938BFC74/188894/DBSCH_SCR_5060_Inquiryintohowtoimprovecompletionra.pdf)

## 2. Discussion

Immunisation has been demonstrated to provide an evidence-based manner of preventing many infectious diseases. These diseases in the past have caused significant levels of morbidity and mortality, a risk that remains if these diseases became endemic again.

### 2.1 Health Select Committee report

The report of the Health Committee, "[Inquiry into how to improve completion rates of childhood immunisation, and Briefings from the Chief Coroner on the coronial process, from Dr Michael Tatley on the adverse reaction process, and from Professor Sir Peter Gluckman on how to improve completion rates of childhood immunisation](#)",<sup>2</sup> (the Report) was released in March 2011. The terms of reference outlined the purpose of the inquiry:

- To collate current statistics for New Zealand children on timeliness of delivery and completion of immunisation and how we compare internationally.
- To assess how well the New Zealand Immunisation Register is working, and the effectiveness of utilisation.
- To search relevant world literature for optimal methods of how to achieve timely and high immunisation completion rates.
- To seek up-to-date information on community concerns, informed consent, and conscientious objection issues.
- To seek an analysis of benefits and disadvantages.
- To define and make recommendations as to what methods could be applied at minimal cost to improve immunisation coverage in New Zealand (bearing in mind the first 60 percent are relatively easy to secure, the next 20-30 percent require more effort, the next five percent lots of effort, and around five percent are declines).

The Health Committee report sets out 30 recommendations to continue progressing towards high coverage and timeliness for vaccinations and to achieve community protection against the specific diseases covered by the current National Immunisation Schedule.

The Government responded to the report on June 22<sup>nd</sup>. Each recommendation in the Report received a specific response from the Ministry of Health and/or the Government in the "Government Response to Report of the Health Committee" on June 22<sup>nd</sup> 2011 (the [Response](#))<sup>3</sup>.

### 2.2 Targets

The health target for 'Children fully immunised at two years age' has already been increased by the Ministry of Health to 95%, to be achieved by June 2012. In 2010/11 Waitemata District Health Board achieved 92% coverage and is working towards the 95% target for this year.

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<sup>2</sup> [http://www.parliament.nz/NR/rdonlyres/BADCF722-D377-4451-8602-1E00938BFC74/188894/DBSCH\\_SCR\\_5060\\_Inquiryintohowtoimprovecompletionra.pdf](http://www.parliament.nz/NR/rdonlyres/BADCF722-D377-4451-8602-1E00938BFC74/188894/DBSCH_SCR_5060_Inquiryintohowtoimprovecompletionra.pdf)

<sup>3</sup> [http://www.parliament.nz/NR/rdonlyres/9DC36C22-72E9-4CAD-B93D-35C422345DC5/194348/DBHOH\\_PAP\\_21651\\_GovernmentResponsetoReportoftheHea.pdf](http://www.parliament.nz/NR/rdonlyres/9DC36C22-72E9-4CAD-B93D-35C422345DC5/194348/DBHOH_PAP_21651_GovernmentResponsetoReportoftheHea.pdf)

The recommendations from the Report suggested raising the bar further in terms of timeliness, with targets set for 95% of children immunised at 6 months and 4 years, and also an age appropriate target to be established for 11yrs. The Government Response to this recommendation acknowledged the importance of timeliness of vaccination and re-stated the current health target. The Government Response also noted that once the health target had been achieved focus would be given to improving coverage and timeliness. The Ministry of Health Response also noted “that targets are important to help reduce vaccine preventable diseases, but they should not be at the expense of an individual’s, parent’s and guardian’s right to make an informed choice”.

### **2.3 Informed Choice**

A number of health programmes including immunisation programmes create tensions between individual choice and population benefit. The decision to not immunise has implications for other individuals. This includes babies, infants and children who are too young to be fully immunised, those for whom vaccination is contraindicated and for other vulnerable people. People who can not be vaccinated may include children with cancer or those taking immune suppressing medications including adults who have received a donor organ.

The right to informed choice is now a well respected part of the New Zealand health care ethos. The medical fraternity are required to communicate effectively with their patients about the risks and benefits of any intervention, including immunisation based on current evidence. If a child and their family/whanau make the choice to not immunise, this choice is respected. However, it is important that these individuals can be identified so that they can be protected from disease by other approaches such as staying home from school during a disease outbreak and also so that they do not put other individuals’ health at risk by sustaining or increasing transmission during infectious disease outbreaks.

A number of the recommendations in the Report relate to immunisation information and making this available and accessible to the various audiences including parents and guardians, and clinical providers. The Government responses identify where this is already being addressed such as the recent publication of the Immunisation Handbook 2011<sup>4</sup> and further information development of the Ministry of Health website. The need to progress this work is acknowledged. The work also involves the ongoing training of involved clinicians.

### **2.4 Education requirements**

The Report recommended that the Government “strengthened the requirements of parents to present immunisation information when their children enrol at early childhood centres or schools” (Recommendation 18). The Response advised that the Ministry of Health would explore this issue further with the Ministry of Education and other relevant departments. Under the Health (Immunisation) Regulations 1995 immunisation providers are required to complete an immunisation certificate for children at 15 months and 4 years.

Parents/caregivers are required to provide informed consent at each vaccination episode and are able to elect not to have all vaccinations on the immunisation schedule. The immunisation certificate has the options of a child being fully immunised, not fully immunised or identifies the diseases that a child has been immunised against.

Early childhood education and care centres and primary schools under current legislation must request the child’s immunisation certificate at or soon after enrolment. The degree

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<sup>4</sup> Ministry of Health. 2011. *Immunisation Handbook 2011*. Wellington: Ministry of Health.

to which this process is followed is unknown. These registers in schools are used by Medical Officers of Health in specific outbreaks to effectively quarantine children with disease and pre-emptively protect those who have not been immunised (or whose status is unknown). These registers were used during the recent measles outbreak and allowed children who required quarantine to be quickly identified. One of the local strategies to increase immunisation has been to raise the profile of these certificates that exist in the Well Child/Tamariki Ora record books, held by parents and guardians.

The Response noted the need to weigh costs of strengthening requirements on parents against the benefits of the expected increase in immunisation rates. Such analysis waits to be done.

In summary the Response stated the “Government supports the Health Committee’s report, and emphasises that it generally reflects current priorities within the Ministry of Health work programme.”

## **2.5 Production of vaccines**

Viruses require cells in order to grow and multiply. To grow viruses for use in vaccines a cell line from that virus is required. Vaccine manufacturers have few options for viral culture because a) viruses can be very selective in what they will grow in and b) the cell line must be free of contamination. The cell line is used to grow the virus but is not generally part of the vaccine formulation. Foetal cells are sterile and essentially immortal and therefore can be used in vaccines for many many years.

Cell lines from two elective abortions from the 1960s are used to make vaccines against the viruses rubella, rabies, chickenpox and hepatitis A. The context for use of these specific cell lines is summarised on the *National Network for Immunisation* website (US).<sup>5</sup> Notably Rubella, prevented by vaccination, is a disease that itself causes spontaneous abortion and congenital abnormality.

## **2.6 Human and Experimental Toxicology paper**

The paper ‘Infant mortality rates regressed against number of vaccine doses routinely given: Is there a biochemical or synergistic toxicity?’ (Miller & Goldman, 2011)<sup>6</sup> uses an ecological design<sup>7</sup> to correlate infant mortality rates with number of vaccines in the schedule for a set of 34 nations. Ecological studies are notoriously unreliable and the term ‘ecological fallacy’ has been given to incorrect inferences drawn from ecological studies. An example of this is a study of people with glasses showing the group has an above average intelligence and then drawing the conclusion an individual wearing glasses must be intelligent.

The authors demonstrate a correlation at population level but not at individual level. In assessing the relevance of this research it is important to appreciate that ‘correlations’ may demonstrate ‘association’ but not causation. The demonstration of causation requires a set of other supportive evidence elements, elsewhere referred to as ‘Hills criteria’<sup>8</sup>

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<sup>5</sup> <http://www.immunizationinfo.org/issues/vaccine-components/human-fetal-links-some-vaccines>

<sup>6</sup> Miller, N. Z. and G. S. Goldman (2011). "Infant mortality rates regressed against number of vaccine doses routinely given: Is there a biochemical or synergistic toxicity?" *Hum Exp Toxicol*.

<sup>7</sup> An ecological design study correlates factors in whole populations, not in individuals.

<sup>8</sup> Hill, A.B. (1965) “The Environment and Disease” Association or Causation?” *Proc R Soc Med* 58:295-300.

There are a number of other potential biases in the paper which make it difficult to draw any conclusions. For example, potential confounding factors such as the type of health system that might affect both the number of doses of vaccine applied, and the infant mortality rate have not been controlled for. Thus, countries with a publicly funded health system may be less inclined to fund vaccines such as chickenpox, but due to a more equitable health system, succeed in achieving a lower infant mortality rate. The decision to only include countries with a lower infant mortality rate than the United States has probably introduced a significant selection bias. Given that it is known that the USA has a relatively high number of vaccine doses compared with other countries, by failing to include countries with a higher infant mortality than the United States (and quite likely lower numbers of immunisation doses), the study has increased the chance of finding a significant but spurious correlation.

There is also the potential for 'reverse causality'. It is plausible that countries with higher infant mortality rates administer more doses of vaccine because they have more diseases that they need to control. Thus higher mortality rates from diarrhoea and meningitis may cause countries to add rotavirus and meningococcal vaccines to their schedules.

There are other methodological issues with the paper that may or may not be significant. No weighting was applied to countries to reflect the degree of precision in infant mortality rate estimates that larger populations produce. Rather, it was decided to exclude four small countries and weight all the remainder equally. The number of vaccines in the schedule is not the same entity as coverage of the population. Injury and other such probably unrelated causes of death were not excluded from the infant mortality rate estimates.

The paper does offer a guarded conclusion with the recommendation that a closer inspection is warranted. Conclusions beyond this should not be drawn.

## **2.7 Immunisation Advisory Centre (IMAC)**

The Immunisation Advisory Centre (IMAC) is an organisation within The University of Auckland. Almost all of their funding comes from a contract held between the Ministry of Health and Auckland UniServices. Auckland UniServices is owned by The University of Auckland and manages research contracts held by the University.

As IMAC are part of The University of Auckland, their primary principle is that all their communication and information is based upon medically and academically sound, evidence-based material. They continually review medical research literature pertaining to immunisation and ensure that their advice and resources reflect the current understanding of the issues.

Their academic base reflects the requirement for all their communications and resources to be based upon current research. There is no requirement to make a particular stance regarding immunisation.

IMAC accept small amounts of additional funding for specific projects, often this funding comes from pharmaceutical companies. Their sponsorship policy outlines how they maintain an appropriate relationship with companies in these arrangements. Central to this is the fact that no funding is dependent upon influence in the creation or communication of IMAC resources, communications or products. One example of this is the fact they do not accept pharmaceutical funding for any resources or communications associated with parents and caregivers. They do accept sponsorship for certain research projects and their biannual immunisation conference.

### **3. Conclusion**

Informed choice is an important aspect of good health care practice. Children and parents/whanau should expect to receive evidence based information about the risks and benefits of any medical intervention. Where a family has serious concerns and don't wish to immunise, steps other than vaccination need to be taken to help protect them. This includes health education and potentially quarantine in the event of an outbreak.

STANDARD MONTHLY REPORTS



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## 5.1 Planning and Funding Update

### Recommendation:

**That the report be received.**

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Prepared by: Denis Jury (Chief Planning and Funding Officer, Auckland DHB), Debbie Holdsworth (Acting Chief Planning and Funding Officer, Waitemata DHB), Julie Helean (Manager Planning and Service Development, Auckland DHB), Janine Pratt (Group Planning Manager, Waitemata DHB)

### Glossary

ALT	- Alliance Leadership Team
BSMC	- Better Sooner More Convenient Primary Health Care
COPD	- Chronic Obstructive Pulmonary Disease
DHB	- District Health Board
DVT	- Deep Vein Thrombosis
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
TIA	- Transient Ischaemic Attack

## 1. Summary

This report updates the Committees on Auckland DHB and Waitemata DHB's Planning and Funding activity for the month of August.

## 2. Summary of activities in common

### 2.1 Planning

Planning for the 2012-13 year at Auckland DHB begins in September with a series of workshops with the newly formed Healthcare Service Groups. The leaders of these groups will begin to scope out activity over the longer term and develop Health Improvement Plans specific to their area of activity. This strategic work sets the scene for developing objectives for the 2012/13 Annual Plan.

Similar activity is underway at Waitemata DHB with the draft timetable prepared and a taskforce forming to provide guidance to the organisation in developing the budgets and non-financial plans which contribute to the Annual Plan.

The development of the next Auckland DHB and Waitemata DHB Annual Plans will be done, as in past years, with close collaboration with other DHBs in the region and will advance the goals of the Northern Region Health Plan.

DHBs planners are working with the Auckland Regional Public Health Service to recommend an approach that helps Health work with Auckland Council in a more proactive way. This work is explained in a separate paper.

DHB planners have also been invited to be part of the national 2012/13 Sector Reference Group to develop the Ministry of Health planning guidance for 2012/13. The northern region has contributed to this group each year and found there to be significant benefit in being part of this process when developing the accountability documents.

## **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*

There are no more planned PHO mergers that the DHBs are aware of. North Waikato PHO, which operates in CMDHB, is still expected to join the National Hauora Coalition but it is not submitting its register as expected for quarter three. Discussions are continuing.

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

#### *Access to Diagnostics*

The implementation to CMDHB is progressing well. The Clinical Triage Criteria was endorsed by Regional Radiology at their August meeting and the Clinical Governance Group is finalising some minor changes before the final version is ready for programming into ProExtra. A proposal was made to GAIHN Alliance Leadership Team on 24 August requesting an investment of \$25,000 to cover unbudgeted programming costs in updating ProExtra, which was agreed in principle by GAIHN Alliance Leadership Team.

#### *Minor Skin Surgery – Skin Lesions*

To date, 22 patient satisfaction surveys have been returned and feedback is extremely positive. A total of 118 GP opinions surveys were returned and overall the feedback was very positive. A final report is being developed and will be circulated to the Reference Group for review. A review of the current price paid to contract GPs under the Regional Minor Skin Surgery scheme was undertaken in July and August. A final report is being developed and will be circulated to the Reference Group for review.

#### *Clinical Pathways*

A Project Plan and Resourcing Plan for development and implementation of pathways have been presented to ACN and Alliance Leadership Team. Signed off by GAIHN Alliance Leadership Team at their August 23 meeting. Operational implementation teams for TIA, COPD and DVT are now meeting.

#### *Acute Demand / Primary Options for Acute Care*

Reporting for period ending August 2011 (NB: referral numbers are at this date incomplete due to the reporting prior to the month end). Preliminary figures for August 2011 show a total of 1433 referrals, YTD 3053 referrals. 88% of all referrals were managed without admission in primary care.

### *After Hours*

The final After Hours proposal was agreed with the PHO/Accident and Emergency Alliance during August, with implementation from 5 September 2011. This proposal was endorsed by DHB Boards in late August.

### **2.2.2 Summary of Annual Plan Targets**

Initiative		Auckland Metro Volumes		Auckland Metro target to end June 2012
		Month (August)	Year to date	
Acute Demand / POAC		1,433	3,053*	The 2011/12 contract and volumes have not been formally confirmed. Contract negotiations are to be finalised for 1st October 2011
Access to Diagnostics	<b>Annual Plan Target 1</b> The rate of referrals that do not meet the clinical triage criteria	19.5% Note: July figures are provided	19.5%	20%
	<b>Annual Plan Target 2</b> 10% increase in the volume of DHB Funded, GP requested diagnostic radiology procedures performed in the community.	1200 Note: July figures are provided	1,200	10,394

### ***Regional Health Targets***

Indicative 2011/2012 Metro-Auckland Targets:

Health Target	Target	Achieved
Immunisations	95%	91%
Diabetes Get Checked	60%	62%
Diabetes Management	73%	66%
CVD Risk Assessment*	90%	80%

\*=Estimated from Quarter Three 2010/11 MoH data.

### **2.2.4 Business Case Update**

#### *Greater Auckland Integrated Network (GAIHN)*

Project Investment proposals for six work streams have been adopted by GAIHN's Alliance Leadership Team. Initial funding of \$2,212,250 has been endorsed in support of programme development and implementation. Funding approvals will be sought at the end of the first quarter through the combined ADHB & WDHB's September CPHAC meeting. Please refer to separate

paper. Any funding request will need to go through Waitemata DHB's Audit and Finance Committee.

Approximately 80% of project and clinical leads are in place for the work streams. They are made up of a mix of secondments and contractors. The remainder will be put in place following the approval of funding by partner organisations.

Work is underway on the implementation phase of the six work streams. Approximately 180 people across metro Auckland are involved in aspects of the programme.

Alliance Agreement & PHO Variation final wording agreed and adopted by three of four PHO partner organisations. Waitemata PHO is still considering their options around signing.

*National Hauora Coalition (NHC)* (Note: This section pertains to ADHB and CMDHB only) Fortnightly meetings between the National Hauora Coalition, CMDHB and ADHB have now transitioned to monthly as the bulk of the work and issues have been resolved (which were around the merging of the PHOs). North Waikato PHO has still not joined the National Hauora Coalition for Quarter three as expected, however discussions are still ongoing.

The Alliance Agreement is moving through the DHB partners (signed by CMDHB and Waikato DHB so far) for sign off. It has been recommended that the draft paper be used for any board discussions so the document is not held up. It will be sent to the National Hauora Coalition once all DHBs have signed. The PHO Better, Sooner, More Convenient Variation has not been received back from Sector Services as yet.

A meeting occurred at the end of July between all five DHBs and the National Hauora Coalition. The DHBs have agreed to try and source baseline data to inform targets for their implementations plans. The National Hauora Coalition and the PHO Performance Programme (PPP) are in discussions on how locality-set targets can inform the National PHO targets. There was also discussion about the creation of Support Alliance Leadership Teams (SALTs) to progress the collection of data, setting of targets and PPP discussion to support the NHC. It is envisioned that a number of these groups will be set up using expertise from the DHBs around specific targets.

It has been agreed that some rationalisation/integration of existing contracts is required before any transfers to NHC. For example in Taranaki, it is expected that fourteen contracts will be merged into three whanau ora contracts. NHC will work with members and local DHBs in other areas to agree which contracts will be transferred on 1 January with the remaining transferred by 30 June 2012.

*Alliance Health + (AH+)* (Note: This section pertains to ADHB and CMDHB only)

A process for recruiting a new Clinical Director by mid September is underway. Alliance Health + has secured clinical secondment capacity (public health physician) from CMDHB to support its clinical leadership. Alliance Health + have decided to reconcile both BSMC and Whanau Ora strategies / activities.

Alliance Health + has recently established an outcomes framework blueprint that will include the following performance measures:

- Clinical Indicators
- Whanau Indicators
- Providers Indicators

## **2.3 Public Health Activities**

### *CDC – measles, TB and meningitis*

During August, notifications of measles have continued. These have been spread across the region and some cases with unknown links. There are large numbers of case contacts notified each day that require considerable follow up.

Many cases have also involved institutional intervention (schools and early child care centres) requiring considerable public health input.

There have been notifications of Meningococcal disease, which are in keeping with what would be expected for this time of year. There has been one death from these notifications in the Auckland region.

A large contact trace is taking place in a West Auckland secondary school this week following the notification of a smear positive Pulmonary Tuberculosis case in a member of the school community.

### *Auckland Unleashed*

ARPHS has continued to coordinate and lead the Working Group which has been established to consider how health can respond to the opportunities that the Auckland Plan (and better relationships with Council) can create to lift health outcomes over the longer term. ARPHS provided a briefing which has since been used for CPHAC papers. Work continues on the ‘think piece’ to describe the opportunities provided by the Auckland Plan.

### *Rugby World Cup*

Rugby World Cup preparations continued in August with training/readiness workshops for ARPHS staff. On-call arrangements have been confirmed, including additional staffing, for the Rugby World Cup period. As well, monitoring/reporting processes based on Ministry of Health directives have been confirmed. ARPHS has confirmed with the Ministry of Health that our terrorism and deliberate criminal act planning, to advise Rugby World Cup and Mass Arrivals planning, is fully organised.

## **3. Auckland DHB update**

### **3.1 Child, Youth and Women’s Health**

#### *Immunisation*

Provisional NIR data as at 30 August 2011 shows 91% overall coverage of all 2-year olds fully immunised. Maori coverage at 89% is slightly lower than last month, however this is likely to change with confirmed data. With Pacific coverage at age two at 93% these unconfirmed results still indicate only a minimal equity gap. Coverage of other ethnicities at age two is Asian 94%, NZE 92%, and Other 84%.

The Ministry of Health is intending to introduce additional timeliness coverage targets at six months and eighteen months. Coverage at these milestone ages is currently relatively low:

- All ethnicities at 6 months 77% (NZE 79%, Maori 57%, Pacific 70%, Asian 86% and Other 80%). There is evidence that if a child receives their first immunisation on time, they are likely to continue to be timely with their immunisation events.
- All ethnicities at 18 months 83% (NZE 86%, Maori 75%, Pacific 79%, Asian 89% and Other 82%).

#### *Well Child Tamariki Ora Services*

As reported previously, 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). The amounts per Well Child provider to be 'repatriated' have now been agreed; however a review clause will be added to the CFA Variation specifically to allow for amendments to the estimated volumes relating to the ADHB provider Well Child service and for the service provided by the Waiheke Health Trust.

#### *B4 School Check programme*

National data supplied by the Ministry of Health on DHB B4SC programme performance in July showed ADHB as the second highest performer. This was probably as a result of late end of year data entry and it is not expected that the same will be seen for August.

The Service Alliance Leadership Team (SALT) which includes ADHB as well as the senior managers from the four PHO providers has renewed its commitment to the programme and the Service Alliance albeit with some changes. It has reviewed the service delivery model and agreed to extend the range of providers to include Well Child providers, and negotiations to this end are underway. ADHB has agreed to manage the risk around non completion of Vision Hearing Tests as ADHB is the provider of these and a B4SC is only considered complete once both the Vision Hearing Tests and the nurse checks are completed.

#### *ADHB Child Health Plan 2012 – 2017*

The draft ADHB Child Health Plan will be available for wide public and staff consultation in early September. It has been through a robust development process driven by a Steering Group with wide intersectoral representation and significant targeted consultation has already occurred e.g. a number of hui with Maori facilitated by He Kamaka Oranga have been undertaken.

#### *Maternity Service Specifications*

The Ministry of Health has published a suite of new draft maternity services service specifications. Both ADHB and Counties Manukau DHB have indicated concerns regarding a proposed change to the definition of post natal care that could have major implications for DHBs whose systems depend upon transfer of women and babies to a primary maternity facility for post natal care. Discussions are continuing. Waitemata DHB agrees with the maternity specifications as the impacts on its services are negligible.

### **3.2 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 an opening planned for late September. Construction is underway at Royal Oak, Wesley and Blockhouse Bay Intermediates with completion planned over the next three months.

### **3.3 Live Within Our Means**

#### *Month's Funding Issues*

A verbal update on any developing funding issues will be given.

### **3.4 Progress against KPIs**

See Appendix 1.

## 4. Waitemata DHB Update

### 4.1 Funding

#### Staff Training & Development

The Waitemata Funding team is working with the Ministry of Economic Development looking at staff development in the areas of procurement and contract management. Additionally, the Ministry of Economic Development is developing a procurement competency framework that we are looking at potentially implementing. Training staff in the procurement area has been difficult to do consistently as there have not been regular programmes in this area available. Auckland DHB staff will be able to participate in the training programme.

The Waitemata Funding Team is also discussing with healthAlliance opportunities for joint training and development. While the type of contracts we work with are fundamentally different the principles of good procurement and contract management are the same. There appear to be a number of areas where we may be able to leverage of each others experience and needs.

#### Pharmacy - Warfarin Pilot Programme

The Pharmaceutical Society and Health Workforce New Zealand have just finished running a pilot programme looking at the ability of community pharmacy to be involved in improving the management of patients on Warfarin. Warfarin is an anticoagulant widely prescribed to prevent ischaemic stroke in patients with atrial fibrillation, prevent deep vein thrombosis and prevent clot formation. Warfarin requires careful titration as too low a dose will be ineffective and too high a dose can result in potentially dangerous bleeding.

Two pilot sites were in the Waitemata DHB area. There were no pilot sites in the Auckland DHB area. The final evaluation report is expected to be available this month. Initial reports indicate that the programme has improved patient compliance with warfarin as measured by the amount of time patients remained within the appropriate therapeutic range. The pilot essentially tested if community pharmacy using point of care testing and consequently titrating dose could improve patient outcomes. Patients would usually go to the community laboratory to get their blood tests and then go to the pharmacy when the results are available. Effectively the pilot removes the need for the patient to go to the community laboratory.

The Pharmaceutical Society has requested that Waitemata DHB fund the two pilot sites ongoing until a decision has been made nationally to make this standard practice or not. The funding request amounts to \$96,000 per annum. At this time we have advised the Pharmaceutical Society that we would not be in a position to consider this funding request until we have a copy of the final evaluation report and can advise the Board on this proposition. A detailed paper on this proposition will be tabled at a later date.

#### Relationships with Rodney and Waitakere Community Health Links and North Shore Community Health Voice

The Chief Executive and the Chief Planning and Funding Officer met, after the last CPHAC, to discuss how best to maintain relationships with the Community Health Links and the Community Health Voice. It was agreed that going forward the Chief Executive would meet regularly with the Health Links and the Health Voice and that they could also raise important issues at any stage directly to him.

In addition, every three months, the Health Links and Health Voice would provide a report to CPHAC updating their progress and any issues they wanted to bring to the Board's attention. It is recommended that the Health Links and Health Voice speak to their paper directly at the meeting

to ensure direct ongoing contact can occur between the Health Links, the Health Voice and CPHAC members.

## **4.2 Funder Finance**

### *Funder Non Government Organisations (NGO)*

The July core result for Funder NGOs was \$28k favourable to budget for the month. Included in this result are adjustments for changes between Funder NGO and Funder IDF, these resulting from post budget transfers in PHO practice and enrollee memberships.

### *Funder Inter District Flows (IDFs)*

The July core result for IDFs was on budget for the month. This is mostly because July month is still too early to determine actual IDF utilisation (there is a six to eight week lead time required for coding completion). An exception is PHO capitation services which are based on enrolment registers and these are within budget. PHO expenditure variances resulting from post budget transfers in PHO practice and enrollee memberships are compensating and have been accounted for within Funder budgets.

### *Funder Consolidated*

The July consolidated core result for Funder was \$28k favourable to budget.

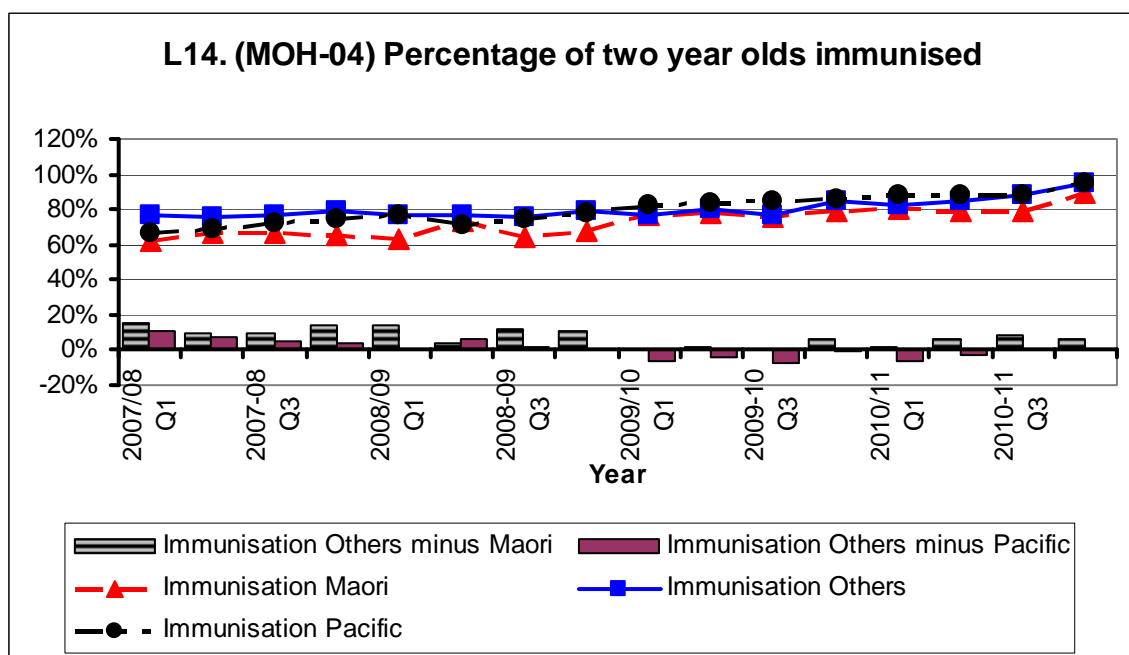
## Appendix 1 - Auckland DHB

### Progress against KPIs

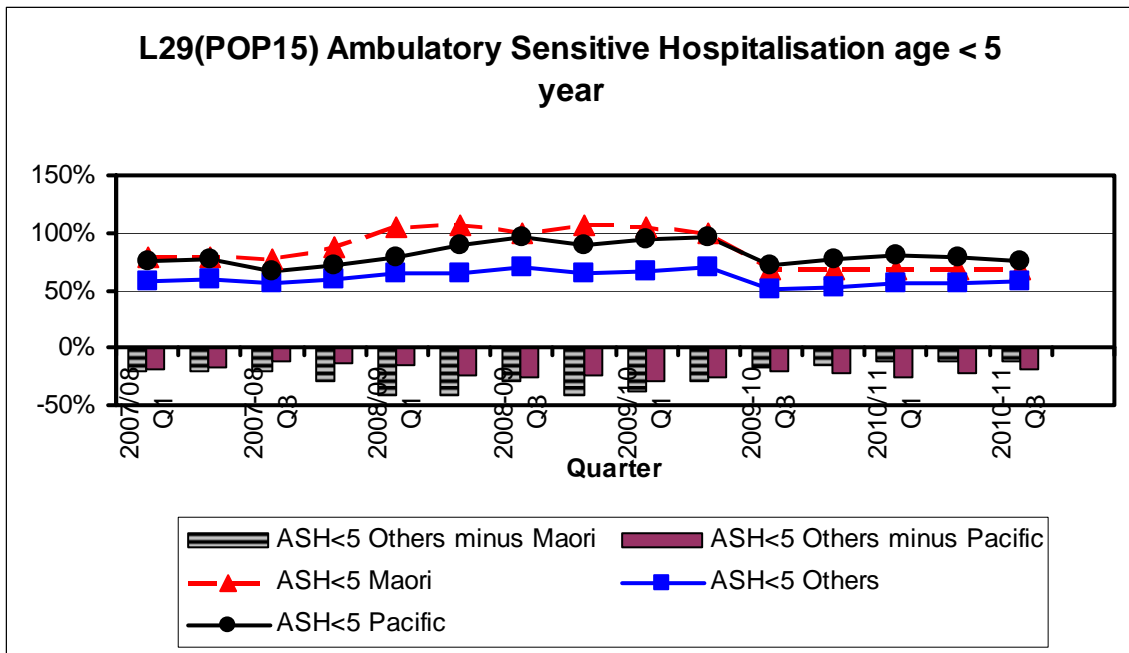
We are working towards agreement to a consistent framework of reporting for both ADHB and Waitemata DHB which will guide future reporting.

Waitemata DHB's performance against KPIs was reported to the full Board at its meeting on the 31 August and is not repeated here.

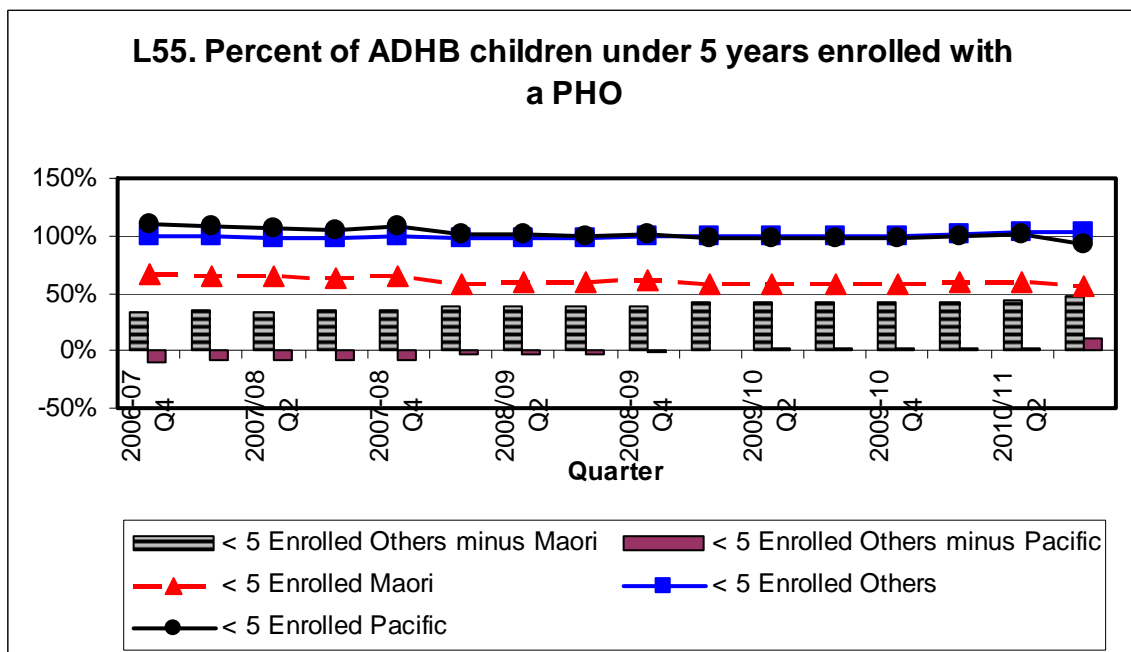
Auckland DHB performance against a number of Key Performance Indicators to the end of the 2010-11 financial year (where this is available) is shown here. There is also commentary for each chart that explains the data and highlights changes of note. Further explanation can be provided verbally at the meeting.



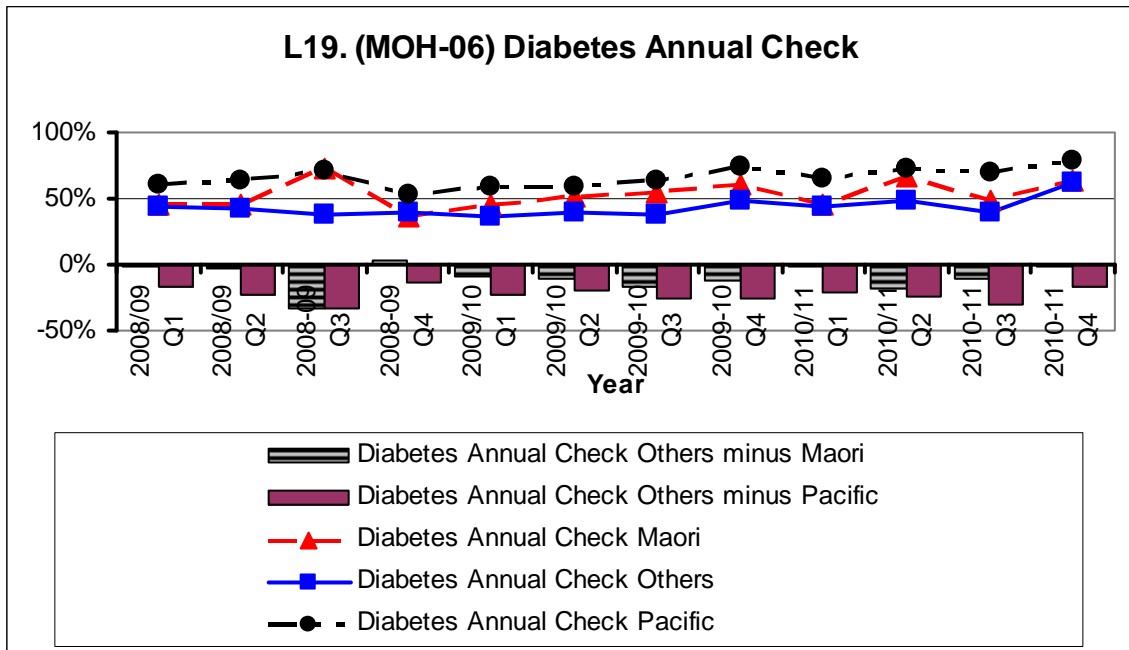
Immunisation coverage at 2 years of age is very positive. The equity gap has nearly closed over the last six months due to a strong focus on effective systems and a culturally acceptable outreach service delivering immunisation in homes.



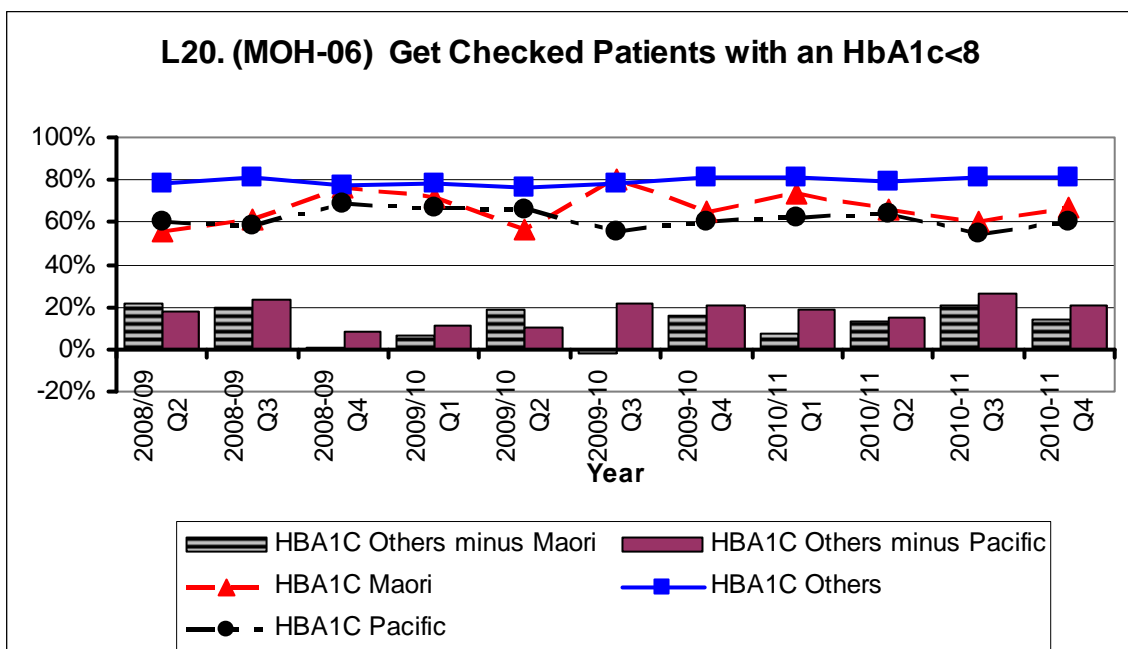
Ambulatory sensitive hospitalisations for under 5s appear to be improving and remain below the national average. This may in part reflect improved immunisation coverage for this population. Rates for Pacific remain high and can be reduced by inter-sectoral efforts such as improved housing.



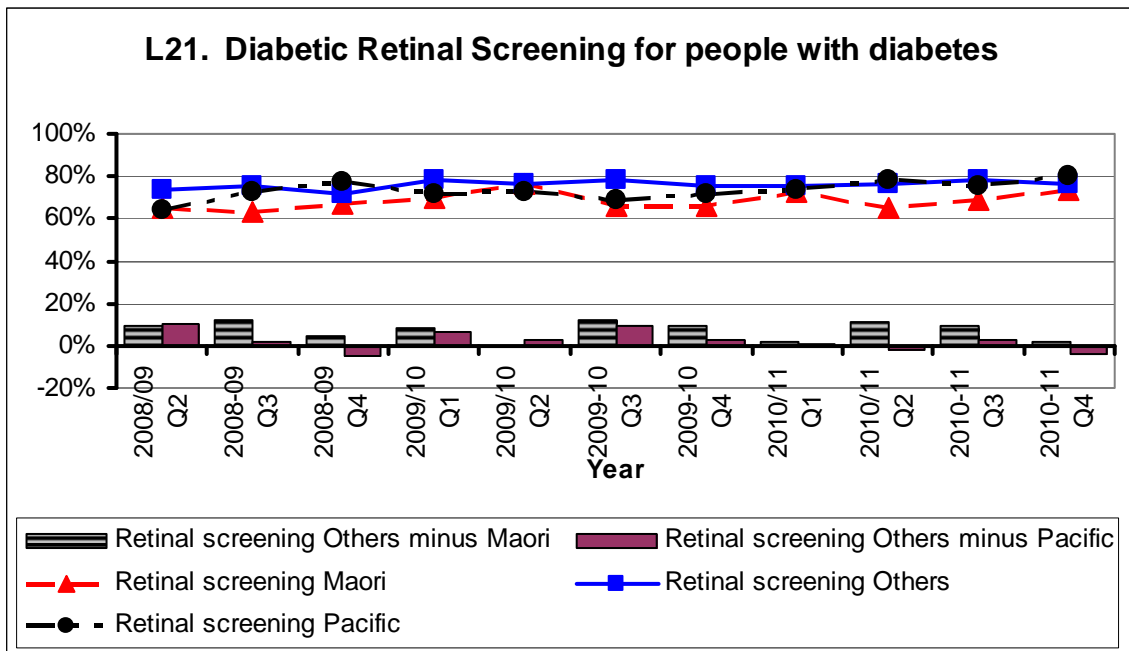
The data suggests a significant equity gap, however data quality associated with recording of ethnicity information in primary care is likely skewing this. Efforts to better connect children to primary care home (and Well Child/Tamariki Ora Provider) will be a focus over the next year.



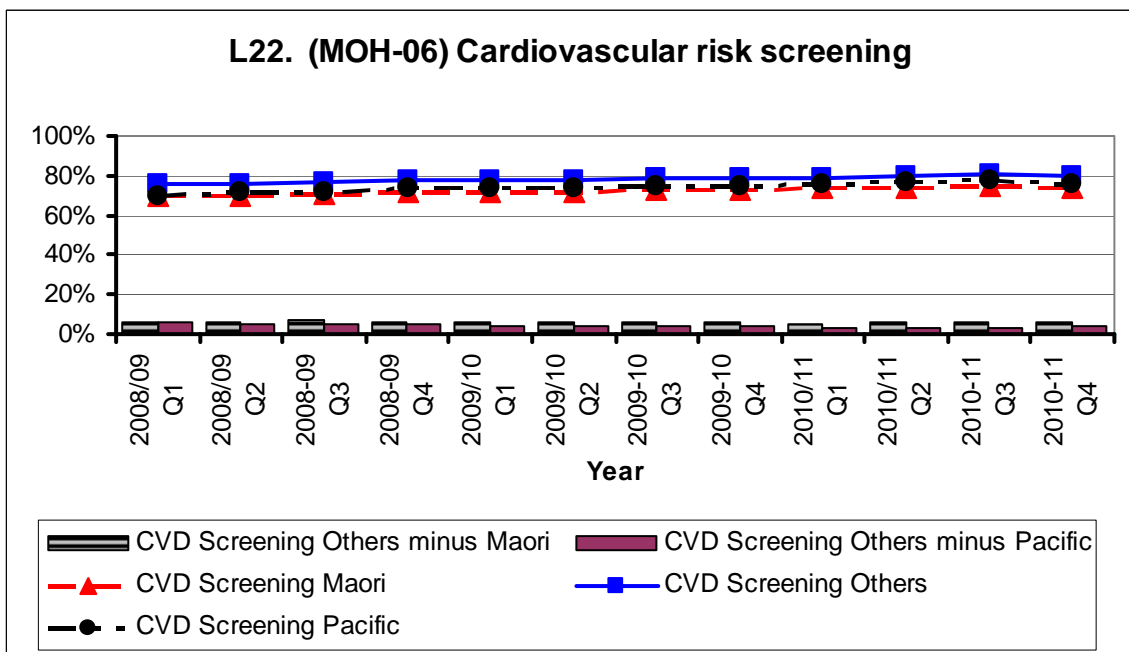
Q4 data showed a significant increase in the number of Diabetes Annual Reviews (DAR's) from the previous quarter, reaching 66% (9 % above target). The "Other" group, which had been significantly underperforming has shown a steady increase from 47% in March, to 50% in April, 53% in May and 67% in June, contributing to an overall Quarter 4 performance for Other of 57% (1% under target of 58%). Performance for Maori and Pacific populations has exceeded target, with Q4 performance for Pacific at 79% and for Maori 63% (against a target of 55%). The gap between Maori and Other has decreased due to the increased performance for Other (although this is not a result of poorer performance for Maori).



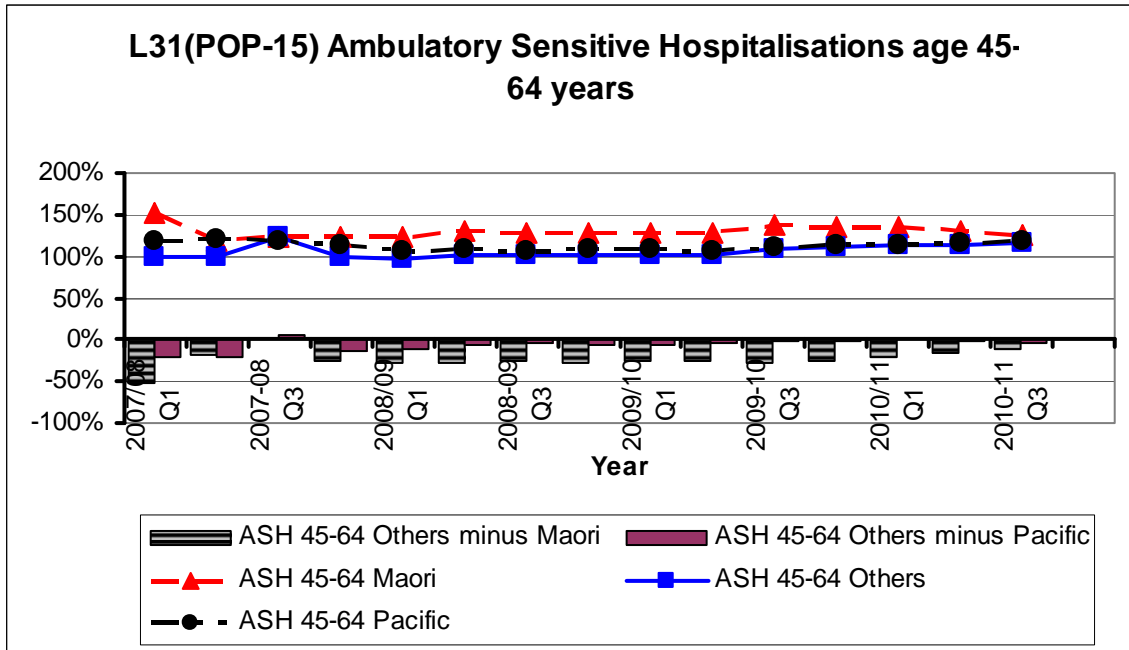
Q4 data shows an increase from the previous quarter of 71% to 74%. While "Other" remained steady there was a slight improvement in diabetes management for Maori and Pacific. In Q3 this was 60% for Maori and 55% for Pacific, while in Q4 this increased to 67% for Maori and 60% Pacific. Both however are still short of the target for these populations of 72%. There are a number of systems work and self management initiatives focusing on our high needs populations that are being rolled out, which are aimed at improving this performance.



The target for retinal screening of 77% was achieved overall at Q4. Differences between the ethnicities are minimal, with Pacific achieving slightly higher retinal screening rates than other groups at 89%, while Maori and Other were 74% and 75% respectively. The graph shows there has been a small increase in retinal screening rates for Maori over the last 3 quarters. There has been a large amount of activity around retinal screening. A community provider has been supporting the delivery of screening volumes to ensure that while demand is increasing, the ability to deliver is not compromised.



The Q4 CVD data shows a 1.1% decrease from the previous quarter to 78.8% (0.2% under target overall). Despite this small decrease, targets for both Maori and Pacific were met (74.3% and 76.1% respectively against a target of 71%), while Other was 0.4% under target. The differences between Other and Maori and Other and Pacific have remained constant. It is difficult to understand where to focus activity as this is a 5 year rolling cumulative figure and it is not possible to see recent improvements separate from activity 5 years ago.



ASH age 45-64, ADHB is significantly higher than the national 100% for all ethnic groups. Primary care and secondary care are working together to initiate many projects and clinical pathways to address these high rates.



6

## GENERAL BUSINESS



RESOLUTION TO EXCLUDE THE  
PUBLIC



## 7 Resolution to Exclude the Public



## 7 Resolution to Exclude the Public

### Recommendation:

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
<b>1. Confirmation of the Minutes of the Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting with Public Excluded held on 10<sup>th</sup> August 2011.</b>	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)]	<b>Confirmation of Minutes</b> As per the resolution from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.

