



Community and Public Health Advisory Committee Meeting

Wednesday 16 February 2011

2:00pm

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

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



Community and Public Health Advisory Committee

For discussion with Board

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD AND COMMITTEE (CPHAC) INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lester LEVY (Chair)	1. University of Auckland Business School 2. New Zealand Leadership Institute 3. Health Benefits Limited 4. Tonkin & Taylor 5. Waitemata District Health Board	Professor of Leadership Chief Executive Deputy Chair Independent Chairman Chairman			1 February 2011
Jo AGNEW	1. Senior Lecturer Nursing, Auckland University 2. Casual Staff Nurse ADHB		Salary Salary		21 April 2010
Peter AITKEN	1. Pharmacist 2. Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
Judith BASSETT	1. Nil				9 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	<ol style="list-style-type: none"> 1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board 	<p>Self-employed</p> <p>Professional Conduct Committee member</p> <p>Professional Conduct Committee member</p>	<p>Fees</p> <p>Hourly fee</p> <p>Hourly fee</p>	<p>Writer, editor and public relations services</p> <p>Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes</p> <p>Lay member of PCC to assess complaints and determine outcomes</p>	7 August 2009
Dr Chris CHAMBERS	<ol style="list-style-type: none"> 1. Employee, Auckland District Health Board 2. Wife employed by Starship Trauma Service 3. Clinical Senior Lecturer in Anaesthesia Auckland Clinical School 4. Associate, Epsom Anaesthetic Group 5. Member, ASMS 6. Shareholder, Ormiston Surgical 7. Surveyor Quality Healthcare NZ 				12 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	25 February 2011
	2. James Henare Research Centre, University of Auckland	Board Member	No fee	Advisory	
	3. Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	4. National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	5. Waitemata District Health Board	Member	Fee (to Ngati Hine Health Trust)		
Lee MATHIAS	1. Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting	1 February 2011
	2. Iris Limited	Director	Fee	Director, company provides services to people with multiple physical disabilities especially cerebral Palsy	
	3. Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited	Provider of business and professional services to midwives and other maternity services providers	
	4. Pictor Limited	Shareholder, Director Director	Fee No fee	Biotech start-up focussing on diagnostic products Estate of late husband	
	5. John Seabrook Holdings Limited	Governance Advisor	Fee	Provider of early childhood education services contracted to	

	6. AuPairlink Limited			the MoE.	
	7. NZ Council of Midwives	Council member	Fee	Statutory Authority	
Robyn NORTHEY	Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB	16 December 2010
	Hope Foundation	Board member	Nil	Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	
Gwen TEPANIA-PALMER	1.				
Ian WARD	1. Chair, Advisory Board, Healthvision Limited		Fee		3 February 2010
	2. Principal/Director C -4 Consulting Limited			Tender to National Shared Services	
Rev Alfred NGARO	1. 4pm Group Ltd	Consultant	Salary	Community Development	11 May 2009
	2. Pacific Advisory Committee, PHAC	Chair	Fee	Pacific Advisory for ADHB	
	3. National Task Force for Family Violence MSD	Member	Fee	PHAC representative	
	4. Family and Community Services national advisory group	Task Force member	Fee	Representative from Family and Community Services national advisory group	
	5. Auckland Safer Communities	Advisory Member		Development and implementation of a comprehensive social intervention logic for supporting families nationally	
	6. Tamaki Achievement Pathways Schooling improvement	Executive member	Voluntary	Development of Auckland Safer City plans	
	7. Tamaki College Board of Trustees	Chair	Voluntary	Chair management committee for cluster of 13 schools in management improvement initiative	
	8. Tamaki Community Development Trust	Elected Trustee	Fee	Disciplinary and property Committee	
		Member	Voluntary	NGO delivering social services within the Tamaki area	

Date: 01/02/2011

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Farida SULTANA	1. Nil				6 August 2008
Lynda WILLIAMS	1. Maternity Services Consumer Council 2. Auckland Women's Health Council 3. Member National Antenatal HIV Screening Implementation Advisory Group 4. Chair Postnatal Distress Support Network Trust Board 5. ADHB Primary Maternity Services Steering Committee	Employee	Salary		4 August 2008

CONFIRMATION OF MINUTES
- WEDNESDAY 17 NOVEMBER 2010

Community and Public Health Advisory Committee Minutes

MEETING DETAILS											
Time and Date	2:00pm, Wednesday, 17 November 2010										
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom										
2	ATTENDANCE AND APOLOGIES										
	<p>The Chair declared the meeting open at 2.02 pm.</p> <p>Committee Members</p> <table> <tr> <td>Dr Brian Fergus (Chair)</td> <td>Susan Buckland</td> </tr> <tr> <td>Dr Chris Chambers</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Pat Snedden</td> </tr> <tr> <td>Ian Ward</td> <td>Rev Alfred Ngaro</td> </tr> <tr> <td>Lynda Williams</td> <td></td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Hilda Fa’asalele – General Manager Pacific Health Naida Glavish – Chief Advisor Tikanga, General Manager Maori Health Janice Mueller – Director Allied Health Lorraine Hetaraka-Stevens – Associate Director Nursing Maori Andrew Coe – Manager PHOs and Primary Care’ Ian Bell – Board Administrator</p> <p>In Attendance</p> <p>Judith Bassett Robyn Northey</p> <p>Apologies</p> <p>Apologies had been received from Jo Agnew, Harry Burkhardt, Bob Tizard, Seiuli Juliet Walker, Lee Mathias, and Taima Campbell. An apology for lateness was recorded for Ian Ward.</p>	Dr Brian Fergus (Chair)	Susan Buckland	Dr Chris Chambers	Rob Cooper	Dr Ian Scott	Pat Snedden	Ian Ward	Rev Alfred Ngaro	Lynda Williams	
Dr Brian Fergus (Chair)	Susan Buckland										
Dr Chris Chambers	Rob Cooper										
Dr Ian Scott	Pat Snedden										
Ian Ward	Rev Alfred Ngaro										
Lynda Williams											
9.2	Evidence for the Impact of Nutrition & Activity on Obesity										
	<p>Andrew Jull, Nurse Advisor Quality was in attendance and presented on Guidelines for Weight Management explaining that the project for guidelines reflected the change from the late 80s in energy density of food and availability of alcohol increasing the percentage of the population that were obese. There were disparities in adults with BMI > 30 being 43% Maori, 65% Pacific and 23% NZEO with similar disparities in children. Disease risk increases with BMI from 21 - 23 and the WHO defines BMI > 25 overweight and BMI > 30 obese. The guidelines were developed to address weight management not prevention, be evidenced based and as a starting point UK and Canadian guidelines were reviewed with the UK NICE guidelines used. Looking at the affects of exercise on weight loss, exercise alone is not statistically significant. Looking at diets, no single diet is more effective than others.</p> <p>The guideline recommendations were to take a comprehensive lifestyle approach that incorporated diet, physical activity and behavioural strategies and that the type of diet should be tailored to the individual and family preferences and increased exercise should be incorporated into weight loss regimes only in combination with other strategies. Bariatric surgery should be considered for people grossly obese.</p>										

	<p>Different BMIs should not be used for different ethnicities and for children the US-CDC BMI for age and sex percentile. For children comprehensive lifestyle approaches needed to be taken including the family.</p> <p>Naida Glavish and Lorraine Hetaraka-Stevens left the meeting at 2:33pm.</p> <p>In conclusion he believed that prevention was effective, there was a need to change the upstream environment and work with strategies positively rather than negatively. Counties Manukau had arranged for sugar to be reduced in McDonalds products and worked on alternatives. The combination of salt/sugar/fat is highly addictive and the political environment is important. The Committee asked for a public health discussion paper on choice, political, regulation with three or four options.</p> <p>Ian Ward joined the meeting at 2:56pm.</p> <p>Any change working with the food industry needed to be at a national level and smoking was still the biggest risk.</p>
3	CONFLICTS OF INTEREST
	There were no declarations of conflicts of interest with any item on the agenda.
4	CONFIRMATION OF MINUTES 20 OCTOBER 2010
	<p><u>Moved Chris Chambers, seconded Pat Snedden</u></p> <p><i>That the minutes of the Community and Public Health Advisory Committee meeting held on 20 October 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>Health Workforce New Zealand had declined to fund the pathways to health careers which would need to be addressed by the Board. The GAIHN implementation plan was still awaiting approval by the MoH.</p>
5	ACTION POINTS 20 SEPTEMBER 2010
	The strategies for children would be provided in 2011.
6.1	Planning and Funding Summary Report
	<p>There were changed requirements for the District Plan with the combined DAP and SOI and the District Strategic Plan dispensed with being covered by a Regional Plan. The DAP was now very prescriptive and there will be a need in addition to develop an Organisational Operational Plan. With Eating Disorder Services the regional mental health managers had become involved to interact with clinical staff led by Clive Bensemman who would monitor the service and referrals to the service required his signoff.</p> <p>The report contained more details on the primary care projects however in addition to GAIHN the MoH were looking for consortia for Integrated Family Health Clinics (IFHC) and ADHB was staying in contact with possible consortia. For services to be devolved there needed to be a range of skills and the final model from NHB, PHOs, DHBs, national regional was evolving.</p>
6.2	Planning and Funding Indicators List and Exception Report
	<p>The transition of B4 School Checks to primary care was progressing. While the immunisation rates overall were slightly over 85% it had not reached the target of 91% and had plateaued. Maori rates were trending up but there needed to be further increase so work was being done on the data at practice level. Pacific had a different way in the community and HVAZ and through the family based on faith was achieving high immunisation rates. While it was suggested that Asian should be a descriptive for a group it was noted that more groups created more data problems and data issues.</p>

7.1	DAP Projects Report
	Ray Naden was Chair of GAIHN and Planning and Funding had appointed David Tucker as liaison with GAIHN.
8	FEEDBACK
	<p>Maori Health Advisory Committee</p> <p>The Committee had received a presentation on cardiac services which was work in progress from which it is hoped equity would evolve. There had been discussions on mental health proposal seeking a direction to involve Ngati Whatua to develop a mental health service that is robust and of high quality. The CEO had undertaken to have a review of HR policies to align HR policies with the Board adopted policy to reflect the workforce to the population of Auckland. The cardiac research needed to be updated to a current model but reflected national data and a Healthcare Excellence process would be used with this methodology having application in other areas.</p> <p>Pacific health Advisory Committee</p> <p>The Committee had had an update on HVAZ from the evaluation project by the School of Population Health which was seeing excellent progress in relationships between churches and PHOs and from Procure on what work they were doing with HVAZ with 14 of the 42 churches who noted that this had been a turning point in their relationship with Pacific. There was a question of sustainability with HEHA funding ceasing in 2012 and a need to integrate HVAZ into business as usual.</p> <p>There had been discussion around the MOU framework and relationship management which was of particular importance for HVAZ.</p>
9.1	MoU Host and Partner DHBs
	<p>The MoU had a host and partner DHBs but for the partner DHBs there will still be relationships with providers with the host focused on transactional. Strategic and operational were separate. ADHB will be the host for Procure.</p> <p>Judith Basset and Lorraine Hetaraka-Stevens left the meeting at 3:52pm.</p> <p>There would be a monitoring report every 3 or 6 months on MoU activities. Waitemata had not chosen to be a host DHB and they were going through a PHO realignment at present although the MoU was going to their Board meeting.</p> <p><u>Moved Ian Scott; seconded Susan Buckland</u></p> <p><i>That the CPHAC recommends to the Board that:</i></p> <p><i>(1) the Board note that approval by the Ministry of Health is required under the Operating Policy Framework;</i></p> <p><i>(2) The Board note that although the Host DHB will be the primary contact for the PHO partner the DHB will still retain direct relationships for key contracts if required;</i></p> <p><i>(3) The Board note that Ministry of Health has approved the Memorandum of Understanding;</i></p> <p><i>(4) The Board approve the Memorandum of Understanding; and</i></p> <p><i>(5) The Board approve that the Chief Executive sign the Memorandum of Understanding.</i></p> <p><u>Carried</u></p>

11	GENERAL BUSINESS
	<p>Magazine Article</p> <p>The Chief Executive noted that when things go wrong there was a need to listen and investigate and the processes of Serious and Sentinel Events and Health Excellence were aimed at eliminating harm. Always families are included. It was critical for ADHB to hold to its values and open disclosure is very important.</p> <p>Brian Fergus was thanked for his Chairing of the Committee.</p>
	NEXT MEETING
	<p>The meeting closed at 4:07 pm</p> <p>The next scheduled meeting is for 2:00pm, Wednesday, 26 January 2011 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Epsom</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	

ACTION POINTS

- **WEDNESDAY 17 NOVEMBER 2010**

**Community and Public Health Advisory Committee
Action Points from the meeting on Wednesday 17 November 2010**

Item	Detail	Designated	Action
Carried forward	A paper on strategies for children to be provided	Denis Jury	Early 2011
9.2	Public Health discussion paper on choice, political, regulation in relation to weight management with three or four public health options.	Denis Jury	

PLANNING AND FUNDING PERFORMANCE

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

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Planning and Funding Functional Group

Summary Report

1. Lifting the Health of people in Auckland City

Planning

The Annual Plan for 2011-12 is in accord with the outline provided by the National Health Board (NHB), outlining Auckland DHB proposed activities for the 2011-12 financial year that meet national, regional and local objectives. The Minister's Letter of Expectation has now been released and helps us focus our local planning on national health sector priorities.

A key change from previous years is the requirement to alert the NHB of proposed service changes for the 2011-12 year. If significant, these will need to be approved by the Minister before being signalled in the Annual Plan. This preliminary approval work is underway.

A copy of the DAP has to be with the MoH on 25 March, and all financial material by 5 March.

Work on the Regional Health Plan is being progressed by NDSA with the help of a Steering Group formed from representatives across the four northern DHBs.

In addition, each DHB is required to have a Maori Health Plan developed prior to the start of the financial year.

Consumer and Community Engagement

Research examining acute and elective patients' experience of the journey from home through to admission into hospital is nearing completion. The results will be fed into Better Sooner More Convenient (BSMC) work and ADHB service improvement initiatives.

ADHB is taking a lead role in ensuring the Auckland Council are well informed about the Auckland region DHBs' current and future strategy for protecting and improving the health of Aucklanders. Local Boards will be engaged to involve place-based communities in ADHB's localities approach to service planning.

Mental Health

Secure Rehabilitation

A full options analysis paper is being prepared, which will include a detailed financial analysis. Opportunities for cost savings elsewhere to fund the new service will be explored. We anticipate that this will be completed in March 2011.

Eating Disorders

This supra-regional project and service development is now complete with the day programme and the full nine beds for the residential service being operational. The necessary service level agreement and operational protocols have been completed and signed. The links between this new service "Thrive", and the Regional Eating Disorder Service (REDS) are now established and working well.

Alternative to Admissions

This project is underway. Suitable premises have now been found in Mount Roskill. We expect the service to be operational in early February 2011.

The interim service continues at the four bed crisis respite house in Hillsborough; this has been contracted with Pathways, the provider for the alternative to admissions service. This service will close in February as the new service gets underway.

Youth Respite

The contract for this service (implemented to replace the Mind Matters service) has been awarded to Affinity Services. This service will operate as an alternative to admission (step-up). Julie Armstrong is on the Affinity Services project group that oversees this development and this group also has ADHB clinical representation. Discussions about operational protocols are well underway, premises have been secured, and the service is expected to be open in February 2011.

Child Health

Immunisation

Provisional data as at 2 February shows ADHB still sitting on 87% coverage at age 2 years. There has been no movement in this coverage for the last seven months despite all stakeholders maintaining a consistent focus on immunisation. However, the ADHB funded data quality improvement project reported on in December is now being implemented across primary care by Immunisation Coordinators and NIR Administrators. This will include training for practice nurses where indicated. The indications are that this project will have a significant positive impact on coverage rates and will also ensure that confidence can be had that the data is 'clean' and accurate. In turn this will allow more effective targeting of strategies to further improve coverage.

Auckland Social Sector Leaders Group: Immunisation

There has been a very enthusiastic response from other sectors to the proposed action plan to facilitate the improvement of immunisation coverage rates across the Auckland metro area. All relevant agencies including Housing NZ, MSD, Corrections, Ministry of Justice, Ministry of Education and the Ministry of Pacific Island Affairs (Te Puni Kokiri and NZ Police still to be confirmed) have suggested activities that they could undertake to improve coverage. It is clear that there will be an ongoing coordination and support role for ADHB in this project.

Primary Care

Regional Progress to Date:

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

- **Contracting Framework**

The three Auckland DHBs have developed a collaborative agreement establishing a host / partner DHB arrangement to simplify the contracting process for cross boundary PHOs.

- **Business Cases**

Active involvement continues to support the three Business Cases in development and rollout of their respective Implementation Plans.

- **Progress with PHO Consolidation**

The amalgamation of the three ProCare Network PHOs into a single entity is on track to be completed 1 January 2011. ADHB as Host DHB for this amalgamation is heavily involved in the variety of systems and processes.

ADHB Specific Progress to Date:

In addition to active involvement in the above regional work programmes, ADHB PHO & Primary Care team work plan progress includes:

- **Progress with the ADHB Primary Care Plan**

Following on from the successful development of the B4 School Checks ADHB District PHO/DHB Alliance discussions are underway with the four ADHB PHOs toward developing a District Alliance. It is anticipated that this alliance will operationalise primary care initiatives for ADHB.

The District Alliance using the ADHB approved Locality Plan (approved 15 September 2010) which aligns to the wards of Auckland Super City will be the ADHB vehicle for achieving:

- Consolidation and operationalisation of the three Business Cases
- Devolution of services
- Functional and functioning IFHC / Whanau Ora Centres

- **Improve Primary – Secondary System Efficiency: The DAP Projects**

1 Access to Diagnostics – Radiology Project:

ADHB is the Lead DHB for this Project which is progressing well in terms of both the establishment of the systems and processes required to support the referrals, and with strong clinical leadership and support. One hundred ADHB Practices were trained and had full ProExtra functionality by the end of 2010 and four of six Community Radiology Providers are now fully operational with the project.

The DAP target of 4,000 procedures will not be met, but importantly the systems to achieve this will be in place well before financial year end. The focus now is to ensure that we are able to produce an annualised target of 4,000 by year end.

Unfortunately a number of the DAP targets were prepared in haste and under pressure and a more realistic view of these have evolved with significantly increased clinical involvement and project implementation.

CMDHB & WDHB 'requirements exercise' is currently progressing.

2 Minor Surgery – Skin Lesions

Provider selection across the region has now been completed. Contracts for the three ADHB providers are being put in place and there is confidence that the target will be met.

3 Clinical Pathways

This project is progressing well and will achieve its target of five new pathways by year end.

4 Acute Demand / POAC

The DAP target of 5,000 additional POAC referrals for the year ending 30 June 2011 will be met; currently total volumes are tracking above target.

5 After Hours Project

Overall the project is on track with good progress is being made with the required financial modelling, population profiling, locality identification and costs establishment. Issues regarding the mechanism for the procurement of providers are currently being addressed.

The cost of After Hours access, an issue that made headlines over the Christmas period, is being addressed through this process. The project is on track to deliver a new After Hours network by 1 July 2011 but the situation that was reported over Christmas is likely to recur at Easter as no changes have yet been implemented.

Currently ADHB is considering the use of its ED for the provision of 2400-0800 Hrs provision.

6 Pharmaceuticals – Optimising Prescribing Project

ProCare has been managing this project and have been hindered by both the recruitment of the appropriate staff and accessing data in sufficient detail. Staff and processes are now in place, and while it is unlikely that the savings target of \$1.5m will be met, the set up costs of \$600k will be covered.

7 Maori Service Devolvement

WDHB and CMDHB are devolving Maori health services currently provided by the DHB and are on tract for completion by financial year end.

2. Performance Improvement

B4SC Programme

This programme has now transitioned to primary care. The smooth and uneventful transition is a result of effective collaboration and detailed planning over the last three months by the ADHB provider and PHO staff. The transition has occurred within the framework of a Service Alliance Agreement. The parties to the Alliance include senior managers and clinicians representing ADHB, ProCare, Te Hononga O Tamaki Me Hoturoa, Health Alliance + and Auckland PHO. Accountability for performance and achievement of targets rests with the Service Alliance. The Ministry of Health has been kept fully briefed about this initiative and is supportive of the approach.

Health of Older People

Home Based Support Services Project

We are now entering into the final phases of implementation with the majority of service changes now well established. Two significant pieces of evaluation of the project are currently underway; one being the review by the Office of the Auditor General of the model of care, and the other a comprehensive review of the project being carried out by the University of Auckland School of Population Health. The reviews are planned to be completed by June 2011 and the results will inform the ongoing development of this service. Two key pieces of work continue:

1 Revised contracting by case mix informed packages of care:

During the last quarter of the financial year a trial of a new case mix cost model will take place. This will test the clinical algorithm which underpins the case weights, and confirm that the revenue associated to each cluster reflects the actual clinical need and the anticipated volumes.

2 Packages of care

Once the cost model has been agreed work will begin to incentivise providers to focus on clients with the highest rehabilitation potential. It is likely that additional revenue streams such as carer support and respite care will also be transferred from ADHB provider to the community providers to be applied by the lead clinician in conjunction with the older person and their family in order to meet their agreed goals.

Streamlined management of High and Complex clients

The pathway remains complicated for this client group, and agreement has been reached to put a small sub group of the Service Development Group together to process map the journey for this group with a view to reducing or eliminating the current duplication that occurs with likely further efficiencies.

Residential Care

A steering group has been established to oversee the development of enhanced residential care services during 2011/12. Significant objectives have been set and presented to the sector which includes enhanced education and clinical support including access to MOODLE, management training and post grad nursing support.

The scoping and roll out of InteRAI for residential care has also been highlighted as a priority and ADHB will act as a lead site in the roll out of this initiative.

Discussions are underway to provide both residential care and home based support providers with an electronic whiteboard, which will provide direct access to the inpatient wards of ACH and direct views of resident location and expected date of discharge.

The Principles of EDEN, which will form the framework for an accredited provider scheme, are also being developed by the steering group.

Disability

The final draft of the Accessibility Audit is complete and has been circulated to the DSAC in advance of a workshop on February 16.

3. Live Within Our Means

Progress with PHO Consolidation

The consolidation of the PHO's continued with two further amalgamations on 1 January 2011. New PHO entities ProCare Networks Limited and Alliance Health are now operational with single patient registers.

Month's Funding Issues

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

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January 2011

Exceptions this month

H6: The NGO audit programme includes contractual / quality based audits of HOP Residential Services by an agreed pool of Designated Audit Agencies, Mental Health by Health and Disability Audit NZ, Personal Health (including Dental and PHOs) by HealthShare Limited and Pharmacies by Medicines Control (MOH). Contractual / quality based audits involve the auditors developing an audit tool based on the contractual Agreement between the funder (DHB) and provider (NGO) and then reviewing the degree of compliance demonstrated towards the components of the audit tool by the provider. Examples of High Risk issues arising include: Medication Management (Controlled Medication Register within HOP Residence not completed correctly) and Assessment (a resident's file had not been reviewed for reassessment despite significant changes occurring over the past two years). Moderate risk issues include: Risk Management (risk management plans for patients accessing MH Dual Diagnosis had not been well documented) and Expiry Dates on Pharmaceuticals (expiry dates were not being assigned to all compounded pharmaceuticals). Low risk issues include: Client feedback (regular client surveys had not been undertaken for a service) and Hand washing facilities (A vanity provision in the form of a sit down bench space with a hand basin was not sighted).

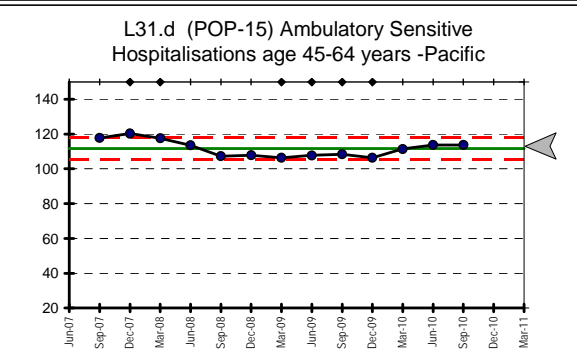
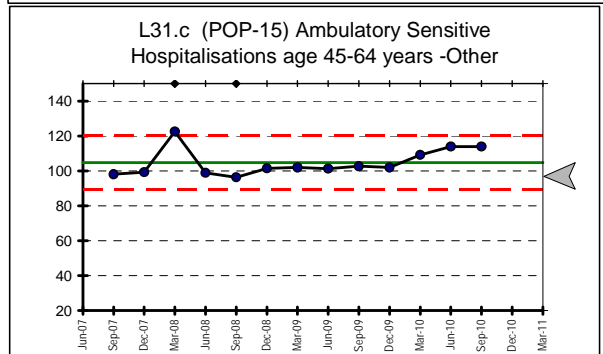
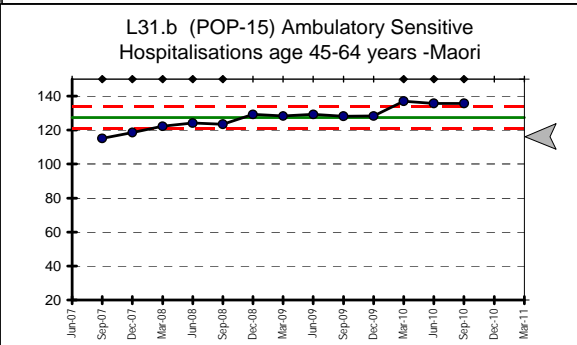
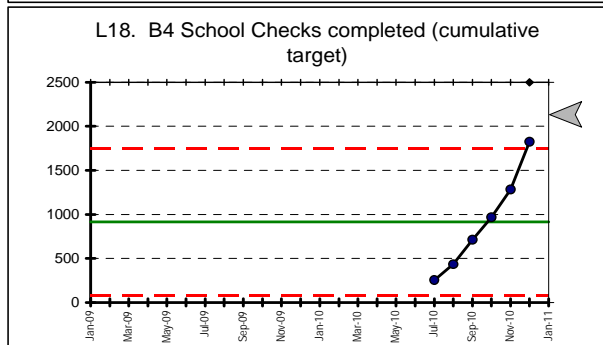
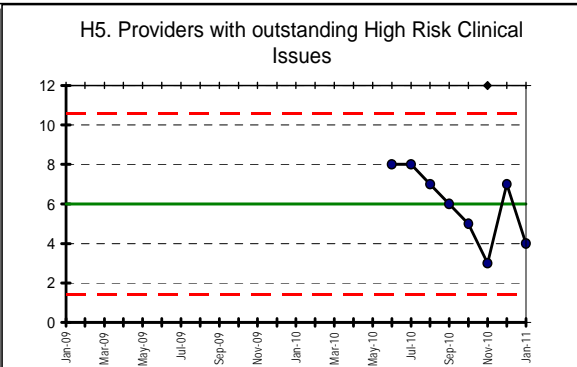
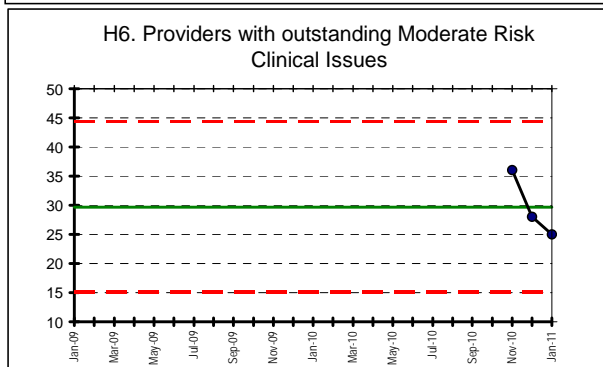
Some providers have had outstanding issues for an unsatisfactory period. For HOP Residential Services, such delays may impact on the extension of their license to operate if HealthCERT (the MOH certification agency) deem the non-compliance material. In all cases, where the DHB deems the risk to service delivery and client safety material, and the provider is reticent in addressing the issue, the DHB may seek to remedy the situation via the terms of the Agreement

During December 10, 40 outstanding risk issues emerged. During the same period, 43 outstanding risk issues were resolved. Within this figure, 8 moderate risk clinical issues were resolved, with 8 new outstanding moderate risk clinical issues added to the total. Of the 25 providers identified: 15 HOP providers, 1 Maori Health provider, 3 Mental Health providers, 1 Orthotic Provider, 1 Pharmacy, 1 PHO and 3 Women and Children's providers.

H5: During Dec 10, 4 outstanding High Risk Clinical issues were resolved, with none added to the list. Of the 4 providers with High Risk Clinical issues, 4 issues are centred with one provider, 2 are linked to another provider, and the final 2 issues are split between the last two providers. 4 issues are due to be resolved within the next week.

L18: Performance has improved in Q2 over Q1. Performance is almost in line with national results, although below the target. The service has transitioned to Primary Care (from 1 January 11 onwards) and current indications are that the uptake by Primary Care has been positive.

L31, b,c,d: In the last few quarters the ambulatory sensitive hospitalisation rates (ASH) for the age group 45-64 were above the national target of a 100% (for the service to be effective, the rate should be below 100%). Many factors were identified as the driver behind these high rates and a presentation for ADHB PHO Forum and the Clinical Advisory Group will take place in the February 2011 meeting. This will be followed by presentations to ADHB providers, clinicians, and the managers. The intention is to have a clear set of measures and initiatives to address and to reduce these rates.



IMPROVEMENT ACTIVITIES

7.1 DAP Projects Report



Auckland District Health Board

District Annual Plan *2010 - 2011*

22 June 2010

Priority and Developmental Work for 2010-11

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

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

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

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

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

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

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

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

High level strategy	Objective	Strategies to achieve objectives
		<ul style="list-style-type: none"> - Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
2.2 Improve leadership capability	2.2.1 Strengthen Clinical Leadership model	2.2.1.1 Refine, implement and monitor integrated governance model 2.2.1.2 Monitor and report against "In Good Hands" implementation
	2.2.2 Improve Senior Leadership Team Performance	2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement 2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care
2.3 Improve Clinical Quality and Professional Governance	2.3.1 Implement regional clinical networks	2.3.1.1 Provide leadership in cancer and cardiac clinical networks 2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care
	2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management 2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas 2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process 2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s 2.3.2.5 Implement Senior Leadership Team 'Walk-around' safety programme i.e. growth and training in clinical leadership 2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement 2.3.2.7 Evaluation against Health Excellence Framework 2.3.2.8 Continue roll out of Cornerstone accreditation across primary care 2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System
	2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity
2.4 Strengthen the health workforce	2.4.1 Ensure workforce capability is matched to service delivery current and future	2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces 2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme 2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015) 2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme 2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce

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

* Refer to appendix 8

Goal 3: Live within our means

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

Group Pack Report

Group/Committee: Community and Public Health Advisory Committees



Goal Level Summary

DAP Projects - total projects: 26

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	19	19	5	3	2	6	2	0	15	3	0	18	0	0	18	0	0	1	1	0	0
2 Performance improvement	7	7	0	1	0	6	0	0	5	2	0	7	0	0	4	3	0	0	0	0	0
3 Live within our means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	26	26	5	4	2	12	2	0	20	5	0	25	0	0	22	3	0	1	1	0	0
Total %	100%	100%	19%	15%	8%	46%	8%	0%	77%	19%	0%	96%	0%	0%	85%	12%	0%	4%	4%	0%	0%

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

High Level Summary - total projects: 19




High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits				
			Plan		Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red		
			Define	Measure																	Analys	Improve
1.1 Reduce inequalities in health status	7	7	4	1	0	2	0	0	7	0	0	7	0	0	7	0	0	0	0	0	0	0
1.2a Improve outcomes for children and young people	2	2	0	1	0	0	1	0	2	0	0	2	0	0	2	0	0	0	0	0	0	
1.2b Improve outcomes for older people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2c Improve outcomes for mental health and addictions	3	3	0	0	0	2	0	0	2	0	0	2	0	0	2	0	0	1	1	0	0	
1.2d Improve outcomes for long term conditions	5	5	1	1	1	2	0	0	3	2	0	5	0	0	5	0	0	0	0	0	0	
1.2e Improve outcomes for Palliative care	2	2	0	0	1	0	1	0	1	1	0	2	0	0	2	0	0	0	0	0	0	
Total #	19	19	5	3	2	6	2	0	15	3	0	18	0	0	18	0	0	1	1	0	0	
Total %	100%	100%	26%	16%	11%	32%	11%	0%	79%	16%	0%	95%	0%	0%	95%	0%	0%	5%	5%	0%	0%	

Objectives

Objective	Objective Owner	Comment
1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	Aroha Haggie (ADHB)	Projects under this objective are progressing as expected. Significant support is being provided to these activities especially in the BSMC space to support the implementation of whanau ora. Whanau Ora Outcomes Framework - We are experiencing some delays in the development of outcomes for the framework however we are seeking to align DHB:MAPO outcomes with those recently development in the primary care and BSMC business case space.
1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	Hilda Faasalele (ADHB)	Overall progress made with Pacific communities and leaders through HVAZ. Working with Alliance Health + at Alliance Leadership level to ensure appropriate services.
1.1.3 Increase access to services for culturally and linguistically diverse populations	Denis Jury (ADHB)	Terend of increasing enrollments in the online cultural competency training modules by both primary and secondary care continues. Focus by the project manager in this area has seen continued increase of uptake of interpreters by primary care.
1.1.4 Support disabled people and improve their access to health care and support services	Denis Jury (ADHB)	DiSAC workshop in Feb will consider the final Disability Responsiveness Audit report -the output should inform planning processes for 2011/12. No progress over the last month from the MoH regarding the IFP fund, although devolution by financial year end is still the target.
1.2a.1 Achieve immunisation targets	Denis Jury (ADHB)	Locally immunisation rates have proved difficult to move above the significant gains that were made previously -activity continues at practice leel to share learnings and review data and process. This is a similar pattern across the region.
1.2a.2 Improve the oral health of children	Denis Jury (ADHB)	Construction of the new dental clinics continues according to plan with clinics at Otahuhu and Stonefields completed since the beginning of Dec, and currently furniture and equipment bening moved in. two new pre-school health promotors and regional

		adolescent coordinator are now in place according to the Oral Health Business Plan.
1.2b.1 Home-based support services and restorative homecare initiatives	Denis Jury (ADHB)	Development of the packages of care pilot and case mix funding models are close to completion and will be piloted during the last quarter of this financial year.
1.2b.2 Quality improvement in residential care	Denis Jury (ADHB)	Pleasing to see a current downward trend in complaints received from residents. Development of the process for introduction of the EDEN programme continues with full support of the relevant providers.
1.2c.1 Increase effectiveness across primary, secondary, tertiary services for mental health and addictions	Denis Jury (ADHB)	All projects progressing satisfactorially, noting that the EDS service is now functional and accepting clients.
1.2d.1 Strengthen community participation and action for long term conditions	Denis Jury (ADHB)	Great to see Auckland Plunket and Ngati Whatua o Orakai Health Services are working together to achieve Baby Friendly Community Initiative accreditation -BFCI coordinator has been appointed.
1.2d.2 Integration of services across primary and secondary care for long term conditions	Andrew Coe (ADHB)	Regional work continues on the establishment of an Auckland Region diabetes network. BSMC DAP targets for for clinical pathways are progressing according to plan.
1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	Andrew Coe (ADHB)	The development of a community based retinal screening service has made good progress over the last month with the new provider and the IS provider working closely together. capital has now been approved for the IS purchase. An interim community provider has been screening approx 370 patients over the last month.
1.2d.4 Support whanau and self resilience for long term conditions	Aroha Haggie (ADHB)	Diabetes Self Management Education. The RFP process has concluded with successful negotiations with the recommended provider, Te Hononga O Tamaki Me Hoturoa. Te Hononga have the existing capacity to deliver aspects of the diabetes self management courses in te Reo and Hindi. They will be building on this great foundation and through partnerships will ensure they are able to respond effectively to all population groups.
1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	Andrew Coe (ADHB)	All projects progressing well, and great to see the increasing number of clients enrolled in the primary care programme.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Increase access and capacity to community diabetic eye screening	National	Analyse				Good to see the two parts of the approach are coalescing with vendors and solutions coming to finalisation. The discussion document process is good to see. It is good to see that activity of the community provider to undertake screening for some of our patients has started.

Legend: Red - , Orange - , Green - 

Goal: 2 Performance improvement

High Level Summary - total projects: 7

	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits		
			Plan		Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure																
High Level Strategy																				
2.1a Efficient and effective Primary health care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	6	6	0	1	0	5	0	0	4	2	0	6	0	0	3	3	0	0	0	0
2.1c Improve quality of hospital care while improving productivity	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0
2.2 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.3 Improve Clinical Quality and Professional Governance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.4 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.5 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.6 Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	7	7	0	1	0	6	0	0	5	2	0	7	0	0	4	3	0	0	0	0
Total %	100%	100%	0%	14%	0%	86%	0%	0%	71%	29%	0%	100%	0%	0%	57%	43%	0%	0%	0%	0%

Objectives

Objective	Objective Owner	Comment
2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	Andrew Coe (ADHB)	ADHB continues participation at national, regional and local level regarding primary care planning and implementation. The GAIHN "Clinical Activity Groups" will be reported back during Jan with potential BSMC approaches -these are currently being reviewed and prioritised.
2.1b.1 Improve access and efficiency of service delivery for primary–secondary system	Andrew Coe (ADHB)	The primary care DAP projects progressing to varying degrees. POAC and acute care will meet the DAP targets; access to diagnostic radiology is progressing well with regard to establishing the systems and processes with good ongoing update by general practice there is question about whether the target can be met (work is focussed in this area at the moment). The rest of the projects are progressing well and there is confidence that the targets can be met.
2.1b.2 Reduce acute demand	Andrew Coe (ADHB)	The regional Extended POAC project on track -current volumes are ahead of target.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Pharmaceuticals	Regional	Measure				Project is now underway although behind schedule. Original benefits unlikely to be delivered within the original timeframes.

Legend: Red - , Orange - , Green -

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

PAPERS

9.1 Northern Regional Health Plan

9.2 ADHB Funding 2011-2012

9.3 Annual Plan and Statement of Intent 2011-2012

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COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE Paper

Date	16 February 2011
To	Community and Public Health Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denis.jury@adhb.govt.nz
Author	Tony O'Connor Ext 26765 tony.oconnor@adhb.govt.nz Julie Helean Ext 4390 julie.helean@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	Northern Region Health Plan
1	<p>As required by the Operational Policy Framework and New Zealand Public Health and Disability Amendment Act, the northern region DHBs and primary care partners are leading the health sector to develop a Regional Service Plan. The northern DHBs refer to this as the Northern Region Health Plan.</p> <p>The process of delivering the Plan and coordinating all stakeholder involvement is being managed through the Northern Region DHB Support Agency (NDSA). The work is being assisted by a Steering Group comprised of members of each DHB.</p> <p>The Northern Region DHB Support Agency submitted a draft plan to the National Health Board on 30 September. The National Health Board feedback on the draft plan focused on the need to:</p> <ul style="list-style-type: none"> • develop an action orientated implementation plan that will resolve service vulnerability for agreed prioritised service areas • specifically demonstrate clinical engagement and leadership • include detailed implications (including financial) and outcomes for the specific implementation actions • include a clear description of the governance decision making and the implementation accountability framework, including evidence of a dispute resolution process • include clear linkages to infrastructure plans including IT and workforce. Other plans should be referenced and align with the regional services plan, including the annual plans. <p>Subsequent work has focused on ensuring the plan has a vision which is inspiring and understood by all stakeholders. This includes confirmation of the mission and strategic focus.</p> <p>In addition to a planning workshop held in November, the Northern Region Health Plan team has been meeting with stakeholders and establishing a project structure which includes clinicians and managers in all levels of the planning process.</p> <p>The next step in the process is to develop a draft document which will be provided to DHB management and Boards for review and discussion in late February.</p> <p>The final, Board-approved version is due with the National Health Board on 11 April 2011.</p>
2	<p>Recommendations</p> <p>It is recommended that the Committee;</p> <ul style="list-style-type: none"> • note the information and timelines

3	<p>Key themes in the Regional Plan</p> <p>Mission</p> <p>To improve health outcomes and reduce disparities by delivering Better, Sooner, More Convenient services. We will do this in a way that meets demand whilst living within our means.</p> <p>Triple Aim</p> <ul style="list-style-type: none"> • Population health • Patient experience • Cost and productivity <p>The “Big Dots” approach</p> <p>The multi-disciplinary workshop held on 12 November 2010 agreed to select three “Big Dot” interventions to meet our goals. These are areas where we can make a significant difference regionally.</p> <p>Aiming for Zero Patient Harm: We want to be the safest healthcare system in Australasia. There is clear evidence-based interventions which, if systematically applied, will save lives, prevent harm to patients, save money, free up capacity and improve productivity.</p> <p>Years and Life. This covers two dimensions:</p> <ul style="list-style-type: none"> • Adding Life to Years: To focus on a set of conditions which if “best designed” would deliver a significant improvement to health of the population, keeping citizens productive, reducing demand on hospital services • Adding Years to Life: To increase the number of years of life in the Northern Region by reducing risks of diabetes and cardiovascular disease in the first instance. <p>Informed Patient Choices: We aim to involve our patients in the decisions that impact their lives, and their families/whanau; there is a range of evidence to support the benefits to the patient as well as the health system by doing this better.</p> <p>Each “Big Dot” will comprise existing initiatives already underway where appropriate, Ministry and Ministerial expectations, as well as some key, new “transformational” strategies.</p>																																										
4	<p>Timeframes for the Regional Plan</p> <p>The NDSA Team working on the Regional plan, DHB Steering Group representatives, planners and other key personnel are working to ensure the planning process is as seamless as possible. The key dates are:</p> <table border="1" data-bbox="204 1346 1410 2096"> <thead> <tr> <th>Action</th> <th>Date due</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td>Signal intentions of service change to the National Health Board</td> <td>28 Jan 2011</td> <td>DHBs (with regional consistency)</td> </tr> <tr> <td>Draft Version 1 available to the Steering Group</td> <td>11 Feb 2011</td> <td>NDSA Team</td> </tr> <tr> <td>NRHP Steering Group Meeting 3</td> <td>15 Feb 2011</td> <td>NDSA Team and Steering Group</td> </tr> <tr> <td>Draft Version 2 available to Executive Management Teams – with financial implications for the Annual Plans outlined</td> <td>17-18 Feb 2011</td> <td>NDSA Team and Steering Group</td> </tr> <tr> <td>Feedback from DHBs and stakeholders</td> <td>From 18 Feb 2011</td> <td></td> </tr> <tr> <td>Board meetings:</td> <td></td> <td>DHBs</td> </tr> <tr> <td> Waitemata DHB</td> <td>23 Feb 11</td> <td></td> </tr> <tr> <td> Northland DHB</td> <td>25 Feb 11</td> <td></td> </tr> <tr> <td> Auckland DHB</td> <td>01 Mar 11</td> <td></td> </tr> <tr> <td> Counties Manukau DHB</td> <td>01 Mar 11</td> <td></td> </tr> <tr> <td>Feedback from Boards</td> <td>From 23 Feb 2011</td> <td></td> </tr> <tr> <td>DHB financial templates for the Annual Plan</td> <td>04 Mar 11</td> <td>DHBs</td> </tr> <tr> <td>Combined Annual Plan/SOI submitted to</td> <td>25 Mar 11</td> <td>DHBs</td> </tr> </tbody> </table>	Action	Date due	Responsibility	Signal intentions of service change to the National Health Board	28 Jan 2011	DHBs (with regional consistency)	Draft Version 1 available to the Steering Group	11 Feb 2011	NDSA Team	NRHP Steering Group Meeting 3	15 Feb 2011	NDSA Team and Steering Group	Draft Version 2 available to Executive Management Teams – with financial implications for the Annual Plans outlined	17-18 Feb 2011	NDSA Team and Steering Group	Feedback from DHBs and stakeholders	From 18 Feb 2011		Board meetings:		DHBs	Waitemata DHB	23 Feb 11		Northland DHB	25 Feb 11		Auckland DHB	01 Mar 11		Counties Manukau DHB	01 Mar 11		Feedback from Boards	From 23 Feb 2011		DHB financial templates for the Annual Plan	04 Mar 11	DHBs	Combined Annual Plan/SOI submitted to	25 Mar 11	DHBs
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	National Health Board		
	FINAL DRAFT to the Steering Group	03 Mar 11	NDSA Team
	Northern Region Health Plan Steering Group	15 Mar 11	NDSA Team and Steering Group
	FINAL DRAFT circulated to organisations	20 Mar 11	NDSA Team
	Northern Region Health Plan due to National Health Board	11 Apr 2011	NDSA Team and SG
4	<p>Long Term Health Sector Plan</p> <p>Government passed the New Zealand Public Health and Disability Amendment Bill in 2010 to help meet the many challenges faced by the public health and disability system. The Act provides the statutory framework for the National Health Board and DHBs to establish a more deliberate approach to ensure which services should be planned, funded and provided at the national, regional and local levels and put a much stronger emphasis on DHB collaboration to plan health services regionally.</p> <p>The changes in the Act and its regulations are designed to support better planning across the sector.</p> <p>The Long Term Health Sector Plan, once finalised by the National Health Board, will:</p> <ul style="list-style-type: none"> - outline the future direction for public health services - focus on service planning and new models of care - provide high-level direction over the next 20 years - describe the challenges the sector faces - options for models of care that offer solutions and implications for the way services are configured in the future - guide future decisions about service configuration and investment at all levels of the system - will support Northland DHB in their long term local and regional planning <p>The National Health Board will use the Long Term Health Sector Plan to inform their review of national, regional, and district plans.</p>		
5	<p>Further detail</p> <p>Further detail regarding the Northern Regional Health Plan is available on the website http://nshint02.healthcare.huarahi.health.govt.nz/nrhp/</p>		
6	<p>Appendices</p> <p>Appendix 1: Northern Region Health Service Plan : Summary of Intervention Logic</p>		

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COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE Paper

Date	16 February 2011
To	Community and Public Health Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denis.jury@adhb.govt.nz
Author	Ajit Arulambalam Planning & Funding Manager, Ext 26560 ajita@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	ADHB Funding for 2011/12
1	<p>Purpose</p> <p>This paper sets out a preliminary analysis of the funding for the 2011/12 financial year which has been allocated to ADHB by Government (Funding Envelope); and identifies implications for the provision of health and disability services for Auckland district residents as well as tertiary level service for the wider regional and national populations.</p> <p>Broad funding allocations are described and the Committee's review and guidance regarding these is sought.</p>
2	<p>Recommendations</p> <ul style="list-style-type: none"> • Note the Funding implications of the 2011/12 Funding Envelope. • Discuss and provide input to the planning assumptions that have been made on allocations across ADHB's hospital and specialist services as well as NGO and community sector. • Endorse the approach that has been recommended to manage the Government's requirement for additional elective service discharges. • Note the projected future increases required in elective volumes.
3	<p>ADHB Funding</p> <p>The Funding Envelope (FE) was received in December 2010 and ADHB received a total increase of \$43.6m, which is a 2.8% increase in the overall Funding Envelope for 2011/12 compared to the current year's funding</p> <p>The various Funding Envelope component figures are shown below, based on the MOH Advice that was received in December of the preceding years; and thus allowing a 'like for like' comparison. Over the year, there are usually some adjustments made on Inter District Flows and other items such as devolution of services and other national services, leading to ongoing revisions of the ADHB's Funding Envelope amount.</p> <p>The slight increase in funding is to cover, what the Funding Envelope terms as being contributions to cost and population growth pressures. In dollar terms, the 2011/12 'contribution' to cost pressure is \$15.7m and the contribution to demographics is \$10.3m; however, \$1.6m of this is specific for the funding of national services at ADHB for Auckland district residents. At this stage, the funding that is actually available to ADHB to allocate to services for its population approximates to \$947.3m which is the Population Based Funding (PBF) component of the Funding Envelope and is a \$24.4m (2.6%) increase over that provided in PBF for the current year.</p>

Funding Envelope Summary Changes from 2010/11 to 2011/12 (\$m)

FE Component	2010/11 (\$m)	2011/12 (\$m)	Change (\$m)	% FE Change
Funding for ADHB based services (Population Based Funding)	822.1	846.4	24.3	2.9%
Funding for services for Auckland population at other DHBs	100.8	100.9	0.1	0.1%
Funding for the provision of national services (Top-Slices)	38.3	39.9	1.6	4.2%
Funding from other DHBs for treating their residents (Inter District Flows)	582.9	600.5	17.6	3.0%
Total Revenue (\$m)	1,544.1	1,587.7	43.6	2.8%

**PBF
increase
2.6%**

ADHB's share of the additional funding that was made to DHBs to manage their demographics growth pressure is lower than its relative population because its resident population has been moving, on average, to a lower health need and reduced socio-economic disadvantaged position compared to other DHBs.

In the following sections, the funding estimates that have been made for 2011/12 are based on the most up to date information from MOH on the amount of funding, as well as on additional services, although not all the funding has been received yet.

The Funding Envelope, together with various national service priorities and local population demand, create implications for ADHB as follows:

- Direction to increase utilisation of community pharmaceuticals, which is estimated at an additional \$1m cost to ADHB above its normal population growth demand – due to a Government commitment given to increase spending on community pharmaceuticals. This excludes the flow-on cost of additional scripts which is paid directly by ADHB to pharmacies within the district.
- ARC growth – Government expectation is that price payments will be increased by 1.72%.
- PHO/Primary Care – rates for 'first contacts' are to be increased by 2%.
- Elective Services to be increased by at least 860 case weighted discharges (approximating an 8% increase in work; \$4.5m).
- Acute services – there is apparent demand over and above the population growth rate.
- MOH/National Health Board (NHB) have advised of a review of the <65 years Disability Support Services by MOH. For the 2011/12 year, NHB intends to adjust the inpatient volumes to reflect 'historical delivery' (rather than actual in 2010/11) as well as adjust the unit price. Early P&F estimates indicate that for ADHB, there will possibly be a revenue reduction of \$2m.
- Policy changes have been made to the payment of extra 'adjusters' for national specialist services traditionally provided at ADHB. For instance, there will no longer be a separate \$15m payment for national paediatric services (Starship); instead, this cost is now part of the overall ADHB adjuster pool allocation. At the same time, however, the national reference price for case weight discharge has been increased and the adjuster pool has been reduced by 33% from \$115m. Nationally, these changes are at a 'zero sum' and the decrease in adjuster pool funding and increase in case weight price will off-set each other; as long as the current system equilibrium is maintained. However, for ADHB which is a large recipient of Inter District Flows (IDF), the fiscal impact will be highly dependent on ensuring that current IDF patient flows are maintained over 2011/12.
- Mental health services have been funded at the 'ring-fence' expenditure requirement that has

	<p>been placed on ADHB (i.e.\$125m); despite the PBF share of funding received by ADHB for mental health being lower (at \$118m).</p> <ul style="list-style-type: none"> • There are also services which are provided to Auckland district residents by, and at, other DHBs; for which payment of \$100m has been forecast for 2011/12.
4	<p>Principles for the Allocation of Funding</p> <p>The overarching principles applied were:</p> <ul style="list-style-type: none"> • To maintain ADHB base services to meet acute demand. • To continue with improving on the 6 Health Targets and other MOH performance requirements. • To implement other Government initiatives and commitments, including the Minister's Letter of Expectations. <p>Accordingly:</p> <ul style="list-style-type: none"> • Budget cost levels for 2011/12 have been proposed to General Managers that will allow ADHB to remain within budget overall. The managers will be expected to manage their 2011/12 costs to within the targets whilst delivering the identified service volumes. • A 2011/12 Production Schedule has been prepared, in consultation with hospital services, for both case weight acute/elective service, and non-case DRG services. In this, hospital acute services will be increased at a growth rate to match the forecast production at 2010/11 <i>plus</i> the projected population growth over 2011/12. • Electives will be an overall 8% increase from current targets across a range of surgical procedures (joint, cataract and cardiac, as well as a 30% increase in Bariatric surgical volumes required by the NHB to 41 cases in 2011/12). Cardiothoracic electives will be set at population growth level only, because currently there is a low and acceptable waiting list and wait times, and any increase shifts resources away from other priorities. • Oncology volumes will be increased to reflect the impact of an anticipated radiation therapy intervention rates increase, due to the MOH 4 week target together with forecast increases in chemotherapy regimes (in line with PHARMAC forecasts). • NGO and other non-provider community services have undergone a prioritization review and subject to cost growth restraint. However, it is noted that services relating to community pharmaceuticals, Health of Older People and Primary Health Organizations are linked to national decision-making and legislative entitlement. • The management of cost and outputs across the health system will be a key accountability of the Health Services Groups (HSG).
5	<p>Funding Allocation and Indicative 2011/12 approach</p> <p>For 2011/12, the target cost levels were set by using the current year's budget costs and applying growth factors that accommodates likely volume and cost growth (the largest % increase is for payments being made due to the merger of PHOs and the shift of regional patient registers to ADHB as the single manager of the merged PHO).</p> <p>The resulting proposed allocations are identified below taking a Health System funding view based on HSGs, which includes both Inter District Flows as well as services in community settings and provided by Non Governmental Agencies.</p> <p>5.1 Service and Volume Change from 2010/11 to 2011/12</p> <p>Service volume targets for the Health Service Groups have been set, taking into account the following:</p> <ul style="list-style-type: none"> • Levels of acute growth, including the work from other DHBs. • Elective performance and management of any elective target increase. • Performance of referrals for specialist assessment – and link to the elective targets. • Performance of treatment follow-ups – and on the need to reduce activity in this area as ADHB

cannot continue to have increased follow ups at the expense of other treatments.

- Diagnostic procedures, e.g. access to scopes. This is an increasing area of growth and future demand needs to be carefully considered.
- Treatments and discharge – often patients start treatment which is ongoing, e.g. avastin; and careful consideration of how this will be managed.
- Support services, e.g. ongoing laboratory and radiology requirements. Is there appropriate capacity in these areas for the service to deliver as required?
- Known service changes –service shift(s) to another DHB, or alternatively new service innovation is underway.

Based on the above, detailed volume schedules were developed. The 2010/11 figure is the contract volume (as per funding and accountability agreement with the MOH); and is used here for comparative purpose.

The current year's service delivery was extrapolated for a full 12 months based on year-to-date volume production as at November 2010 month end.

Acute Case-weighted discharges

HSG	<i>For Auckland Population</i>			<i>For IDF Population</i>		
	2010/11 (CWD)	2011/12 (CWD)	Comment	2010/11 (CWD)	2011/12 (CWD)	Comment
Cancer	1,659	1,977	Oncology Volume inc.	3,499	3,654	Increase as agreed with other DHBs.
Cardiac	5,022	5,188	Volume inc to deliver on wait times & lists	8,401	8,734	
Children's	8,183	8,713	Projected demand inc.	12,999	13,265	
Women's	6,668	6,740	Population growth demand	2,662	2,723	
Adults	28,832	28,997	Includes Ophthalmology & ambulatory services	14,063	14,975	
Mental Health	n/a	n/a		n/a	n/a	
Total CWD	50,364	51,615		41,624	43,351	

Elective Case-weighted discharges

HSG	<i>For Auckland Population</i>			<i>For IDF Population</i>		
	2010/11 (CWD)	2011/12 (CWD)	Comment	2010/11 (CWD)	2011/12 (CWD)	Comment
Cancer	No CWD	No CWD		No CWD	No CWD	Increase as negotiated with other DHBs.
Cardiac	2,390	2,464	Mgt of waiting list	6,474	6,548	
Children's	619	658	Demand forecast	2,991	2,688	
Women's	1,357	1,417	Population growth demand	593	649	
Adults	10,720	11,406	High volume increase	8,043	8,332	
Mental Health	n/a	n/a		n/a	n/a	
Total CWD	15,086	15,945		18,101	18,217	

The above elective work includes the NHB's Health Target requirements.

Non case weight discharge services

HSGs also deliver services which are non case weight discharges and include specialist assessments, follow-ups, and programmes; within which a range of individual and group outpatient attendances and nurse-led clinics occur. These all have different counting methodologies and various reporting frameworks.

- FSA – First Specialist Assessments – the point of usual entry for patients who are referred from primary care or another specialist and or another DHB. This is considered key to the pipeline of delivering on elective discharges as well as giving confidence to referrers about access availability to ADHB services. More and more, with practice changes, minor and low level treatments are also being performed (e.g. skin lesions removal).
- FU – Follow Ups – typically, to monitor progress of a surgical intervention or medical course of medication. With the aging population and more chronic and long term disease management processes, particular patients are asked back periodically; again where ever feasible, this is being moved to primary care to allow continuity and local access.
- Programmes – encompasses a range of service activity, from screening programmes to nurse-led clinics.

For ease of illustration, the percentage change from the current year's annualized activity is summarized and shown below:

Non Case-weighted services (% change from 2010/11 to 2011/12)

HSG	Service Type	% Change ADHB	% Change IDF	Comments
Adults	FSA	6.7	7.0	Pipeline volume for 8% elective increases.
	FU	3.3	7.1	Proportionate increase for post treatment checks & monitoring.
	Programmes	9.5	-15.9	Increase for rehab; other DHBs will be providing local access & services.
Cancer	FSA	-3.0	49.9	Local decrease but within timeframes & other DHBs to increase in order to meet national timeframes.
	FU	-11.5	7.9	As above; locally, more liaison with primary care/GPs and use of virtual consultations.
	Programmes	41.5	25.1	Overall planned increase to meet national 4 week time frame for radiation therapy.
Cardiac	FSA	7.1	2.5	To continue local surgery throughput & demand growth.
	FU	-7.3	1.1	Overall service shift to virtual consultations.
	Programmes	6.9	14.9	Based on demand projections for rehab therapy.
Children's	FSA	-1.6	-5.3	Lowering need; but higher acute presentations (noted earlier).
	FU	8.5	-6.9	At ADHB, more ongoing monitoring for chronic illness; other DHBs intend to provide local access.
	Programmes	0.1	-25.9	As above.
Women's	FSA	3.7	13.8	Increase to meet projected demand.
	FU	-28.9	-34.2	Decrease due to 'first-time' treatments at FSA for low level interventions e.g. Mirena insertions, and use of primary care.
	Programmes	10.2	9.0	Current utilization projects growth upwards.
Operations	Programmes	11.1	13.6	Increase in theatre & diagnostic services in line with projected acute growth and elective/FSA growth.
	Total	8.1	-2.5	

It is likely that some of the proposed activity levels will be dependent on capacity and staffing. Thus, management decisions will be taken over the coming months on cost-effective ways of maintaining the necessary levels of activity.

NGOs and Other services in Community Settings

ADHB also funds a variety of community based services for the Auckland population, which are used by other DHB populations.

For Auckland population, there is a 2.9% increase, which is driven by government directed spending and growth in demand due to legislative entitlement. The larger 23% increase in IDF spend on NGOs is due to the estimated impact of patients from CMDHB and other DHBs who will be on the merged PHO being managed by ADHB.

NGO Services change from 2010/11 to 2011/12 (\$m)

	Auckland		IDF		Total	
	2010/11 (\$m)	2011/12 (\$m)	2010/11 (\$m)	2011/12 (\$m)	2010/11 (\$m)	2011/12 (\$m)
NGO Providers – 4% Increase for extended LOS in maternity services. Other providers have no cost or demographic growth	20.8	21.7	4.5	4.6	25.3	26.3
Community Pharmaceuticals – overall 6% increase based on Pharmac forecasts, new drug utilization and additional script fees	93.3	97.5	26.5	29.9	119.8	127.4
Mental Health – no cost or demographic growth has been factored in yet.	18.0	18.0	15.0	15.0	33.0	33.0
Health of Older People -	96.9	99.1	8.1	8.2	105.0	107.3
Community Labs - 6% for increase coverage/tests	22.0	23.0	52	55.4	74.0	78.4
Community Palliative Care - service change/development	3.8	4.0	0.2	0.2	4.0	4.2
Primary Health Organizations – six fold increase in IDF due to additional merged PHO register lists, & a directed 2% rise in 'first contact' rates	110.2	112.4	3.4	22.6	113.6	135
Total (\$m)	365.0	375.7	109.7	135.9	474.7	511.6

6 Elective service MOH target Volume Increase Management

6.1 Context

The MOH is implementing the Government's requirement for an additional 4,000 discharges per annum and has targeted the majority of the increases to ADHB and Waitemata DHB. Included in these discharges are specific surgical procedures, such as cataracts, joints, cardiac and bariatric surgery. ADHB currently funds these procedures and a range of other surgical and medical procedures on an elective basis (e.g. ophthalmology, ORL, urology and dermatology).

At 31 December 2010, ADHB was at 89% of its Health Target, approximately 600 cases behind the Health Target plan of 11,149 discharges. This target is a 14% increase over the volume achieved in 2009/10. ADHB is currently re-planning its discharges through to 30 June 2011 with outsourcing and new capacity becoming available; but achieving the Health Target for 2010/11 will nonetheless be a challenge.

For 2011/12, ADHB is required to further increase its elective volume by 864 discharges, 8%, over the 2010/11 Health Target. For 2011/12 therefore, the volume target is 12,013 discharges and this would place ADHB at around 94% of its 'equitable share' of the national target of 143,999 discharges (i.e. ADHB's equitable share is 12,830).

Thus in future years, in order to move to the equitable share of 12,830 discharges from the 2011/12 Health Target of 12,013 discharges, ADHB will need to increase its elective services by a further 817 discharges plus an ongoing portion of the annual 4,000 increase in discharges as its equitable share of the Government's objective (with ADHB's share estimated at being around 400 per

annum). It is possible that by 2014/15, ADHB will be required to deliver 14,000 discharges (a further 2,000 discharges or 17% increase over the 2011/12 requirement).

This level of increased elective discharges is in excess of the discharges contained in the business case for the GSU expansion when planning for the ADHB population. In addition, consideration of IDF flow increases at these levels (e.g. ADHB delivers 38% of Waitemata DHB elective discharges) will further multiply the capacity requirements.

Counting Electives

6.2 DHBs have different practices in terms of what is coded as an elective discharge. A recent MOH analysis advised that the national average is 8% of elective discharges for the removal of skin lesions and ophthalmology (avastin injections), while the rate at ADHB is recorded at 4% (with some DHBs having up to 15%). The lower rate at ADHB is because it, in adopting best practice, does not include avastin injections and a portion of skin cancers as inpatient procedures. In the current year, ADHB has also treated some 652 avastin and 454 skin cancers as outpatients. These are not part of the MOH count.

Thus, to bring ADHB within the national averages, 400-600 discharges relating to these procedures could be coded in 2011/12 to bring ADHB in line with other DHBs.

Currently, internal discussions are ongoing, regarding:

1. Negotiating with MOH, a lower Health Target and base volumes to recognise both the need to grow demand in a considered way and the persistent Population Based Funding skews that make increased investment in elective services, difficult, or
2. Negotiate a lower elective base so that additional elective revenue is not at risk should we not achieve the Health Target, and
3. Volume adjustments related to outpatient procedures.

7 Board consideration of these issues will be required at a later date.

Key Risks

Description of Risk	Mitigation
1. Production at higher volume levels may exceed marginal costs, particularly in resource-intensive services e.g. surgeries.	Careful budget control and productivity improvement.
2. Lead time(s) to develop appropriate capacity may delay delivery.	Service and pipeline capacity planning.
3. Un-budgeted high level of acutes.	Trade-off analysis and management with other services.
4. High growth in demand due to legislative entitlement and demographic growth (Aged residential care, ARC); and similarly health gain initiatives & extra funding for drug use by Government policy will increase ADHB spend on pharmaceuticals.	ARC – continue with Home-based support services development to relieve pressure on rest homes Pharmaceuticals – participate in national DHB/Pharmac initiatives (including closed control) to manage drug use and dispensing costs.
5. NGO sector has not had a cost or demographic adjustment for the current year and there are expectations of recognition by ADHB of the fiscal impact of cost and demand growth.	Close review on a case by case basis and link to demonstrable impact of cost or demand.
6. The current level of funding made available to ADHB may prove insufficient for the scope and scale of services that are demanded over the year.	Close management of cost of service and support of productivity improvement and cost containment strategies.
7. The impact of the primary care business cases and any subsequent devolution has yet to emerge.	Work closely with the primary care business case groups to identify and develop appropriate budget requirements.

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COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE

Paper

Date	16 February 2011
To	Community and Public Health Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denis.jury@adhb.govt.nz
Author	Tony O'Connor Ext 26765 tony.oconnor@adhb.govt.nz Julie Helean Ext 4390 julie.helean@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	2011-2012 Annual Plan and Statement of Intent
1	<p>Purpose</p> <p>Preliminary Annual Plan and planning issues and direction for CPHAC discussion and guidance for on-going development.</p>
2	<p>Recommendations</p> <p>It is recommended that the Committee;</p> <ol style="list-style-type: none"> 1. Note Ministerial, national and regional requirements of the 2011/12 Annual Plan. 2. Review and provide guidance regarding the ongoing development of the Annual Plan. 3. Note the timeline and process to completion of the plan and submission to the MOH.
3	<p>Planning context</p> <p>3.1 Minister's priorities and expectations</p> <p>The Ministers priorities and expectations determine much of the content in the ADHB's AP for 2011-12. The Minister's priority areas from 2010-11 continue into 2011-12:</p> <ul style="list-style-type: none"> • Shorter stays in Emergency Departments • Improved access to elective surgery • Shorter waits for cancer treatment • Increased immunisation • Better help for smokers to quit • Better diabetes and cardiovascular services <p>The Ministers letter of expectations states that strong priority is given to improving frontline services within available resources. More specifically:</p> <ul style="list-style-type: none"> • Improving service and reducing waiting times • Clinical Leadership • Services Closer to Home

	<ul style="list-style-type: none"> • Health of Older People • Regional Collaboration <p>All DHBs must provide specific action plans to clearly demonstrate how it effectively takes ownership of financial performance, including purchasing, productivity and quality improvements (including removing duplication and eliminating waste) and further reducing administrative overheads.</p> <p>3.2 Regional Context</p> <p>The Regional Health Plan sets the strategic context for the Annual Plan, as required by the national planning framework. The Northern Region Health Plan is discussed under agenda item 9.1.</p>
4	<p>Living within our means</p> <p>All services have been provided with Operating Cost Targets for there FY2012 Budgets which include an overall productivity improvement in the order of 3.0% over FY2011. Funder and Provider Services are due to provide first cut views of their Financial plans by 25 February. In addition Provider Arm services are prioritising their capital budget within an overall capital target of \$58.5m.</p>
5	<p>Maori Health</p> <p>ADHB and Te Runanga o Ngati Whatua (TRONW) signed a Memorandum of Understanding in 2001 in order to make a shared statement about how we will share information and decision making responsibilities to advance the health objectives of both parties. We will need to develop our relationship further to achieve this, and with regard to the Annual Plan a way of doing that is working with Te Kahupokere (the health office of TRONW) and the Ngati Whatua representatives on MHAC to develop a document that is signed by the Chair of the ADHB Board and the Chair of the Te Runanga o Ngati Whatua.</p> <p>The National Health Board requires DHBs to prepare a Maori Health Plan. A timetable for the development of the DHB's first Māori Health Plan will be confirmed over the next month. The Plan will focus on achieving Whanau Ora to reduce disparities between Māori and non-Māori and to improve the health of the Māori population in ADHB. The development of the Maori Health Plan and the Annual Plan will be done in parallel with Whanau Ora expected to be an ongoing component of future Annual Plans.</p>
6	<p>Health Service Groups</p> <p>The newly formed Health Service Groups will drive changes in specified areas of activity: cancer, child health, mental; health, adult services, and women's health. All Groups will be responsible for activity across the spectrum of care, from prevention through to palliative and rehabilitation.</p> <p>In addition to implementation of DAP initiatives work will be required to establish the Health Service Groups as functional units and the systems and processes to support their full participation in planning and development for the 2012-13 financial year.</p>
7	<p>Issues and Risks</p> <p>The key challenges will be ensuring that the Annual Plan reflects the regional agreements, specifically the regional health plan actions and the DHB's contributions to the GAIHN, AH+ and NMPHOC annual plans, while maintaining commitments to local priorities, all within the funding envelope, and we ensure that our timeframes allow for appropriate engagement with our Iwi partners.</p> <p>While DHBs are required to breakeven year on year with no changes to service coverage, there will need to be careful consideration of all contracts in the 2011-12 year to manage costs while not negatively impacting on health gain and patient experience.</p> <p>The usual practice of having various iterations of the planning documents reviewed by the Ministry will be replaced by one Annual Plan review period in March. This requires that the</p>

	<p>document (and all supplementary templates) be in final draft form in the first week of March.</p> <p>Although the Annual Plan is conforming to the National Health Board guidelines and template, the mapping of finances against the four output classes will be difficult. This is a new requirement which needs considerable analytical work.</p> <p>The timeframes for the Regional Health Plan makes incorporation of regional and local priorities and actions in an integrated way within the Annual Plan difficult. Ideally the Annual Plan would follow the strategic direction and focus within the Regional Health Plan, however this is yet to be confirmed.</p>																																															
8	<p>Draft Annual Plan Document</p> <p>Early draft Annual Plan will be circulated under separate cover prior to the meeting.</p>																																															
9	<p>Timeline and process</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Meeting</th> <th>Required</th> </tr> </thead> <tbody> <tr> <td>16 Feb</td> <td>CPHAC</td> <td> <ul style="list-style-type: none"> Review early draft of AP and provide guidance Note developing Regional Plan </td> </tr> <tr> <td>1 March</td> <td>Finance Committee</td> <td>Review budget and recommendations to Board</td> </tr> <tr> <td>2 March</td> <td>Board</td> <td> <ul style="list-style-type: none"> Approve budget Review any AP planning issues and appropriate Delegate authority to CPHAC to approve AP and SOI for submission to NHB on 25 March following Chair and CEO approval </td> </tr> <tr> <td>4 March</td> <td></td> <td>Budget and financial templates submitted to NHB</td> </tr> <tr> <td>16 March</td> <td>CPHAC</td> <td>Approve AP and SOI for submission to NHB</td> </tr> <tr> <td>25 March</td> <td>Chair and CEO</td> <td>Final approval and submission of AP to NHB</td> </tr> <tr> <td>5 April</td> <td>Finance Committee</td> <td></td> </tr> <tr> <td>6 April</td> <td>Board</td> <td></td> </tr> <tr> <td>20 April</td> <td></td> <td>NHB provides feedback to DHBs</td> </tr> <tr> <td></td> <td>CPHAC</td> <td>Discussion on any preliminary feedback</td> </tr> <tr> <td>3 May</td> <td>Finance Committee</td> <td></td> </tr> <tr> <td>4 May</td> <td>Board</td> <td>Approve sign-off process for final AP</td> </tr> <tr> <td>18 May</td> <td>CPHAC</td> <td>AP presented as final</td> </tr> <tr> <td>May (day tbc)</td> <td></td> <td>AP due at NHB</td> </tr> </tbody> </table>			Date	Meeting	Required	16 Feb	CPHAC	<ul style="list-style-type: none"> Review early draft of AP and provide guidance Note developing Regional Plan 	1 March	Finance Committee	Review budget and recommendations to Board	2 March	Board	<ul style="list-style-type: none"> Approve budget Review any AP planning issues and appropriate Delegate authority to CPHAC to approve AP and SOI for submission to NHB on 25 March following Chair and CEO approval 	4 March		Budget and financial templates submitted to NHB	16 March	CPHAC	Approve AP and SOI for submission to NHB	25 March	Chair and CEO	Final approval and submission of AP to NHB	5 April	Finance Committee		6 April	Board		20 April		NHB provides feedback to DHBs		CPHAC	Discussion on any preliminary feedback	3 May	Finance Committee		4 May	Board	Approve sign-off process for final AP	18 May	CPHAC	AP presented as final	May (day tbc)		AP due at NHB
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10	<p>Appendix</p> <p>One-page diagram linking the early draft Annual Plan's strategic direction and key areas of focus.</p>																																															

10

CONFIRM

10.1 Action Points for next CPHAC Meeting

10.2 CPHAC Feedback to Board

Use Forms at beginning of Meeting Pack

11

GENERAL BUSINESS

APPENDICES

12.1 Northern Region Health Service Plan: Summary of Intervention Logic

12.2 Draft ADHB Annual Plan 2011-2012

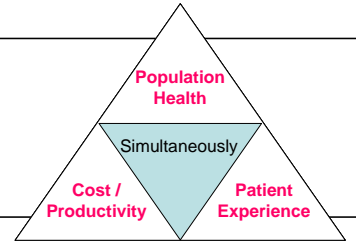
12.3 ADHB Annual Plan 2011-2012: Strategy and Key Focus Areas

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Northern Region Health Service⁹¹Plan (print to A3)

Our 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**



Our Region's Strategic Challenges

- Disparities in health status and health outcomes linked to ethnicity and socio-economic deprivation
- Demand for health care services, and particularly acute care, is predicted to exceed the level of health care resources
- The cost of providing publicly funded health services is growing at an unsustainable rate, influenced by demand pressures, new technologies and labour costs
- Delivery of care is fragmented between primary and secondary services and is based around an episodic model of care which does not work well for people with long term and complex conditions.
- There are substantial human and financial costs to our community associated with failures in health and disability services.

Our Strategic Goals

	1. Population Health: Lift Health Outcomes of Northern Region Population - Life and Years (Longer, healthier, more independent lives)	2. Patient Experience: Better Services; Aim for Zero Harm and Performance Improvement	3. Cost / Productivity: Ensure capacity to meet demand whilst living within our means
Objectives and expected outcomes	<p>1.1 Minimise impacts from diabetes and cardiovascular disease evidenced by</p> <ul style="list-style-type: none"> • Reduced incidence and impact of diabetes • Amelioration of disease symptoms and or delay in their onset • Support healthy behaviours to reduce the population rates of obesity <p>1.2 Improve quality of life for older people and their family / whanau, evidenced by :</p> <ul style="list-style-type: none"> • more older people able to age in the environment of their choice • Older people requiring support or care receive services appropriate to their needs <p>1.3 Improve quality of life for people with mental health and addiction problems and their family / whanau, evidenced by:</p> <ul style="list-style-type: none"> • Improved outcomes for people with enduring and or severe mental illness • Acute episodes are minimised, clients achieve greater stability in their condition <p>1.4 Healthier safer children evidenced by :</p> <ul style="list-style-type: none"> • Early identification and interventions with vulnerable children and their family / whanau • Healthier teeth and gums • reduce death and disability associated with diseases that can be prevented through immunisation • Lower incidence of communicable disease • More mothers and babies experiencing the benefits of breastfeeding • Access to antenatal and post natal health services and support to enable women to give their babies the best start in life • Healthier environments, lifestyles and communities <p>1.5 Minimise impacts from cancer evidenced by:</p> <ul style="list-style-type: none"> • Reduced incidence and impact of cancer; for curable cancers increased likelihood of survival; for incurable reduced severity of symptoms • Support healthy behaviours to reduce the population rates of sun exposure and smoking and to lower the prevalence of smoking related conditions 	<p>2.1 Improve quality of health care</p> <ul style="list-style-type: none"> • improved patient / client outcome • patients who are more satisfied with their care • people receive quality services from NGOs <p>2.2 Improve safety of health care</p> <ul style="list-style-type: none"> • fewer adverse clinical events resulting from patient care <p>2.3 Support an expanded range of services available in the community evidenced by</p> <ul style="list-style-type: none"> • More primary care; ambulatory rehabilitation and extended care services being provided outside of the Northern Regions Public hospitals • Improved primary / secondary / tertiary integration <p>2.4 Appropriate health and disability services are able to be accessed in a timely manner when needed</p> <ul style="list-style-type: none"> • Rapid access for patients with acute needs • elective services restore/ maintain peoples' functional independence 	<p>3.1 Regional resources are used effectively and services delivered efficiently with minimal wastage</p> <p>3.2 The health needs of the community have been anticipated with appropriate investment in workforce and staff mix</p> <p>3.3 Manage infrastructure and assets to ensure safe, efficient and effective services evident by</p> <ul style="list-style-type: none"> • Regional collaboration on capital asset planning • Delivering major infrastructure developments on time within budget <p>3.4 Work in partnership to effectively influence health and wellbeing outcomes evident by</p> <ul style="list-style-type: none"> • Improving involvement of internal and external partners in the planning and provision of health services <p>3.5 Invest in information systems and technology which will provide for : ... <i>what aspect do we put here ?</i></p>
High Level Measures (short, medium and long term)	<p>1.11 Reduce morbidity and mortality from Diabetes and Cardiovascular disease (including disparities between different population rates)</p> <p>1.12 Diabetics receiving annual free checks in Primary Care who have good blood sugar management</p> <p>1.13 Reduced incidence and prevalence of heart disease</p> <p>1.14 Improved CVD risk assessment</p> <p>1.21 Increased rates of 85+ able to live independently</p> <p>1.22 Change in distribution of home based support services towards older people with higher support needs</p> <p>1.23 Avoidable admissions from residential care to emergency departments</p> <p>1.31 Decrease in mental health and addiction problems</p> <p>1.32 Access rates to hospital based services of people with severe mental disorders</p> <p>1.33 Relapse prevention planning rates for those with enduring mental health conditions</p> <p>1.34 The number of new cases requiring intervention by specialist staff</p> <p>1.41 Decrease the rates of Ambulatory Sensitive Hospital (ASH) admissions for children</p> <p>1.42 Immunisation and vaccination rates</p> <p>1.43 Lower incidence of communicable childhood diseases</p> <p>1.44 Increase in breast feeding rates</p> <p>1.45 Referrals to health services from whanau in housing programmes</p> <p>1.51 For breast cancer, cervical cancer and major cancers: new cases; survival rates; mortality rates.</p> <p>1.52 Population smoking rate indicators</p> <p>1.53 Incidence of smoking related hospital admissions</p>	<p>2.11 Readmission to hospital</p> <p>2.12 Clinical measures of quality</p> <p>2.13 Patient experience; satisfaction and complaints measures</p> <p>2.14 Outpatient Did not attend (DNA) rates</p> <p>2.15 Compliance with contracts</p> <p>2.21 Rate of potentially avoidable hospitalisations</p> <p>2.31 number of IFHC's implemented</p> <p>2.32 rate of GP consultations for high need populations (of rate for non-high need populations)</p> <p>2.33 Increased numbers of Primary Options for Acute Care (POAC)</p> <p>2.41 Improved patient journey to and through EDs</p> <p>2.42 Standardised intervention rates for elective surgical services [S14]</p>	<p>3.11 Specialist DNA rates</p> <p>3.12 Elective and arranged DOSA</p> <p>3.13 Minimal delivery variation once good practice is identified</p> <p>3.21 <i>Which Workforce measures???</i></p> <p>3.31 Inpatient bed variance from predicted need by DHB</p> <p>3.32 DHBs achieve consensus on service delivery volumes by facility</p> <p>3.33 <i>???</i></p> <p>3.41 Clinicians engaged in development and management activities</p> <p>3.42 number of planned clinical networks successfully implemented established across Region</p> <p>3.42 Number of public/ private partnerships explored and converted to successful implementation</p> <p>3.51 <i>take from RISP/NISP</i></p>

Note : Indicative:
 • Objectives and outcomes
 • High level measures

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ADHB Annual Plan 2011 – 12 strategy and key areas of focus

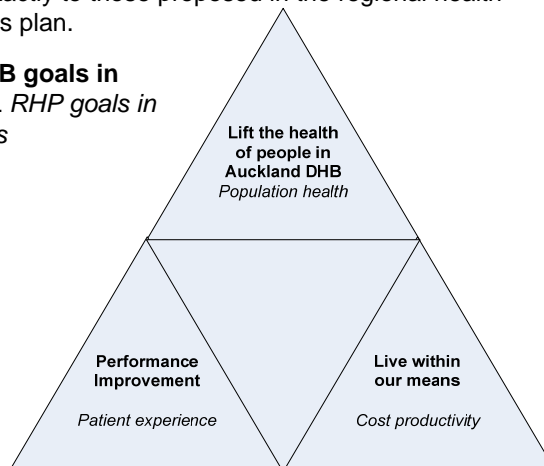
ADHB Vision:

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

Strategic Goals REFER MODULE 2 OF THE ANNUAL PLAN

It is proposed that ADHB continue to use the strategic goals that have been in place since 2005. They have worked well to balance health gain with patient experience and process improvement and financial management. The goals also map exactly to those proposed in the regional health services plan.

ADHB goals in bold. *RHP goals in italics*



Our DHB's Strategic Challenges – (which mirror the strategic challenges addressed by the Regional Plan)

- Meet the needs of the ADHB population, while meeting our regional and national obligations
- Demand for health care services is predicted to exceed the level of health care resources available
- Disparities in health status and health outcomes linked to ethnicity and socio-economic deprivation
- The cost of providing publicly funded health services is growing at an unsustainable rate, influenced by demand pressures, new technologies and labour costs
- Delivery of care is fragmented between primary and secondary services and is based around an episodic model of care which does not work well for people with long term and complex conditions.
- There are substantial human and financial costs to our community associated with failures in health and disability services.

Lift the health of people living in Auckland DHB

Performance Improvement

Living within our means

ADHB Objectives and expected outcomes
REFER TO MODULE 3 OF ANNUAL PLAN

Reduce inequities, priority populations
Maori and Pacific

Healthier, safer children

- Ministers immunisation targets met locally and regionally

Impacts from cancer, diabetes, &
cardiovascular disease are minimised

- Ministers target for hospitalised smokers provided with advice & help to quit met

Improved quality of life for people with
mental health and addiction problems
& their family / whanau

Improve quality of life for older people
and their family / whanau

Treaty partnership and inter-sectoral
collaboration

Operationalise the Health Excellence
Framework

- Clinical leadership
- Excellence in healthcare delivery
- Patient comes first
- Engaged workforce

Organisational development

- Operationalise the Health Service Group model

Development of primary care

- BSMC business cases

Improve primary-secondary integration

Improve quality and safety

- Minister's target for shorter stays in Emergency Department met
- Minister's target for Improved access to elective surgery met
- Minister's targets for cancer treatment met
- Minister's targets for CVD and diabetes services met

Partnership with Universities and private
health-sector providers

Breakeven position maintained

- Manage revenue
- Manage cost

Financial sustainability

Productivity improvement

Free up resource to invest in
healthcare improvements

- Regional collaboration

Elimination of waste and variation

NRHP Objectives and expected outcomes

Minimise impacts from diabetes and
cardiovascular disease evidenced by

Improve quality of life for older people
and their family / whanau

Improve quality of life for people with
mental health and addiction problems
and their family / whanau

Healthier safer children

Minimise impacts from cancer

Improve quality of health care

Improve safety of health care

Support an expanded range of services
available in the community

Appropriate health and disability
services are able to be accessed in a
timely manner when needed

Regional resources are used
effectively

The health needs of the community
have been anticipated with appropriate
investment in workforce and staff mix

Manage infrastructure and assets to
ensure safe, efficient and effective
services

Work in partnership to effectively
influence health and wellbeing
outcomes

All content early draft only

Community and Public Health Advisory Committee Agenda

MEETING DETAILS	
Time and Date	2:00 p.m. – 5:00 p.m. Wednesday, 16 February 2011
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre
Members	Dr Lee Mathias (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Lester Levy, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.
Apologies	
In Attendance	Garry Smith, Dr Denis Jury, Taima Campbell, Hilda Fa'asalele, Naida Glavish, Janice Mueller, Ian Bell.

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2	Attendance and Apologies	005
3	Conflicts of Interest	007
4	Confirmation of Minutes Wednesday 17 November 2010	017
5	Action Points Wednesday 17 November 2010	023
6	Planning and Funding Performance 6.1 Planning and Funding Summary Report 6.2 Planning and Funding Indicators List and Exception Report	027
7	Improvement Activities 7.1 DAP Projects Report	041
8	Feedback from Maori Health Advisory Committee and Pacific Health Advisory Committee	057
9	Papers 9.1 Northern Regional Health Plan 9.2 ADHB Funding 2011-12 9.3 Annual Plan and Statement of Intent 2011-2012	059
10	Confirm 10.1 Actions Points for next CPHAC Meeting 10.2 CPHAC Feedback to Board	083
11	General Business	085

Community and Public Health Advisory Committee Agenda

	Item	Page No
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NEXT MEETING		
	Date and Time: 2:00 p.m. – 5:00 p.m. Wednesday, 16 March 2011 Venue: Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre	

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