



Community and Public Health Advisory Committee Meeting

Wednesday 16 March 2011

2:00pm

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

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



Community and Public Health Advisory Committee

For discussion with Board

CPHAC Meeting Date:	
Feedback By:	
DAP	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
KPIs	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
RISKS	
RECOMMENDATIONS	
1.	
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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	Fee	Biotech start-up focussing on diagnostic products	
	5. John Seabrook Holdings Limited	Director	No fee	Estate of late husband	
		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	1. Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB	16 December 2010
	2. Hope Foundation	Board member	Nil	Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	
	3. Northern Region Ethics Committee	Member			
Gwen TEPANIA-PALMER	1. Waitemata District Health Board	Board member	Fee		2 February 2011
	2. Manaia PHO	Board member	Fee paid to NHHT		
	3. Ngati Hine Health Trust	Chair	Fee		
	4. Awanmarangi Waonangi	Committee member			
	5. Te TAitokerau Whanau Ora	Committee member			
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	Advisory Member		Development and implementation of a comprehensive social intervention logic for supporting families nationally	
		Executive member	Voluntary	Development of Auckland Safer	

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
	6. Communities Tamaki Achievement Pathways Schooling improvement	Chair	Voluntary	City plans Chair management committee for cluster of 13 schools in management improvement initiative	
	7. Tamaki College Board of Trustees	Elected Trustee	Fee	Disciplinary and property Committee	
	8. Tamaki Community Development Trust	Member	Voluntary	NGO delivering social services within the Tamaki area	
Farida SULTANA	1. Nil				6 August 2008
Lynda WILLIAMS	1. Maternity Services Consumer Council	Employee	Salary		4 August 2008
	2. Auckland Women's Health Council	Employee	Salary		
	3. Member National Antenatal HIV Screening Implementation Advisory Group				
	4. Chair Postnatal Distress Support Network Trust Board				
	5. ADHB Primary Maternity Services Steering Committee				

CONFIRMATION OF MINUTES
- WEDNESDAY 16 FEBRUARY 2011

Community and Public Health Advisory Committee Minutes

MEETING DETAILS											
Time and Date	2:00pm, Wednesday, 16 February 2011										
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom										
1	KARAKIA										
	The Chair declared the meeting open at 2:00pm and introductions were made. The Chair then lead the meeting with the Karakia.										
2	ATTENDANCE AND APOLOGIES										
	<p>Committee Members</p> <table> <tr> <td>Dr Lee Mathias (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Judith Bassett</td> <td>Susan Buckland</td> </tr> <tr> <td>Dr Chris Chambers</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Lester Levy</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td>Ian Ward</td> </tr> </table> <p>In Attendance</p> <p>Peter Tranter – Procure Lynda Williams</p> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Ajit Arulambalam - Planning and Funding Manager Taima Campbell – Executive Director Nursing Aroha Haggie – Maori Health Gains Manager Peter Lowry – Director Elective Performance Janice Mueller – Director Allied Health Dr Tony O’Connor – Consultation Manager Leannie O’Connor – Manager Planning and Funding, Pacific Health Dr Andrew Old – Public Health Physician Ian Bell – Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Peter Aitken, Hilda Fa’asalele and Naida Glavish. An apology for lateness had been received from Chris Chambers.</p>	Dr Lee Mathias (Chair)	Jo Agnew	Judith Bassett	Susan Buckland	Dr Chris Chambers	Rob Cooper	Dr Lester Levy	Robyn Northey	Gwen Tepania-Palmer	Ian Ward
Dr Lee Mathias (Chair)	Jo Agnew										
Judith Bassett	Susan Buckland										
Dr Chris Chambers	Rob Cooper										
Dr Lester Levy	Robyn Northey										
Gwen Tepania-Palmer	Ian Ward										
3	CONFLICTS OF INTEREST										
	There were no declarations of conflicts of interest with any item on the agenda. Robyn Northey advised that she was a member of the Northern Region Ethics Committee.										

4	CONFIRMATION OF MINUTES 17 NOVEMBER 2010
	<p><u>Moved Lee Mathias, seconded Susan Buckland</u></p> <p><i>That the minutes of the Community and Public Health Advisory Committee meeting held on 17 November 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
5	ACTION POINTS 17 NOVEMBER 2010
	<p>Children</p> <p>It was proposed to have strategic discussions with each Health Services Group (HSG). The Child Health Improvement Plan (2nd Edition) was being revised on a whole systems basis from which an implementation plan would follow</p> <p>Public Health</p> <p>Weight management is a national issue. The Committee had received a presentation from Dr Andrew Jull who was on the working group which developed the Obesity Treatment Guidelines. These guidelines had been signed off by the MoH. Current government policy was focused on education and self-management rather than regulation. There has been a reduction in public health promotion funding.</p> <p>The discussion focused on what was appropriate of treatment and care at ADHB level for weight management?</p>
6.1	Planning and Funding Summary Report
	<p>The Eating Disorders Service was operating with 9 residential beds and day programmes with this being the first time the service was delivered by an NGO. There were close links to the ADHB services.</p> <p>It was thought that immunisation data was held in practice registers but may not have been put on National Immunisation Register. The challenge was to access hard to reach populations with a suggestion that social media be used.</p> <p>The target should be 95% and the Maori Health Advisory Committee had this as an important target. The trend for Maori was upward.</p> <p>Access to diagnostics radiology programme was now confident that the 4,000 procedures target would be met counting Waitemata procedures currently in a separate pathway. Counties Manukau would be rolling out the Procure tool developing processes in practices. Savings in the pharmaceutical project should cover costs.</p> <p>Chris Chambers joined the meeting at 2:30pm.</p> <p>POAC is Primary Options for Acute Care being a programme designed to take some of the acute load.</p> <p>The after hours care project was addressing the historically patchy service between the hours of 5pm and 10pm and 10pm to 7am with a number of different services such as telephone triage, two separate contracts with White Cross and White Cross at Ascot being open over night. However, as these services are based on a business model using casual workforce cost to the patient and the DHB is high.. Counties Manukau use their ED. The project sought to have a more systemised service with consistency of charges and to get coordination of services and linkages based on the principle that there was no more money but funding could be redistributed.</p> <p>The approach is to have a network of 10 clinics regionally distributed through a tender process. Another issue was that between 12pm and 8am there were low numbers and this group of patients tended to be transferred to hospital. While there was a responsibility in the national contract for general practitioners to provide a service there is no funding in the capitation funding. The Clinical Director of ED was supportive of using ED at a fraction of the cost of that paid for after hours</p>

	<p>services. The economies of scale will help to resource ED. A regional approach was being taken.</p> <p>InterRAI was a national programme to get consistency of assessment for residential care. It is hosted by Canterbury with funds contributed by DHBs and MoH.</p> <p>Engagement with Auckland Council was through Local Boards as well as the CEO being on an inter-sectorial group including the Council. There was involvement with spatial planning which included advice on the location of health services in relation where populations were going to grow.. This includes any other advice on health issues. There were good contacts with the Local Boards for input to their plans. The spatial plan was at a high level covering population growth, transport corridors etc. with detail more in the Local Board plans. ADHB did make submissions to the Auckland Council Annual Plan.</p> <p>It was noted the Waitemata and Counties Manukau are devolving health services for Maori currently provided by the DHB. These are to be advised to the Chair of the Maori Health Advisory Committee.</p> <p>The Ministry of Social Development had a Community Link project to have more shared agencies working together. Their frontline staff had been trained in smoking advice. Community nurses could link back to the other agencies and take a Whanau Ora approach.</p> <p><u>Moved Jo Agnew; seconded Susan Buckland</u></p> <p><i>That the Planning and Funding Summary Report be received.</i></p> <p><u>Carried</u></p>
6.2	Planning and Funding Indicators Exception Report
	<p>There were a number of NGO providers with outstanding audit issues. The Committee considered that the question of cancelling contracts was a judgment issue. Legal advice was that this could probably not be done. The Committee supported the process and pathway to improvement with clear goals and supported a firm line based on patient safety with the corrective pathways to be well documented.</p> <p>The Planning and Funding Indicators Exception report was received.</p>
7.1	DAP Projects Report
	<p>For Goals 1 and 2 satisfactory progress was being made although there were delays in three projects.</p> <p>Retinal screening in the community was being established, despite some resistance from the internal service. The Board has approved the software and an agreement has been made with Auckland Eye Clinic for the service to be supplied through a network of optometrists. With the current service there is high Did Not Attends (DNA) for Maori and Pacific. The Counties Manukau provider had lower DNA. Care pathways have been delayed by the PHO changes in primary care. This has also affected devolution.</p> <p>Baby Friendly Community Initiative was a WHO initiative endorsed by the MoH. The Committee is committed to achieving high breast feeding rates as it was based on good science.</p> <p>The DAP Projects report was received.</p>
8	FEEDBACK FROM MAORI HEALTH ADVISORY COMMITTEE
	<p>The Maori Health Advisory Committee had discussed immunisation and the regional future with the combining of resources. This will be subject to another meeting. The Committee had received a presentation from GAIHN. It was of note that they had not addressed it to Maori in particular. The comment was made that to find progress for Maori was also difficult within the ADHB papers.</p>
9.1	Northern Regional Health Plan
9.2	ADHB Funding 2011-2012
9.3	Annual Plan and Statement of Intent 2011-2012

	<p>The papers were all linked and were considered together. Margaret Wilsher was the sponsor of the Northern Regional Health Plan which had three high level goals with a focus on the national health indicators and disparities. There were a number of objectives for diabetes, CVD, older people, child health and the patient's experience based on "do no harm".</p> <p>Production looked at grouping regional services and shared services. The National Health Board's national services plan was not out yet so the regional plan has to be done so it is based on best knowledge. The Board's strategic directions would be fed into the process. The principles of Whanau Ora need to be woven into the plans. Whanau Ora governance wanted local delivery as far as possible using the existing capacity within the state sector. The plan needed a contextual statement, mindful of the aspirations of Whanau Ora, and measurements over time.</p> <p>The Annual Plan had been circulated and would come to the next CPHAC for signoff. It was suggested that in the next version track changes be used. The Summary of Key Developments was discussed with a need to include electives and ED as areas of focus on performance. As noted Whanau Ora should be woven into the document.</p> <p>Acquiring shares with the change in Shared Services was discussed and it was suggested that the vulnerable services be listed. \$5m for process improvements and innovation was identified in the budget</p> <p>The three reports were received.</p>
10.1	Actions Points for next CPHAC Meeting
	<p>The final DAP would go to the next meeting for signoff. Actions carried forward were the strategy for children and the question of what could be done for weight management at DHB level.</p>
10.2	CPHAC Feedback to Board
	<p>There were no recommendations to the Board.</p>
11	GENERAL BUSINESS
	<p>There were no items of General Business.</p> <p>The Chair noted the need for the Board's strategic framework and the aim of increasing value to the population and the need to be looking outwards by the organisation following the Better Sooner More Convenient strategic view to underpin decisions.</p> <p>Targets are serious and ADHB should strive to be a centre of excellence.</p>
	NEXT MEETING
	<p>The meeting closed at 5:04 pm</p> <p>The next scheduled meeting is for 2:00pm, Wednesday, 16 March 2011 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Epsom</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	

ACTION POINTS

- WEDNESDAY 16 FEBRUARY 2011

**Community and Public Health Advisory Committee
Action Points from the meeting on Wednesday 16 February 2011**

Item	Detail	Designated	Action
Carried forward	A paper on strategies for children to be provided	Denis Jury	Early 2011
Carried forward	DHB level options for weight management	Denis Jury	Carry Forward
6.1	The Waitemata and Counties Manukau are devolving health services for Maori currently provided by the DHB and these are to be advised to the Chair of the Maori Health Advisory Committee.	Denis Jury	Done
9.3	That in the next version of the Annual Plan track changes be used.	Denis Jury	This was attempted, but the changes were of such significance that the document became difficult to read. Track changes will be used from the version considered in this agenda.

PLANNING AND FUNDING PERFORMANCE

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

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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 has been developed in accord with the NHB template. This covers Auckland DHB priority activities confirmed for the 2011-12 year that will meet national, regional and local objectives.

Feedback received from the February meeting of CPHAC has been incorporated. A further draft of this work is being submitted to CPHAC to approve prior to the handover date, 25th March. All financial material was submitted to the NHB on 4th March as required.

Auckland DHB is in close connect with planners from the other DHBs in the region to ensure that our work is closely aligned. We are treating 2011-12 as a transition year in terms of regional work and hope to demonstrate more regional activity when the Northern Region Health Plan is finalised and approved.

At the operational level, each Health Service Group (HSG) will develop a service plan. These business plans will outline the specific actions and accountabilities for the 2011-12 year within that HSG and cover a much wider range of activity than the Annual Plan.

Mental Health

Alternative to Admissions

This project is underway. Suitable premises have now been found in Mount Roskill. The service is now operational with a phased implementation taking it to full operation in April 2011. It is anticipated that the interim service in Hillsborough will be closed at the end of March.

Muslim Mental Health

This project continues to operate successfully, led by Affinity Services. The project worker at Affinity has met with all local mosques and Imams. Regular liaison with the Trans-cultural team at the provider arm takes place.

The project report will be ready in March 2011, and a more academic paper is being prepared for publication towards the middle of this year. Initial project outcomes were presented at the March Network North Coalition meeting for the region; there was significant regional interest and further updates have been requested to assist with possible replication.

Improving Access for the LGBT Community

We have started a project which is similar in scope to the Muslim Mental Health project in that it seeks to improve access to general mental health services for a vulnerable group.

Research indicates that the lesbian, gay, bisexual, and transgendered (LGBT) community have higher levels of alcohol and other drug use, as well as mental health problems; likely caused by societal stigmatising.

This project will undertake a stock take of current best practice in Auckland, review the international literature, interview consumers, and develop an effective model of support to improve access to services.

The project will report in October 2011. The project was presented at Network North Coalition meeting in March with much regional interest and a request to report on progress to the region.

Online therapy

Work is being done to finalise the roll-out of this national programme. We anticipate being invited to participate in April 2011. PHO's have been advised and expressed some interest and some concern about the potential for additional costs.

Links between mental health and primary care have been established in planning and funding.

Child Health

Immunisation

Provisional data as at 1 March shows a slight increase in coverage at age 2 years to 88% for all ethnicities (Maori 75%, Pacific 89%, NZE 87%, Asian 91% and Other 87%). Although it can't be confirmed, the increase probably reflects additional immunisation data entered on the National Immunisation Register (NIR) as a result of the early stages of implementation of the primary care data quality improvement project. Indications are that the next 2 months should see further increase as a result of this project. Maori coverage rates remain a concern particularly at 6 months (59%) and 18 months (69%). An audit is currently being undertaken of the data on Maori children not fully immunised who turn 2 years in the quarter to see if any patterns can be identified in order to inform strategies to address the low rates. As at 1 March there were 47 Maori 2 year old children in ADHB who were not fully immunised.

Auckland Social Sector Leaders Group: Immunisation

This multi-sector programme is progressing well with all stakeholders well engaged. A number of government agencies have agreed to identify an 'Immunisation Champion' and a role description has been completed. Actions planned over the next period include holding a meeting with all of the nominated contact people or Champions and organising education for them about immunisation as well as a Frequently Asked Questions document.

Primary Care

Regional Progress to Date:

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

- **Contracting Framework**

Payments have continued to PHOs under the contracting arrangements as planned.

- **Business Cases**

Active involvement continues to support the three Business Cases in development and rollout of their respective Implementation Plans. There is however, a perception amongst some PHOs that the DHBs are not supporting GAIHN. This relates to issues around funding, and is currently being worked through with the GAIHN ALT.

- **Progress with PHO Consolidation**

The National Maori Coalition has advised that they wish to form into a single PHO. This will need to be carefully worked through, particularly from WDHBs perspective where there is a clear policy of contracting with two PHOs only.

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

The second meeting occurred in February of the four ADHB PHOs and they continue to work toward developing a District Alliance. It is anticipated that this alliance will operationalise primary care initiatives for ADHB and in the meeting they discussed potential work areas for the coming year.

The membership of the District Alliance, and its terms and conditions were finalised at its February meeting. 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 Regional Annual Plan projects

Access to Diagnostics-Radiology

As noted previously this project is behind target on the basis of increases in primary accessed radiology procedures year to date but remedial activity is being put in place and we have a degree of confidence that the targets will now be met with the contribution of increasing volumes from CMDHB and WDHB. Catch up volumes are anticipated during March – May.

Agreement has been reached regarding the inclusion of radiology in the regional e-referrals and in the meantime ProCare is customizing some aspects of ProExtra to meet CMDHB requirements as an interim solution until the proposed e-referrals “radiology” is completed for implementation in primary care. WDHB is taking part in the analysis but has reserved its decision regarding the use of ProExtra. However increased volumes through their present system of triage for radiology can be validly counted as part of the target.

Minor Surgery - Skin Lesions

Provider selection across the region has now been completed and contracts are currently being prepared for the successful respondents. This project is now proceeding to plan and there is confidence that the target will be met.

Regional Clinical Pathways

All five pathways will be fully developed and implementable by 30.06.11 as required by the Annual Plan target. However, there was an additional target that there would be a reduction in FSA for Dyspepsia of 30% which is unlikely to be met but there will be a reduction of FSA of 20% across all of the pathways being developed.

Acute Demand / POAC

This project is tracking to plan and there is confidence that the target will be met. There are however some risks, particularly associated with a tender process and the likely number of respondents and the ability to achieve efficiencies compared to the present price. These are being mitigated through the design of the RFP process.

After Hours

Project is currently tracking to plan but there are a number of risks which need to be managed. In particular the design of the process to manage the conflicts of the various parties who have been involved in this project and the public law requirements will be critical. In addition, the provision of out of hour's services has a high public profile.

Pharmaceuticals CMDHB & ADHB Project

Delays occurred due to the inability to recruit suitable staff -these have now been resolved. Although delayed there is confidence that the establishment costs will be recovered (\$600k) and further analysis is being undertaken to determine the return above this.

Maori Service Development

These projects have progressed more slowly than anticipated and while the original target of 31.12.10 will not be met CDHB and WDHB are working toward completion by financial year end.

Health Targets – CVD & Diabetes, and Immunisation

Key Deliverable: Accelerate progress to meet the national health targets by shifting from DHB specific targets to regional targets

Progress against these targets is reported by DHB as part of each quarter report, see links on the NSFL.

Initiative	Regional Volumes		Target to end June 2011
	Month	YTD	
Acute Demand / POAC (Cases)	1,307	10,526	15,000
Access to Diagnostics / Radiology			
DAP Target 1 (Referrals by GPs to non DHB Providers)	49	127	4,500
DAP Target 2 (Referrals by GPs to DHB Provider)	1,062	10,868	16,000+
Skin Lesions (Community based procedures)	65	374	1,200
National Targets			
• Immunisation	• 87%		• 90%
• Diabetes Detection	• 45%		• 55%
• Diabetes Management	• 62%		• 70%
• CVD Risk Assessment	• 80%		• 80%

2. Performance Improvement

Community Pharmacy

Several proposals are out for consultation in the sector currently and include those that impact on the national contracting process as well as PHARMAC's Exceptional Circumstances Policy review. These close on 25 March 2011. There is a regional submission being developed to respond to this.

Oral Health

The key activity in the oral health portfolio is the implementation of the Child and Adolescent Oral Health Business Case (OHBC).

Mobile Dental Units

Three level one diagnostic mobile dental units have been commissioned and are currently being utilised for service provision by ARDS. The next level one diagnostic mobile dental unit is due for delivery in May 2011.

The level two treatment unit has been further deferred to allow time for the Project Team to investigate the options available in the Orakei area.

Fixed clinics

The Oral Health Business Case planned a total of thirteen new clinics consisting of one existing clinic refurbishment and twelve new fixed clinics to be completed by mid-2012.

Five new clinics are underway ('phase one') and planning has begun for the next five.

Progress to date of the phase one clinics is as follows:

1. **Sylvia Park (2 Chair Clinic)** – Service provision is underway in this clinic.
2. **Pt England (4 Chair Clinic)** – Service provision is underway in this clinic
3. **Otahuhu (3 Chair Clinic)** –Furniture and equipment has been moved in and the clinic has started seeing patients. Arrangements for the formal opening are being organised with the school.
4. **Stonefields (3 Chair Clinic)** – Furniture and equipment has been moved in and the clinic has started seeing patients. The formal opening of this clinic to be organised.
5. **Balmoral (2 Chair Clinic)** – Construction is currently one week behind schedule and there has been a delay in the delivery of a fire door. The dawn building blessing is due to be held in early March.

Progress on the phase two clinics is as follows:

1. **Avondale Intermediate (3 Chair Clinic)** –The dawn site blessing for this clinic has been tentatively scheduled for 11 March.
2. **Royal Oak Intermediate (3 Chair Clinic)** – The consultants are currently completing consent and OPW documentation for lodgement with Council. Lease documentation has been signed and returned by the school for ADHB to sign. The documentation for re-pricing has been issued and closes on 7 March.
3. **Wesley Intermediate School (2 Chair Clinic)** – Consultants have completed site surveys and are preparing documentation for OPW

and building consent lodgement. Lease document has been signed by ADHB and will be delivered to the school for signing.

4. **Blockhouse Bay Intermediate (3 Chair Clinic)** – Babbage Consultants are currently producing consent and construction documents for lodgement with Council. Lease document has been signed by ADHB and will be delivered to the school for signing.
5. **Ponsonby Intermediate School (3 Chair Clinic)** - Babbage Consultants have updated their drawings based on the new site and have completed the lease plan. Lease document has been signed by ADHB and will be delivered to the school for signing.

Progress on the phase three clinics is as follows:

1. **Orakei Primary School (2 Chair Clinic)** - This site is the alternative to a level 2 mobile unit. Possible site for a 2 chair light clinic at the alternative vehicle entry appears feasible. Discussions with the school and the Ministry of Education are being held to try and get some decisions on the wider issues facing the school, so that they can then confirm viability of the clinic.
2. **Mt Roskill Primary School (4 Chair Clinic)** - Possible road frontage site discussed with school principal but also needs to be discussed with the principals of the other three schools to look at all the options on the total site.
3. **Auckland Normal Intermediate (3 Chair Clinic)** - Refurbishment and extension considered possible
4. **Waiheke Island (1 Chair Clinic)** - Refurbishment and renovations of the existing clinic is possible. A plan for this clinic has been submitted to the Ministry of Health for approval

Service Level Agreement with ARDS

Auckland DHB and Waitemata DHB (the provider) continue to discuss the Service Level Agreement. While it was hoped that this would be signed off by both parties by the end of last year, there are still some minor operational matters and responsibilities to be resolved. The DHBs are working together to resolve these and it now envisaged that the updated Service Level Agreement will be completed in quarter three.

Snug Homes

Since 2005/06 ADHB has been providing funding of \$50,000 p.a. to this multi-sector supported housing insulation and retro-fitting programme. Free insulation has been provided to low income families with priority given to families of children who have received treatment at Starship Children's Health Service for respiratory illness. This is supported by good evidence about the link between dry, warm housing and respiratory illness particularly in children. The major funders of the programme have been the Energy Efficiency and Conservation Authority (EECA) and the ASB Communities Trust. Others have included the then Auckland City Council and the Starship Foundation.

It is likely that the ASB Communities Trust will cease funding the programme in 2011/12 and unless a new major funder is found this programme is at risk.

Fertility Services

It has been decided that the regional contract managed by WDHB with Fertility Associates for provision of fertility services will go to tender. It has been

regionally decided to retain the public provider and consequently the services provided by ADHB's Fertility Plus will not be included in the tender.

3. Live Within Our Means

Progress with PHO Consolidation

There continues to be movement in the PHO sector with Total Healthcare Otago PHO's practices (a CMDHB PHO) joining Te Hononga PHO for the next quarter and HealthWest PHO joining ProCare. These moves will be verified on 1 April 2011.

Month's Funding Issues

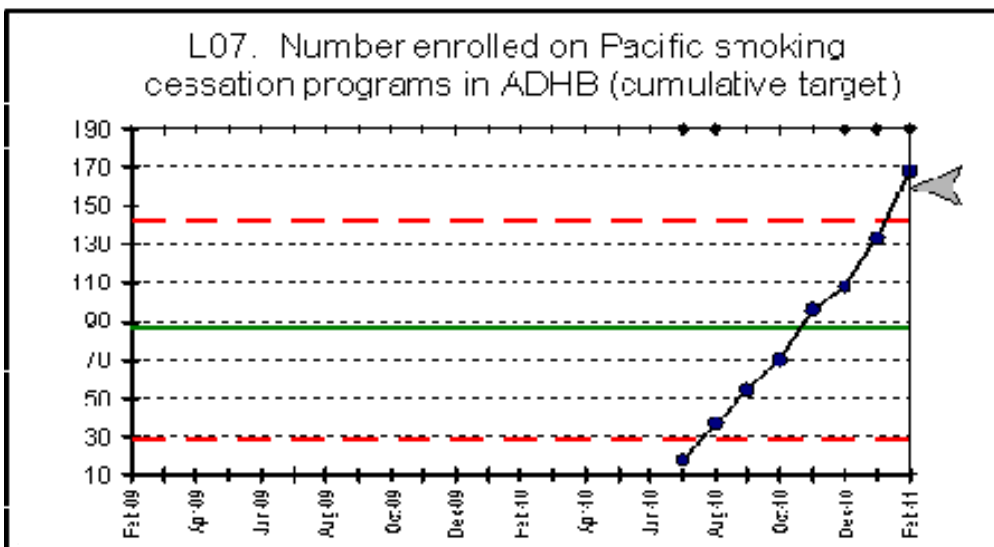
A verbal update on any developing funding issues will be given.

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February 2011

Exceptions this month

L07. The target for the 8 month mark has been exceeded. To date, 168 clients have enrolled with the programme. The July 10 to February 11 target is 160. December 10 and January 11 figures show a steady increase of new clients enrolled with the programme, however an intense effort in February 11 resulted in the enrolment of 35 new clients. This increase was due in part to an intense promotion and marketing of the service amongst networks, collaboration with PHO Smoke free coordinators and proactively visiting GP practices. Strengthening relationship with hospital Smoke free coordinators and churches is planned for the next few months as a means to increase clients numbers.



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Project: Diabetes

45

Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

Date of Delivery: 55% June 2011

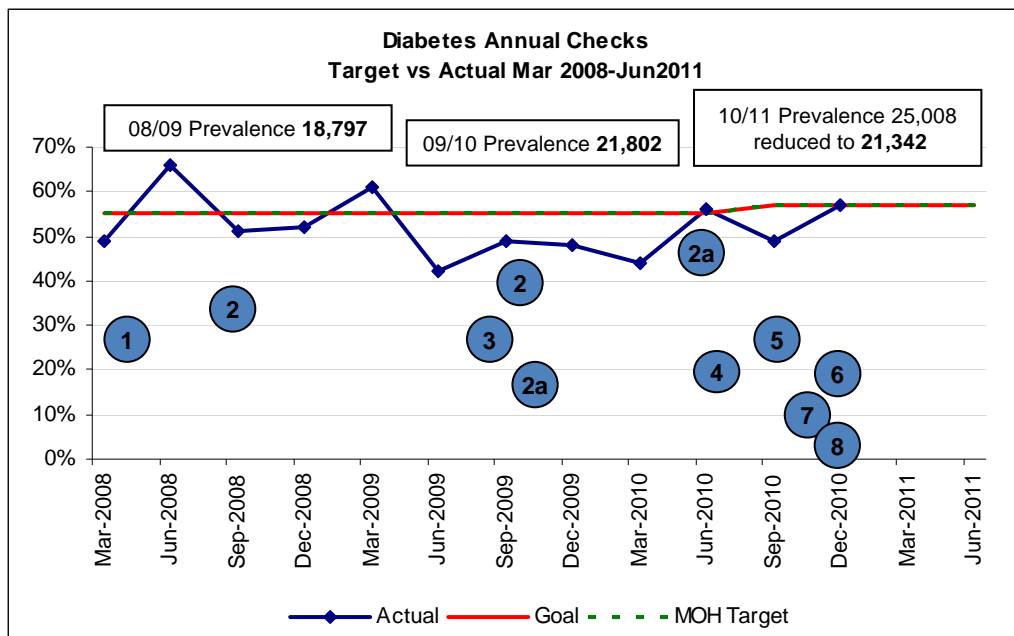
Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team

Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
- 2) Practise based data (results) feedback
- 2a) Increase other feedback options
- 3) Improved understanding of IT linkages in Practice systems
- 4) Paper from the Auckland Diabetes Advisory Team to CPHAC requesting funding to implement improvements in diabetes care and management that will impact on National Health Targets.
- 5) Routine reports to clinical advisory leadership meetings
- 6) CPHAC initiatives for long term conditions quality improvement coordinators and population audit tool beginning to be implemented.
- 7) Regional shared care pathway work
- 8) Regional shared target setting and service outcomes



Project Risks / Comments:

Q2 shows we are now meeting target for DGC, however this is primarily due to the MOH decreasing the denominator for the expected number of people with diabetes. The number of Diabetes Annual Reviews for the Pacific and Indian populations are performing over 20% above target, with reviews for Maori now also above target under the revised prevalence. However, the performance for the Other group continues to underperform against target (42% against a target of 58%). In order to improve performance, the DHB is working with primary care to implement a comprehensive range of activities to improve DGC numbers and initiate an overall quality improvement framework. One initiative is a contract with the PHO's (through Auckland PHO) to employ long term condition quality improvement coordinators to work with all our priority practices to improve get checked performance. The first two coordinators start in February 2011. Another initiative is the funding of a Population audit tool for each practice to enable them to better interrogate their practice management system to identify and manage their population with long term conditions. This contract will be signed shortly. [Please note that the activity from Tongan Health Society has been estimated due to their data not being received in time for this report].

Project: Diabetes

46

Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

Date of Delivery: 79% of people with diabetes will have a HbA1c \leq 8%

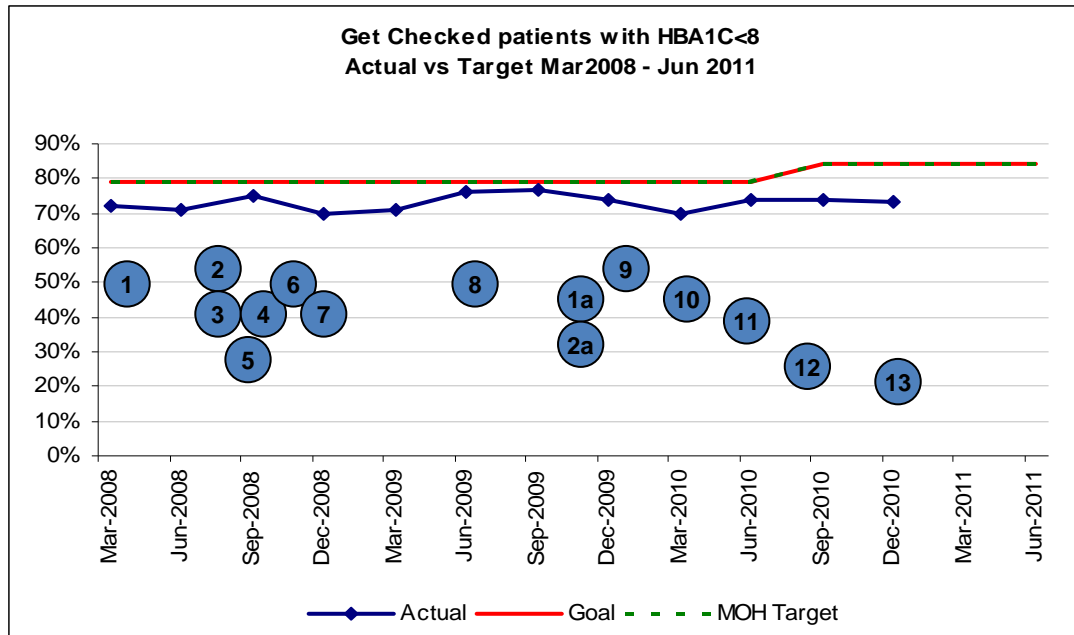
Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team

Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
- 1a) reinforce awareness
- 2) Practise based data (results) feedback via various mediums including Health point
- 2a) increase feedback processes
- 3) Direct Secondary Service phone support for GPs
- 4) Increased community shared clinics with secondary care
- 5) Increased SEAsian Nurse Specialist access
- 6) Widened opportunity for self management to include greater than 2 year or less diagnosed people with diabetes
- 7) Improved culturally appropriate self management courses
- 8) Improved understanding of IT linkages in Practice systems (linking PPP)
- 9) Auckland Diabetes Advisory Team – structured agreed district plan of action
- 10) Redesign the supported self management to meet needs of population
- 11) Developing shared care pathway for Diabetes
- 12) Regional shared care pathway work including clinical workshop
- 13) Implementation plan being developed for diabetes coordinators (quality improvement roles) and population audit tools for each practice.



Project Risks / Comments:

Q2 of 2010/11 performance continues in the same trend as the previous quarter, and we have only achieved 73% against a target of 84% of people having an HbA1C $<$ 8. The main areas of underperformance are in our diabetic management of Maori and Pacific populations. As noted in the DGC report, the activities currently being put in place to improve the DGC targets should impact on management in the long term. Additionally a new contract is being signed with Te Hononga O Tamaki Me Hoturoa to provide Diabetes Self Management Education for the ADHB region. With their focus on providing to our high needs populations, we look to see improvement in the self management capacity of our high needs populations with diabetes.

Project: Cardiovascular Risk Assessment

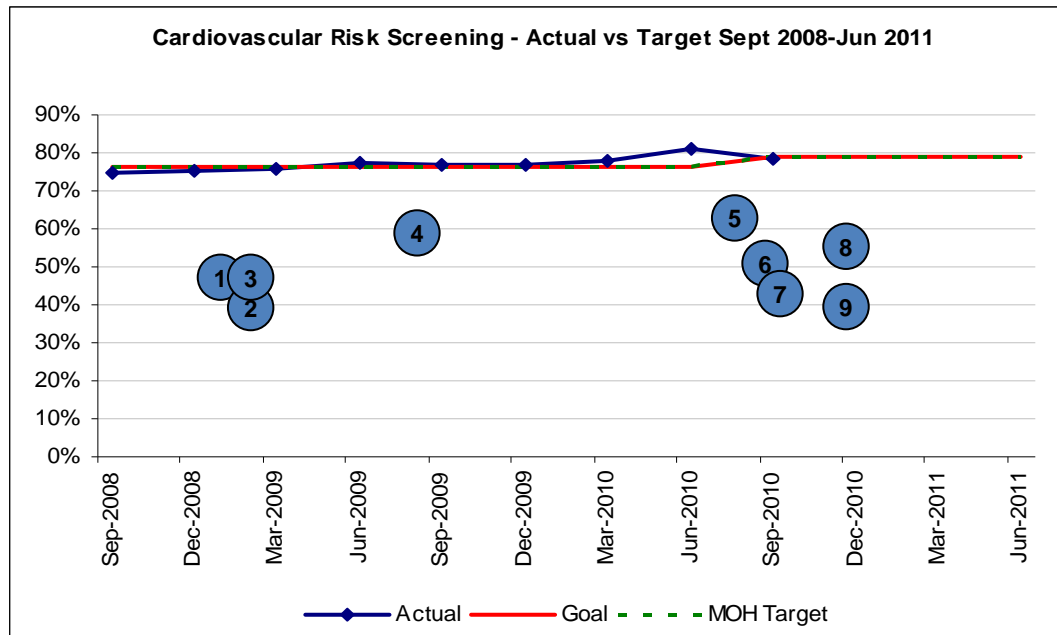
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

Date of Delivery: Overall goal is to have 80% of eligible population CVD risk assessed every five years.

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team



Project Risks / Comments:

Q2 CVD data is not available from the MOH until February 2011. However the previous quarter showed that we are very close to reaching our overall target (78.5% against a target of 79%).

We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract.

Recent and Current activities:

- 1) Support the uptake of an electronic CVD tool
- 2) Training and information system support for electronic tool
- 3) IT help line for GPs for risk assessment tool
- 4) Increase the cumulative incentive payments for achieving both good assessment and good management together
- 5) Review and reshape incentives to link with PPP targets
- 6) Enhance links to Green Rx and maximise primary care uptake
- 7) Continue to work in various workplaces to enhance CVD risk assessment for men
- 8) Link in with research looking at ways to optimise Pacific males participation in health self management
- 9) Work regionally to have similar focus on incentive goals

Project: Increased Immunisation

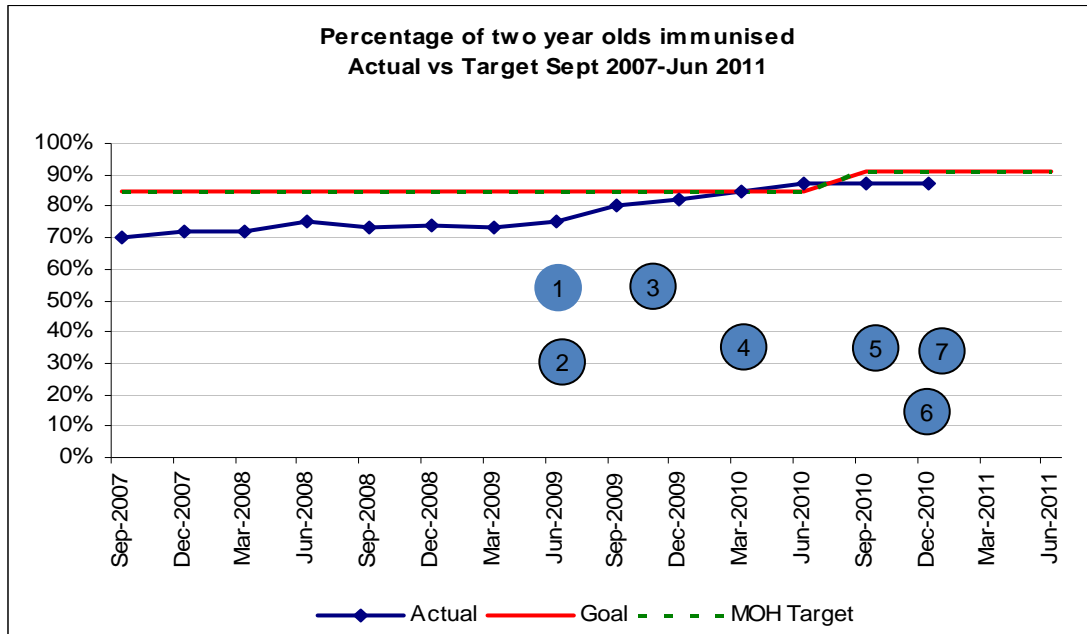
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

Date of Delivery: 1 July 2010, 1 July 2011 and 1 July 2012

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

Steering Group: Richard Aickin, Carol Stott, Aroha Haggie, Hilda Faasalele, Ruth Bijl, Alison Leversha, IMAC, Auckland PHO, Public Health, Plunket, Commissioner for Children Office, Ministry of Health



Current activities

1. Practice level reporting available
2. Primary care Immunisation Co-ordinators funded - ongoing
3. ADHB Immunisation Strategy approved
4. Funding application made to Starship Foundation to fund social marketing programme
5. Data cleansing project in primary care approved and funded
6. Scoping project for multi-agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices begins with final results expected by June 2011.

Project Risks / Comments:

Coverage for Quarter 2, 2010/11 (2 years olds full immunised all ethnicities) remains at 87%. The data quality and practice nurse education project targeting systems issues has just began and is expected to result in increased coverage. Maori coverage at all milestone ages remains a challenge as does timeliness, in particular at 6 and 18 months. Opportunities to further engage high needs families through initiatives in MSD, MoE, Corrections and other agencies may help facilitate access for those highest needs children and their families/whanau.

IMPROVEMENT ACTIVITIES

7.1 DAP Projects Report

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	14	4	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	19	6	0	25	0	0	22	3	0	1	1	0	0
Total %	100%	100%	19%	15%	8%	46%	8%	0%	73%	23%	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

	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
High Level Strategy																					
1.1 Reduce inequalities in health status	7	7	4	1	0	2	0	0	6	1	0	7	0	0	7	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	14	4	0	18	0	0	18	0	0	1	1	0	0
Total %	100%	100%	26%	16%	11%	32%	11%	0%	74%	21%	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)	HVAZ work and evaluation with Pacific churches/communities continues. PHO Parish Community Nurses and health workers have agreed on Action Plan and who holds primary responsibility for each objective. Activities/objectives related to Health targets. Pacific Nurse SME Co-ordinator has started within HVAZ and is engaging with key churches to begin programme with samoan speaking churches. Strong interest following successful implementation at CMDHB. Community Leaders meeting held with good support and interest for ongoing health initiatives. Pacific Best Practice education session delivered to CYFS/ADHB Liaison programme for senior staff across ADHB. Awaiting evaluation and reports from combined workshops held with Le Va. ADHB Pasefika Week commences March 7th - ADHB services, external agencies and Pacific providers/NGO's to profile their 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 and uptake of interpreters by both primary and secondary care continues.
1.1.4 Support disabled people and improve their	Denis Jury (ADHB)	Disability Responsiveness Audit report was accepted in principle by DiSAC and the recommendations are currently being reviewed for a staged implementation. No progress over the last month from the MoH regarding the IFP fund, although devolution by financial year end is still the target.













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access to health care and support services		
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 level to share learnings and review data and process. Initial results from the data review at practice level does show a number of immunisations not recorded in the NIR and the recorded ADHB intervention is likely to increase over the next two months as a result of this work. There is a similar pattern of little change in intervention rates 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 and now seeing patients. The fourth new mobile unit id due for delivery in may and equipment for this is cuurently being ordered. Two new pre-school health promotors and regional adolescent coorordinator 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)	Develpment of the packages of care pilot and case mix funding models have been completed and are currently being reviewed / agreed by the providers and are planned tol 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 continued downward trend in complaints received from residents in aged residential care. Development of the process for introduction of the EDEN programme continues with support of the relevant providers -a set of principles to support this programme will be signed off by providers in march.
1.2c.1 Increase effectiveness across primary, secondary, tertiary services for mental health and addictions	Denis Jury (ADHB)	All projects progressing satisfactorially (EDS is now fully functional according to the service contract).
1.2d.1 Strengthen community participation and action for long term conditions	Denis Jury (ADHB)	Auckland Plunket and Ngati Whatua o Orakai Health Services continue to work together to achieve Baby Friendly Community Initiative accreditation.
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 satisfactorly
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 progressing the last month with the new provider and IS working closely together; capital has now been approved for the IS purchase and sign-off is in process. An interim community provider is currently working through a chort of 666 patients.
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. and implementation of the expanded services is progressing.
1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	Andrew Coe (ADHB)	All projects progressing well, with clients in the primary care programme now at the planned levels. Palliatice care service redesign is progressing more slowly than planned and new approaches to manage this change are being reviewed at the moment.

Exceptions

			On	On	Expected
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Project	Coverage	Phase	Time	Budget	Outcome	Sponsor Review
Develop Care Pathways for people with Long Term Conditions	National	Define				Good to hear about other discussions on alternate mechanisms for improving information sharing and role integration . The regional clinical advisory teams will also add value to this work and many of the team are part of those groups which is laudable. It will be good to see some of the outputs from these groups soon.
Increase access and capacity to community diabetic eye screening	National	Analyse				It is a concern that teh CAPEX sign off is yet to be approved. this will have implications on the timelines for the addition of the community provider. I note all strategies to complete this process are being done.
Māori Service Development	Regional	Define				Merger activity to date has been complex and time consuming. Progress has been made although slow. A project framework is under consideration. Additional activity is planned to get the project back on track.
Palliative Care Redesign	ADHB	Analyse				Delays - clarity around the way forward expected from steering group meeting scheduled for the end of March.

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 Improve	Act Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red	
			Define	Measure																	Analyse
High Level Strategy																					
2.1a Efficient and effective Primary health care	2	2	0	0	0	2	0	0	2	0	0	2	0	0	1	1	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	4	4	0	1	0	3	0	0	2	2	0	4	0	0	2	2	0	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	0
2.2 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.3 Improve Clinical Quality and Professional Governance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.4 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.5 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.6 Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	7	7	0	1	0	6	0	0	5	2	0	7	0	0	4	3	0	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%	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" have reported back to the GAIHN ALT and programmes and funding are currently being reviewed. A number of RFPs are currently being prepared and complexities around these with regard to conflicts of interest and public law requirements are being worked through with all stakeholders.
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, access to diagnostic radiology is progressing well with regard to establishing the systems and processes with good ongoing update by general practice there is now increasing confidence that 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 to achieve DAP targets.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
After Hours	Regional	Improve				Good sector engagement to date. A future state strawman has been developed and costing / pricing activity has been completed. An RFP process is currently under development.

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Skin Lesions	Regional	Improve				Project is now back on track. Contracting arrangements are currently being worked through.
Pharmaceuticals	Regional	Measure				Project is now underway although a little behind schedule. Original benefits identified may not be delivered although work is underway to forecast benefits likely for the end of the financial year.

Legend: Red - , Orange - , Green - 

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

REVIEW

9.1 Annual Plan 2011-12



COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE

Paper

Date	Wednesday 16 March 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 for NHB Review
1	<p>Purpose</p> <p>To provide a current draft of the ADHB Annual Plan for review and approval to submit to the National Health Board on 25 March 2011. Work will continue on the document subsequent to this CPHAC meeting and the final draft will be signed off by the Chair and Chief Executive as previously approved.</p> <p>We have noted the request from the previous CPHAC meeting to “track changes” from the draft plan submitted at that time. However, we found that with the substantial changes made to that early version of the plan the document became very difficult to read, and it was therefore decided to modify it directly and track changes from the version on this agenda.</p>
2	<p>Recommendations</p> <p>It is recommended that CPHAC;</p> <ul style="list-style-type: none"> • Review and provide guidance regarding the ongoing development of the Annual Plan. • Approve the Annual Plan as indicative of the version to be approved by the Chair and CEO for submission to the National Health Board on 25 March 2011.
3	<p>Planning context</p> <p>3.1 Auckland DHB Board's priorities</p> <p>The ADHB Board's Letter of Priorities was received early March. Each item of CPHAC's February feedback has been allocated to an 'owner' to ensure a suitable Annual Plan response.</p> <p>3.2 Regional Context</p> <p>A draft of the Northern Region's Health Plan was due to be released on 9 March. We are regularly communicating with our regional DHB colleagues to align our Annual Plans as closely as possible. See issues and risks below for further discussion.</p> <p>3.3 National context</p> <p>No information about planning at the national level has been released for inclusion in the Annual Plan. The National Health Board's review of the draft Annual Plan will be the only review round prior to the submission of a final Annual Plan on 20 May. There is regular communication about the plan in the interim, however, such as about service changes proposed by the DHB that may be considered significant.</p>

4	<p>Living within our means This paper draws the Committee's attention to the narrative component of the Annual Plan. The CFO is managing the sign-off process for the financial component.</p>												
5	<p>Issues and Risks There will be changes to the Annual Plan document right up until it is submitted to the NHB for review on 25 March. This means the version viewed by CPHAC will not be the version submitted for review. As per the February meeting of CPHAC, sign-off on the 25th March version has been delegated to the CEO and Board Chair.</p> <p>A considerable amount of work has been undertaken this year to develop the detail of the Northern Region Health Plan. The updated draft is expected to be released on 9 March. At that time we will focus on showing how the ADHB's Annual Plan and the Northern Region Health Plan align.</p> <p>Given the problems with the timing of the regional work, the Annual Plan is unlikely to include as many specific actions as we would like. As indicated by the National Health Board, planning for the 2011-12 is a transition year with regard to Regional Health Plans. More detail and a higher profile will be required of regional work in 2012-13.</p> <p>Regional planners are working closely together to arrive at a suite of output class measures for the Statement of Intent component of the Annual Plan. This work sits in module four and, unlike module three, covers DHB activity across all our health service delivery, including our business as usual work. While the four northern DHBs are aiming to get a common set of measures for the region, this may prove to be ambitious for the 2011-12 year and to help resolve this issue the DHB's are engaging Audit NZ.</p> <p>The issues covered here relate only to the non-financial aspects of Annual Plan development.</p> <p>The issues and risks described in the 16 February 2011 CPHAC paper about the Annual Plan remain. In addition to the above, they are:</p> <ul style="list-style-type: none"> ○ Meeting our regional commitments alongside our local obligations within the funding envelope and while delivering health gain and excellent care for our patients ○ Ensuring that the timeframe for development of the AP allows for appropriate engagement with our Iwi partners ○ The usual practice of having various iterations reviewed by the Ministry being replaced by one Annual Plan review period in March. ○ Ensuring the Annual Plan conforms to the National Health Board guidelines and template requires considerable work ○ Ensuring the Annual Plan follows the strategic direction and focus within the Regional Health Plan which is yet to be confirmed. 												
6	<p>Draft Annual Plan Document Updated draft Annual Plan will be circulated to under separate cover prior to the meeting.</p>												
7	<p>Timeline and process</p> <table border="1" data-bbox="204 1765 1401 2112"> <thead> <tr> <th data-bbox="204 1765 411 1798">Date</th> <th data-bbox="411 1765 691 1798">Meeting</th> <th data-bbox="691 1765 1401 1798">Required</th> </tr> </thead> <tbody> <tr> <td data-bbox="204 1798 411 1906">16 Feb</td> <td data-bbox="411 1798 691 1906">CPHAC</td> <td data-bbox="691 1798 1401 1906"> <ul style="list-style-type: none"> • Review early draft of AP and provide guidance • Note developing Regional Plan </td> </tr> <tr> <td data-bbox="204 1906 411 1977">1 March</td> <td data-bbox="411 1906 691 1977">Finance Committee</td> <td data-bbox="691 1906 1401 1977">Review budget and recommendations to Board</td> </tr> <tr> <td data-bbox="204 1977 411 2112">2 March</td> <td data-bbox="411 1977 691 2112">Board</td> <td data-bbox="691 1977 1401 2112"> <ul style="list-style-type: none"> • Approve budget • Review any AP planning issues as appropriate • Delegate authority to CPHAC to approve AP and SOI for submission to NHB on 25 March </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 as appropriate • Delegate authority to CPHAC to approve AP and SOI for submission to NHB on 25 March
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		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	CPHAC	Discussion on any preliminary feedback if available
29 April		NHB provides feedback to DHBs
3 May	Finance Committee	
4 May	Board	Approve sign-off process for final AP
18 May	CPHAC	AP presented as final
20 May		AP due at NHB

10

PAPERS

10.1 Community Dialysis

10.2 Mental Health and Addictions Strategic Plan

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Community & Public Health Advisory Committee Paper

Date	Wednesday 16 March 2011
To	Community and Public Health Advisory Committee
From	Dr Denis Jury, Chief Planning and Funding Officer Email: denis.j@adhb.govt.nz ; and Dr Barry Snow, Medical Director Adult Health Services Email: BSnow@adhb.govt.nz ; and Margaret Dotchin, Nurse Director Adult Services Email: MDotchin@adhb.govt.nz
Author	Karen Holland, Project Manager Community Haemodialysis Units
Functional Group	Planning and Funding Functional Group
Subject	Devolvement of Adult Haemodialysis Services into Community Settings
1	<p>Purpose</p> <p>ADHB in partnership with primary care seeks to devolve Adult Haemodialysis (HD) into community settings, situated in localities with the largest clusters of current and projected numbers of adult patients requiring dialysis.</p> <p>This paper seeks approval for a proposed new model of care while a separate and later paper will seek approval for the partnership and financial and infrastructure arrangements to support the new service.</p>
2	<p>Recommendations</p> <p>It is recommended that CPHAC advise the Board to:</p> <ol style="list-style-type: none"> i. Approve ADHB Renal Services to work in partnership with primary care to design, devolve, and deliver Adult Haemodialysis (HD) services in community settings ii. Approve ADHB Renal Services to design, develop, and deliver in partnership with primary care, integrated kidney disease prevention, early intervention, and chronic kidney disease management services
3	<p>Description of Solution (Option)</p> <p>International and national evidence suggests that to adequately focus on the populations and localities of highest need HD Units need to be built in community settings. This shifts HD services closer to people's homes, and provides a better integration of primary and secondary care services both at the HD Unit for current patients, and in the surrounding communities for at risk populations.</p>
4	<p>Background</p> <p>Current and projected population and burden of disease analysis identifies three localities in the ADHB district as already having the highest incidence of patients requiring HD. The data reveals disproportionate numbers of Pacific and Maori greater than 45 years of age currently using, and projected increasing volumes requiring, ADHB HD services from the following localities:</p> <ul style="list-style-type: none"> • Glen Innes / Panmure area;

- Onehunga, and the
- Western boundary,

The ADHB Department of Renal Medicine currently faces a number of challenges in delivering HD services including:

- Current Haemodialysis Units (HD Units) are stretched to capacity
- Annually increasing demand for new Haemodialysis (HD) spaces. Increasing at the rate of 10 – 14 new patients per year (N.B. HD patients require 3 sessions of HD per week of 4 – 5 hours duration)
- Green Lane Clinical Centre (GLCC) Building 14 Basement HD site requires (at least) major refurbishment to remain operational for community patients, and
- The need to expand programmes aimed at preventing or delaying the progression of renal disease in the very large number of patients with Chronic Kidney Disease (CKD) levels 3 and 4 in the community.

HD Demand Projections Based on Australia & NZ Dialysis Transplant Registry Data [ANZ Registry]

	2009	2010	2011	2012	2016	2021	2026
Using Equation	509	525	540	565	664	787	911
Using Population	509	526	542	562	640	753	861

- Using Equation – the straight line trend equation used for data analysis
- Using population – population structure by age, gender and ethnicity

In accordance with the New Zealand Dialysis Care Standards, 2008 (NZ Renal Advisory Board) patients should dialyse three times per week for at least four hours on each occasion. There are three common settings where adult patients dialyse:

- Hospital based HD (dependent care)
- Home based HD (independent care), and
- Community based which is commonly named satellite HD (where shifts are a mix of patients that do self care HD under direct supervision, and some patients that require constant supervision while they are dialysing).

The aim is to continually shift the more stable end of the dependent care HD patients to the satellite services where they still receive specialist clinical oversight, and to continually shift the highly competent self care HD patients from satellite services to home based Haemodialysis. There are a small number of patients that move from home HD to satellite HD as they require more clinical oversight as their condition deteriorates and /or their ability to cope reduces.

To accommodate the current high demand for HD from ADHB patients the Renal Service has:

- In addition to the mix of patients requiring constant supervision while they dialyse and those performing assisted self care HD under direct supervision; one shift of fully dependent care HD patients has been scheduled into the Carrington satellite unit without any clinical consequences
- Auckland City Hospital has two HD sites and one temporary site. The patients who dialyse in the building 1 site are the frailest of the dialysis population, the majority of these patients will need to remain in this unit. The patients using building 56 site all require constant supervision (dependent care) while dialysing, there is no clinical reason why they need HD on a hospital site. The third temporary unit on Ward 42 is used to dialyse the overflow patients (currently 18).
- ADHB purchases from private provider Nephrocare HD for the further overflow of ADHB patients (currently 18) requiring dependent care HD

5	<p>Options Considered</p> <p>Do nothing</p> <p>This is not an option as current capacity is stretched, and further any early intervention programmes will take time to prevent or delay significant numbers of patients with CKD (levels 3 & 4) from requiring HD in the near future</p> <p>Contracting HD Services to Private Providers</p> <p>There is only one current private HD provider in the Auckland region, but is not able to provide a comprehensive specialist renal service (i.e. does not include dietician and social work etc needs of patients). Renal Services have been identified by the Minister of Health for incentives to address shortages in this specialist health workforce – thus we do not want to enter arrangements that will further strain an already overloaded workforce.</p> <p>An Integrated Primary and Secondary Care Service Model</p> <p>This approach offers the best solution if we are to manage the burgeoning demand for HD, and at the same time implement comprehensive prevention and early intervention strategies to reduce in a long term sustainable way the numbers of patients with chronic kidney disease, of which Diabetes Type 2 is a major contributor.</p> <p>An integrated primary and secondary care model for HD and incorporating prevention and early intervention strategies is the preferred approach.</p>
6	<p>Issues and Risks for Chosen Option</p> <p>The preferred approach of an integrated primary and secondary care model will require a significant change in the current model of care. We believe, however that the risk is low because the ADHB renal physicians support shifting all except the most highly dependent HD patients into community based HD Units, together with a shift of a number of Specialist Nephrology clinics into the satellite services. Further it is the strong desire of the nephrologists and the full nephrology clinical team to re-site outpatient clinics to satellite services.</p> <p>These changes will bring dialysing patients into more regular contact with: nephrologists, dieticians, chronic kidney disease specialist nurses, and hypertension prevention nurse specialists. Consequently patients dialysing at the Community HD Units will have more regular formal and informal interaction with the full specialist nephrology team, which will result in improved quality of life for patients but is also likely to prolong their life (and number of years on HD). Currently the average time ADHB patients spend on Haemodialysis is 4.5 years (Australia & NZ Dialysis Transplant Registry [ANZ Registry]).</p> <p>After piloting with the DEFEND study (Delay Future End Stage Nephropathy due to Diabetes) ADHB HD Service developed a Chronic Kidney Disease (CKD) programme of active intervention for patients with CKD levels 3 and 4. This involves intensive management by senior nurses and dieticians aimed at preventing or slowing the progression of renal disease. This initiative has been very successful but currently only reaches a small minority of the target population. Further development of this service in partnership with primary care services as part of the proposed new model of care is a priority.</p>
7	<p>Budget Implications</p> <p>This paper seeks CPHAC endorsement for the proposed strategy to alter the model of care for HD patients involving the devolution of HD and related services into community settings in partnership with primary care, and the satellite services will be situated in localities with the largest clusters of current and projected numbers of future dialysing adult patients.</p> <p>There are a number of primary care organisations in different localities who have expressed interest in working with ADHB on these developments. It is planned that CPHAC endorsement of the new strategy will be followed by development of detailed analysis of partnership, financial and infrastructure arrangements and that approval for these will be sought at the May meeting of the ADHB Audit and Finance Committee.</p> <p>Current modelling indicates a cost neutral position.</p>

8 Regional / National Implications

Repatriation of the Waitemata DHB patients from July 2010 does not relieve the pressure as the service was on overload to accommodate these patients. The continual inflow of new patients will quickly fill any vacated places, with outsourcing to the private provider Nephrocare continually in use to meet the overflow numbers.

There are models for community located HD Units (satellite units) that provide experiential evidence from both the perspectives of patients and their significant others/whanau; and from HD Unit staff and primary care and secondary care services. These learning's will inform the design and delivery of the proposed new primary and secondary care integrated model of care for chronic kidney disease prevention, early intervention, and management.

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Community and Public Health Advisory Committee Paper

Date	Wednesday 16 th March 2011
To	Community and Public Health Advisory Committee (CPHAC)
From	<p>Dr. Denis Jury, Chief Planning and Funding Officer Greenlane Clinical Centre, Building 13, Level 8 Phone: (09) 630 9943 extension 8071 Email: DenisJ@adhb.govt.nz</p> <p>Dr Clive Bensemann, Director of Mental Health Services Level 5 Admin Suite, Building 32, Auckland City Hospital Ph: (09) 375 7105 Email: clive.benseman@adhb.govt.nz</p> <p>Fionnagh Dougan, GM Clinical Services Mental Health and Addiction Level 5 Admin Suite, Building 32, Auckland City Hospital Ph: (09) 375 7105 Email: FionnaghD@adhb.govt.nz</p>
Author	<p>Robert Ford, Planning & Funding Manager, Mental Health & Addiction</p> <p>Julie Armstrong, Asst Planning & Funding Manager, Mental Health & Addiction</p>
Functional Group	Planning & Funding Functional Group
Subject	Mental Health & Addictions Strategic Plan
1	<p>Purpose</p> <p>The attached paper provides contextual information about mental health services and presents a draft strategic plan for review and endorsement of continued development.</p>
2	<p>Recommendations</p> <p>It is recommended that CPHAC;</p> <ul style="list-style-type: none"> • Reviews and provides comment on the proposed strategic development of ADHB Mental Health Services as outlined in the draft plan • Endorse the strategic direction outlined in the draft plan
3	<p>Background</p> <p>The paper provides an overview of mental health services provided to the population of ADHB, and presents the strategic plan within that context. Our goal is to maximise the utilisation of available resources to ensure access, and sustain effective services that meet the needs of those who are most vulnerable. This may require a reconfiguration of the current mental health system.</p>

4	<p>Budget Implications</p> <p>The strategic plan will be delivered within available resources.</p>
5	<p>Regional / National Implications</p> <p>This strategic plan aligns with both regional and national strategies particularly the actions identified in Te Tehuhu and Te Kokiri, which were recently endorsed by the government. The emphasis will be on the following areas: access to services and improved health outcomes, improving system performance, tackling alcohol and other drug related harm, and improve services for children and youth.</p>
6	<p>Mental Health and Addictions: Context and Strategic Response</p> <p>Our Aims:</p> <ul style="list-style-type: none"> • To develop a system within the ADHB locality which ensures that any door is the right door for accessing mental health and addiction services. • That the system is reconfigured and services are developed that align to an evidence base which demonstrates improved outcomes for consumers, in particular those with higher prevalence rates. • That where evidence exists the system and services will be configured to provide value for money alongside quality and effectiveness. <p>Our Focus</p> <p>The draft strategic plan has been developed in partnership with ADHB Maori and Pacific Health colleagues and has utilised the ADHB Mental Health & Addictions Service Development Group as a point of reference. A separate external reference group has been consulted. This includes the NGO sector and has recently been expanded to incorporate senior clinicians and managers from ADHB clinical services.</p> <p>The draft strategic plan is aligned with national strategies, in particular Te Tahuhu (2005-2015), and Te Kokiri (2006-2015), and regional strategies. The actions identified in Te Kokiri and endorsed recently by the government are presented in this strategic plan and tailored for ADHB population.</p> <p>In five years time services should allow access for a greater number of people including vulnerable groups, easier movement across the continuum of care and integration of care pathways. The physical health of those with a mental disorder should be improved. Our services will be planning for major demographic changes such as the aging of the ADHB population.</p> <p>The ADHB draft strategic plan includes these aims:</p> <ol style="list-style-type: none"> 1. Promotion, Prevention, and Education 2. Build Mental Health and Addiction Services 3. Responsiveness of Services 4. Workforce for Recovery and Social Inclusion 5. Māori Mental Health 6. Primary Care Mental Health 7. Addiction 8. Quality Management and Continuous Improvement <p>Details of the objectives and actions are detailed in the draft plan in the Appendix.</p> <p>Within this plan we are focusing on four interconnected areas:</p> <ol style="list-style-type: none"> 1. Improving outcomes for Maori and Pacific people, as we know that services are not as accessible as they need to be to achieve the outcomes we want.

2. Improving access to services, as part of the government's intentions for better, sooner, more convenient health care.
3. Improving services for children and young people.
4. Improving services that tackle the impact of alcohol and other drugs for individuals and families, or whānau.

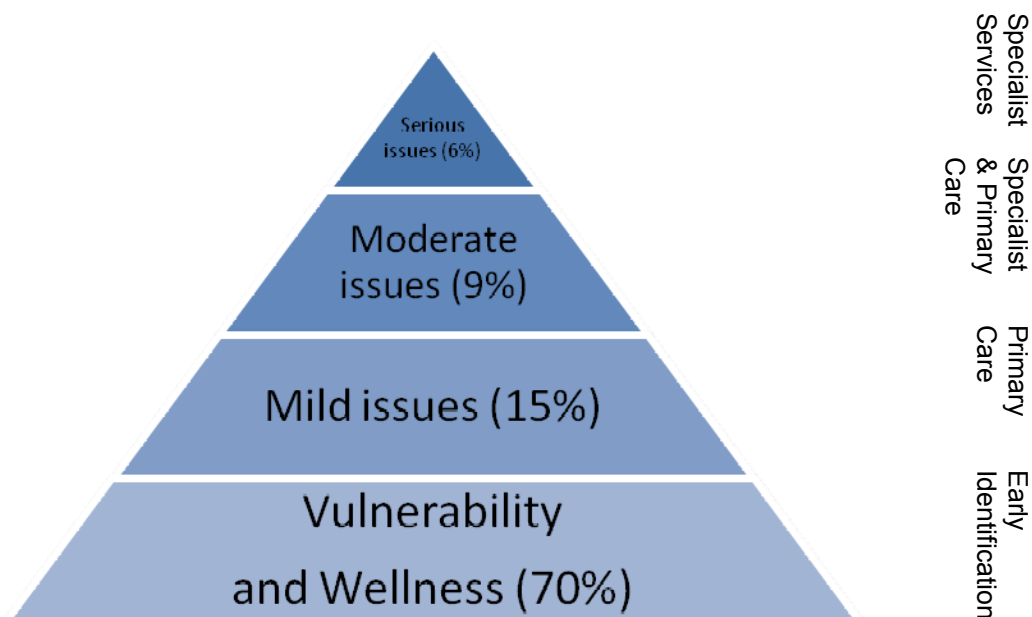
A recent ministerial action plan (2010) updating Te Tahuhu emphasises similar areas for focus: improving access; lifting performance and improving outcomes; tackling alcohol and other drug related harm; integrating efforts with services for children and young people.

Overview

The continuum of mental health services is illustrated in the diagram at the end of this paper and presents the breadth of services across different age groups and different providers.

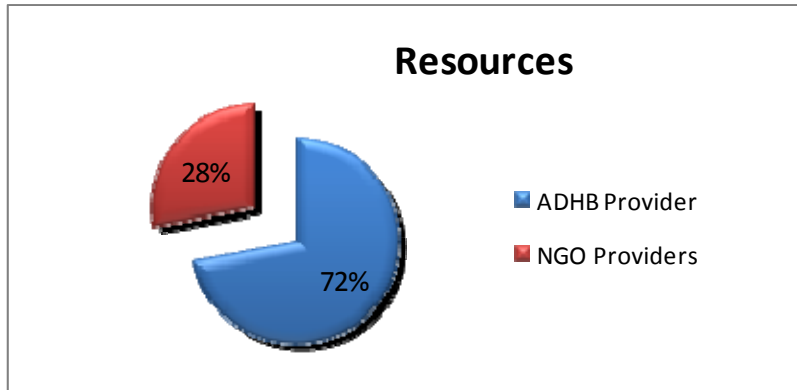
The services we provide to individuals, whānau, and families are underpinned by knowledge of the broad range of factors that contribute to a person's wellbeing and mental health. In addition our understanding of a person's experience of mental health is characterised by the concept of 'recovery', which holds that people can become well again, albeit that they may live with a particular condition.

The extent of the problem or illness that people experience correlates to the level of intervention provided. Equally the configuration of services from the continuum that the sector offers to people is also linked to problem severity. This produces a pyramid effect, where the largest number of people are regarded as being either well, in recovery, or vulnerable, and problems of greater intensity affect fewer people but require more specialist services. This is depicted in the following diagram:

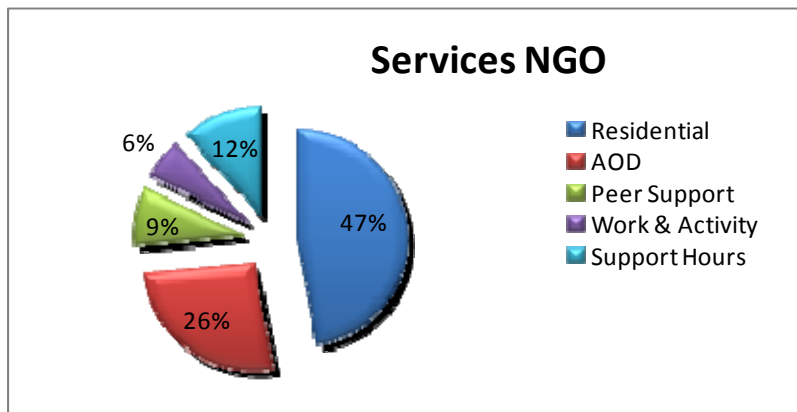


Our Resources

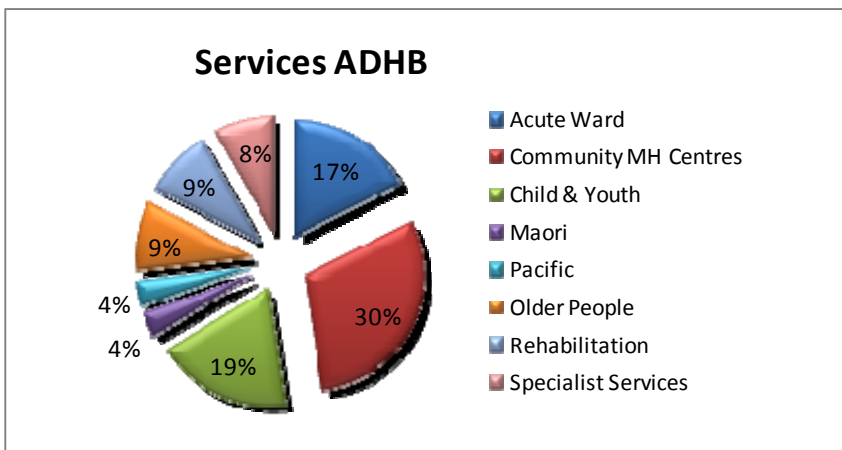
At present the resources available for mental health and addictions are distributed as shown in the Resources diagram below.



The DHB typically provides all of the hospital based and clinically based services, whilst the NGO sector focuses more on community services especially support and residential facilities. The distribution of funding within the NGO sector is illustrated in the Services NGO diagram.

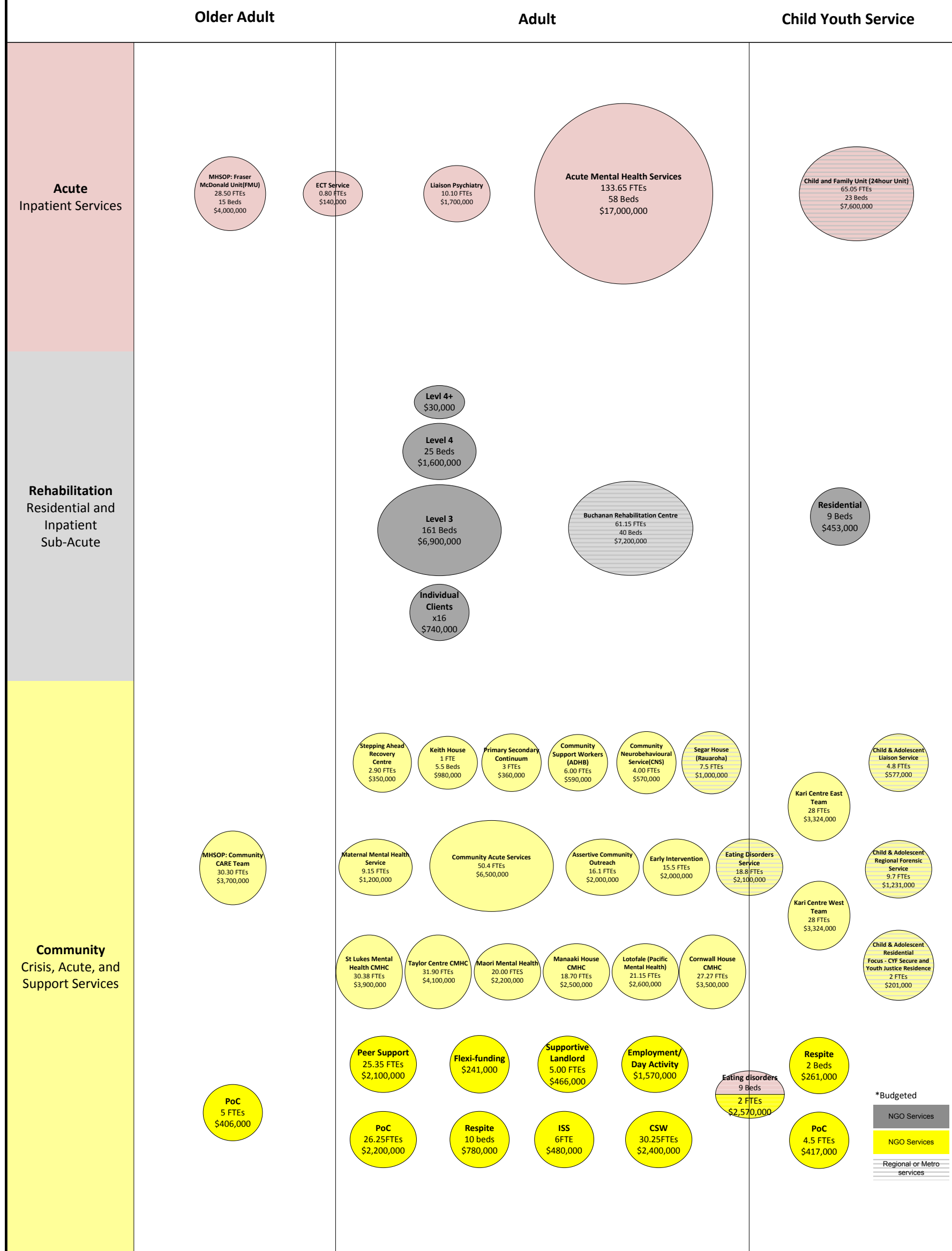


For the DHB provided services the distribution of funding demonstrates the focus on clinical services and provides some indication of how resources are spread across the different age groups (see below).



	<p>Targets and Indicators</p> <p>At present there are no specific national targets for mental health. This is unlikely to change this year but targets for mental health and addiction will probably be introduced next year (2012).</p> <p>At present we report activity against four performance indicators to the Ministry of Health, these are:</p> <ol style="list-style-type: none"> 1. Improving health status for people with severe mental illness (access rates to services – DHB & NGO services) 2. Mental Health volumes (simple input measure for beds and FTEs - DHB) 3. Improving mental health services using relapse prevention planning (DHB) 4. Alcohol and Other Drugs (AOD) waiting times (DHB & NGO services)
7	<p>Appendices available on request</p> <p>Mental Health and Addictions Strategy 2010-2015</p>

Auckland District Health Board Service Distribution 2010 – 2011*



*Budgeted
 NGO Services
 Regional or Metro services

11

FOR INFORMATION

11.1 Current Consultation Proposals – PHARMAC and 20 DHBs



Community and Public Health Advisory Committee Briefing Paper

Date	Wednesday 16 March 2011
To	Community and Public Health Advisory Committee (CPHAC)
From	Denis Jury Greenlane Clinical Centre, Building 13, Level 8 Phone: 09 630 Email: denisJ@adhb.govt.nz
Author	Hazel Rook (ADHB) & John Kristiansen (WDHB)
Functional Group	Planning and Funding Functional Group
Subject	Current consultation proposals from PHARMAC & 20 DHBs
1	<p>Purpose This paper is intended to give the Auckland and Waitemata CPHACs a high level overview of the two current consultation proposals by PHARMAC and the 20 DHBs and their impact for Community Pharmacy:</p> <ol style="list-style-type: none"> 1. PHARMAC and 20 DHBs Consultation Proposals on Pharmaceutical Schedule Rules and Community Pharmacy Services, which are intended to give shape to the new national pharmacy contract to replace the existing one which expires 31 August 2011. Auckland and Waitemata DHBs are submitting a joint response to this proposal. 2. PHARMAC's review of the Exceptional Circumstances Policy, which aims to improve the process for patients accessing pharmaceuticals that are not listed in the Pharmaceutical Schedule. The northern region DHBs are submitting a regional response to this proposal. <p>The boards are requested to note the contents and intended actions</p>
2	<p>Recommendations It is recommended that CPHAC;</p> <ol style="list-style-type: none"> 1. Note the contents of this paper as an overview of proposed changes to the Community Pharmacy Services contract
3	<p>Description of Solution</p> <p>PHARMAC & 20 DHBs Consultation Proposals The proposals were released publicly on 18 February 2011 and the consultation runs until 18 March 2011. Auckland and Waitemata DHBs intend to make a joint submission. While the details of this are still to be worked through it is envisioned that the submission will generally;</p> <ul style="list-style-type: none"> • Support the intent and direction of the proposals • Request further analysis and modelling is done as to how the changes to close control rules will impact on DHBs in terms of cost • Request more work is required on the detail of the proposal to include working with relevant providers involved in long term conditions, community mental health and aged residential care. <p>Exceptional Circumstances (EC) Policy PHARMAC are conducting an extensive consultation about their proposed changes to the EC policy and it was presented to the Regional Funding Forum on 8 February 2011. Feedback has been sought from both clinical and Funding and Planning staff and there appears to be broad support for their proposal. In particular, the measures that aim to make the process more efficient and transparent. The proposed prerequisites for the Urgent Clinical Circumstances (UCC) pathway are considered to be too restrictive and that this process could also provide access to a funded product for patients with allergic reactions to a Schedule product (as is currently catered for under the existing system). There is agreement with PHARMAC that some funding decisions may appear unfair but it promotes a more consistent approach nationally. The Northern DHBs will be submitting a regional response by the due date of 25 March 2011.</p>

4 Background

PHARMAC & 20 DHBs Consultation Proposals

The nationally negotiated pharmacy contract is due to expire on the 31 August 2011. This contract was rolled over in 2010 to allow for this national review process to take place. The timeframes are extremely tight and there is still uncertainty in the sector as to whether or not the new contracts can be put in place before the existing ones expire. However the northern region have made a commitment in their district annual plans to locally implement the new contract within the nationally agreed timeframes.

Issues with the current contract include:

- A focus on medicines rather than on the patient and their needs
- Inconsistent application of a multi-disciplinary team approach
- Variable recognition of community pharmacy's clinical skills and expertise
- Uncertainty about whether patients with the highest health needs are receiving the level of support that community pharmacy could provide
- The fee for service (i.e. fee per script item) funding model incentivises a focus on the medicines supply chain function rather than a patient service focus
- Community Pharmacy Agreement expenditure has been growing at 7-8% each year compared with DHBs funding path which has been growing at 2.5-3% each year. This level of growth is out of proportion to expected accountable growth. DHBs expect expenditure on Community Pharmacy Agreements to cost about \$380 million in 2010/11.
- In 2009/10 Auckland DHB's dispensing fees costs grew by more than 9% from the previous year to \$31.4 million dollars. Waitemata DHB growth was over 12%, which equates to \$28.4 million dollars.
- Growth in the use of Close Control (the more frequent dispensing of pharmaceuticals intended to support patients with adherence to their medicine regime) has been growing unevenly across DHBs and accounted for \$78 million of dispensing fees in 2009/10. It is felt that this system is open to abuse and is used to fund compliance packaging for patients.

The PHARMAC schedule changes intend to;

1. Change the current close control rule to significantly limit its use in its current form
2. Specify in the Pharmaceutical schedule that people in Age Related Residential Care (ARRC) Intellectual Disability and Mental Health Community Residences and Penal institutions can receive monthly dispensing
3. In conjunction with the DHBs, develop a patient-centered service focusing on compliance and adherence for people with high needs living in the community. Auditable access criteria would apply and an electronic patient-centered Special Authority could be used as the mechanism to implement the service.

The new contract focuses on patient groups;

- People living with long term conditions,
- People living in Age Related Residential Care (ARRC)
- People with Mental and Intellectual Disabilities, living in community residences funded by the DHBs or the Ministry of Health

The contract changes propose that patients who meet these criteria are cared for from a list of potential services suited to their needs, of which close control and compliance packaging would be options.

Exceptional Circumstances Policy

Exceptional Circumstances (EC) offers people access to medicines that aren't otherwise funded through the Pharmaceutical Schedule, or through DHB Hospitals. There are three separate schemes operating at the moment, each with distinct criteria; Community, Hospital and Cancer Exceptional Circumstances. PHARMAC are undertaking a review of the EC Policy to improve the process.

PHARMAC are proposing a new EC scheme – Named Patient Pharmaceutical Assessment (NPPA) – to provide improved access to pharmaceutical funding consideration for more individuals. NPPA would consider funding for individuals for treatments prior to their assessment for Pharmaceutical Schedule listing for the relevant indication. Within NPPA there would be three distinct pathways by which individual patients can apply for funding for pharmaceuticals not listed on the Pharmaceutical Schedule; each application would be considered against preset decision criteria:

1. **Unique Clinical Circumstances (UCC)** – for patients whose clinical circumstances are so unusual that it would be expected that they are the only patient in that situation, and that PHARMAC would not have considered them when making a Schedule funding decision;

	<p>2. Urgent Assessment – would give wider access to medicines for patients in a serious clinical circumstance who would either experience a significant deterioration in health or would lose the opportunity for a significant improvement in quality of life before a Schedule assessment is completed. Patients qualifying under this pathway may be part of a group of patients with a similar condition;</p> <p>3. Hospital Pharmaceuticals in the Community (HPC) – would provide funding consideration where it would be more affordable for the DHB to fund the medicine in the community for a patient under its care than to pay for another form of treatment. This pathway is similar to the current HEC process but has been streamlined to reduce the administrative burden.</p> <p>PHARMAC also intend to remove the distinction between cancer treatments and other community pharmaceuticals to reduce confusion by health professionals who complete the funding applications. In all cases, the application process will be simplified and the transparency of decisions on applications will be improved. In an effort to further increase the efficiency of the proposed programme and to reduce paperwork, PHARMAC are proposing a trial during which DHBs will be exempted from the HPC requirement for medicines that cost less than \$500 for a maximum three month course. However, this trial will only be available to DHBs that are able to provide monthly reports about this type of utilisation.</p>
5	<p>Options Considered</p> <p>a) Submit individual DHB submissions – this could reflect the impact of the proposals on specific DHBs such as the rural nature of Northland or the high population of long term condition patients in Counties Manukau DHB.</p> <p>b) Regional submission – will support the intention of the change of direction for the new pharmacy contract but stipulates that there is still much work to do to get it into a working model. Submitting on the exceptional circumstances will show appreciation for the wide ranging consultation process that is being out in place and accepting the offer of being able to put forward alternatives.</p>
6	<p>Issues and Risks for Chosen Option</p> <p>PHARMAC & 20 DHBs Consultation Proposals</p> <p>There has been no financial modelling done to consider the potential financial impacts of the proposals. It is intended that the changes to the close control rules will release funding back into the community pharmacy pool which will then cover the costs of the increased use of close control for those living in ARRC and penal institutions. The northern region has six prisons in its district, the national prison population has been projected to reach somewhere in the region of 8000-9000¹ inmates, there is no information on what proportion of these would likely require the dispensing of medications through close control. Auckland DHB has the largest number of Aged Residential Care Facilities in the northern region with a capacity for approximately 3500 residents. This could mean a greater financial impact on Auckland DHB than others nationally. It is also possible that those currently utilising close control and compliance packaging could still be eligible under the long term conditions criteria therefore increasing the access and therefore costs associated with this dispensing option.</p> <p>Exceptional Circumstances Policy</p> <p>Spending on EC is likely to increase. Their proposal would see a shift in the balance of funding towards funding more pharmaceuticals for individuals prior to a Schedule assessment, via the proposed Urgent Assessment pathway. Budget management would remain as it is under the current scheme. Funding for pharmaceuticals approved under the HPC pathway will continue to be met by DHB hospitals. PHARMAC acknowledge that there could be scenarios with the NPPA decision-making process that may appear to be inequitable or inconsistent. For example, a funding consideration could be approved for a patient via a NPPA pathway, but following an assessment for inclusion in the Pharmaceutical Schedule, funding for subsequent patients with the same clinical circumstances might be refused. However, it should be noted that the current EC process is also prone to apparent inconsistencies because funding, priorities, and available evidence may vary year to year.</p>
7	<p>Budget Implications - See above section on issues and risks</p>
8	<p>Regional / National Implications</p> <p>Both proposals are from a national perspective. The PHARMAC & 20 DHBs Consultation Proposals have been developed nationally with regional representation inputting into the shape of the final proposals. While the proposals are clearing steering community pharmacy in the right direction and ensuring national consistency on issues which seem to be expounding the pharmaceutical budget growth it is unclear as yet how the proposal will deliver the desired changes. The Exceptional Circumstances Policy has been developed by PHARMAC over the last two years and they have consulted widely to understand the issues with the current system and are consulting both clinical and non-clinical DHB staff on the changes now.</p>
9	<p>Appendices available on request</p> <p>1. PHARMAC & 20 DHBs Consultation Proposals on Pharmaceutical Schedule Rules Community Pharmacy Services</p>

¹ <http://www.justice.govt.nz/publications/global-publications/f/forecast-2005-2010-prison-population/4-results-and-recommendations>

- | | |
|--|--|
| | <ol style="list-style-type: none">2. Pharmacy Services Proposals Feedback Form3. 18.02.11 Media release Pharmacy Consultation4. Exceptional Circumstances Policy |
|--|--|

12

CONFIRM

12.1 Action Points for next CPHAC Meeting

12.2 CPHAC Feedback to Board

Use Forms at beginning of Meeting Pack

13

GENERAL BUSINESS

14

APPENDICES

14.1 Mental Health and Addictions Strategic Plan

Integrated Mental Health and Addictions Strategy 2010 – 2015

November 2010

Mihi

E nga mana, e nga reo, e nga karangatanga tangata
Ko te Toka Tu Mai o Tamaki Makaurau tenei
E mihi atu nei kia koutou
Tena koutou, tena koutou, tena koutou katoa.

Ki a tatou tini mate, kua tangihia, kua mihia kua ea
Ratou, kia ratou, haere, haere, haere.
Ko tatou enei nga kanohi ora kia tatou
Ko tenei te kaupapa, Hauora oranga hinengaro, o te Toka Tu Mai
Hei huarahi puta, hei hapai tahi mo tatou
Hei oranga mo te katoa.

No reira tena koutou, tena koutou, tena koutou katoa.

Forward

Statements from chairs of the DHB and Runanga

Contents

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Section Three: The Way Forward.....	16
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Treaty of Waitangi Statement

Auckland DHB recognises and respects the Treaty of Waitangi as the founding document of New Zealand. The Treaty of Waitangi is the fundamental relationship between the Crown and iwi. It provides the framework for Māori development, health and wellbeing.

The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes and measures to enable Māori to participate in, and contribute towards, strategies for Māori Health improvement. The measures are a response to the Crown's desire to have greater Māori participation in the health and disability support sector with a view to improving Māori health outcomes, and reducing health disparities between Māori and other population groups. The measures also reflect the Crown's overall partnership with Māori under the Treaty of Waitangi and its commitment to protecting Māori health. The measures include:

- Provision for Māori membership on boards of DHBs
- Provision for Māori membership of DHB committees
- Training for board members to ensure they are familiar with Treaty issues, Māori health issues, and Māori groups or organisations in the DHB
- A requirement for DHBs to establish and maintain processes to enable Māori to participate in and contribute to, strategies for Māori health improvement
- A requirement that DHBs continue to foster the development of Māori health capacity for participating in the health and disability sector and for providing for their own needs
- An expectation that DHBs provide relevant information to Māori to enable effective participation.

This legislation recognises and respects the principles of the Treaty of Waitangi in order to improve health outcomes for Māori. References to the Treaty of Waitangi in this document derive from, and should therefore be understood in this context.

As a Crown Agency, Auckland DHB will demonstrate how Treaty responsibilities are managed within the health sector by our commitment to the principles of partnership, participation, and protection. These principles are outlined by the Ministry of Health to provide direction to the health sector and form the basis of the Auckland DHB Te Tiriti O Waitangi Policy.

Our Commitment to the Treaty of Waitangi

Our Treaty relationship is with Te Runanga O Ngati Whatua through a formalised Memorandum of Understanding. This Treaty partnership is operationalised within Auckland DHB through the Runanga office of Te Kahupokere.

Further relationships and arrangements with other iwi groups and Māori communities residing in the Auckland DHB will be developed and strengthened. If firm relationships with iwi and Māori communities are in place, then this provides a sound platform to lift the health status of all Māori in the Auckland DHB area.

Treaty Principles in Action

Partnership

Te Runanga o Ngati Whatua as manawhenua, is a partner with Auckland DHB at the governance level

- Memorandum of Understanding with Te Runanga o Ngati Whatua and its health operational arm in the Runanga Auckland office Te Kahupokere
- Ngati Whatua, as the manawhenua partner with Auckland DHB at the governance level. This actively protects Māori interests in health planning and funding
- Auckland DHB has a Māori Health Advisory Committee
- Consultation with Iwi Māori in planning health and disability services and regarding service and other changes.

Participation

Māori engagement in planning, development and delivery of health and disability services

- Responsible and responsive to Māori communities in our district and those who use our services
- Active involvement of manawhenua and mataawaka communities in identifying health needs, in providing health services and in our plans to improve health and disability services
- Engagement with Māori regarding the impact that service and other changes may have on Māori communities and organisations
- Assistance to further develop Māori providers in our district.

Protection

Equity of participation, access and outcomes for all Māori.

- Adhere to the Auckland DHB Tikanga Best Practice Policy to protect the rites/ rights of Māori, respect the tikanga of manawhenua and practically contribute to providing services that are responsive
-

Māori enjoy the same level of health as non-Māori	to Māori needs and interests
Safeguard Māori cultural concepts, values, and practices	<ul style="list-style-type: none">• Services will meet the rights/ rites, needs, interests and aspirations of Māori• There is commitment to the Māori Health Strategy, He Korowai Oranga, Whānau Ora and other national policy• Use of the health equity assessment tool (HEAT)• Also the ADHB Prioritisation Framework (based on the national prioritisation framework), which incorporates whānau ora into decision making.• Whānau Oranga Hinengaro

Section One: Setting the Scene

Mission

To plan, fund, deliver, and evaluate within available resources a system that promotes and enables recovery for those affected by mental health and addiction problems

Vision

That the people of Auckland have good mental health, emotional wellbeing, and are free from addiction.

Values

Openness: in our relationships with all those involved in mental health and addiction as consumer, provider (NGO & DHB), funder, planner, whānau, or family; and that the contribution of each to recovery is valued.

Accessibility: that unnecessary obstacles to access are removed, so that any door is the right door for accessing services in mental health and addiction.

Evidence Based Practice: that existing and new services are innovative, evidence based, and competent in their ability to deliver effective specified outcomes for consumers, whānau, and family.

Value for money: that we provide and develop services that are good quality, efficient, and provide value for public money.

Background

Assessment of need for mental health services suggests that at least as many as 25% of people experience some sort of mental health or emotional problem in their lifetime (WHO 2001), and about 20% of people seeing their GP have a mental health problem (ibid). The level of need for addiction services at different levels of therapeutic intensity appears to be from around 5% to 10% of the population.

The principle source of information for the prevalence of mental health problems in New Zealand is Te Rau Hinengaro : the New Zealand Mental Health Survey (Ministry of Health 2006 - Oakley-Browne, Wells, & Scott),
For this strategy the key information from that survey is:

- the most prevalent problems are anxiety, substance misuse, eating disorders, and mood disorders.
- Māori experience mental health problems at a higher rate than the general population,

-
- Māori also have a lower rate of contact with a healthcare provider than the general population, yet they have increased contact as the severity of the problem increases.
- Rangatahi also have higher rates of mental health problems (anxiety, substance misuse, depression, and conduct disorders), compared to other young people (Tania Wellean, personal communication based on literature review for indigenous mental health 2010).

The group in which mental health disorders were most common are children and young people with substance misuse being the most prevalent.

For older people the most common mental health problem is depression, with presentation to a healthcare provider tending to be at a later stage of the problem. Mental health problems experienced by older people (55+) are often unrelated to aging; 20% of this group but often linked to complex needs and neuro-degenerative disorders.

Māori living in Auckland district are a young population with just under half aged less than 25 years. Data from the New Zealand Deprivation Index (NZDep) within the 2006 Census show that over half of Māori live in deciles 8–10, where a score of 1 represents the least deprived and 10 is given to the most deprived (Ministry of Health, 2007).

Health data shows Māori are over-represented in mortality and morbidity statistics and have increased hospitalisation for many conditions that are modifiable and amenable to prevention and health care treatment (Auckland District Health Board, 2008a; Baxter, 2008). There is a known association between physical health and mental health, and Māori with physical health problems will be at increased risk of mental health problems (Baxter, 2008).

Te Rau Hinengaro, states that over half of Māori surveyed had experienced at least one mental health disorder at some time in their life and most Māori (with at least one disorder) experienced serious or moderate severity.

Analysis of local data (The Health & Disability Intelligence Unit Health & Disability Systems Strategy Directorate, 2009) shows Māori have significantly higher prevalence rates than the total population of Auckland DHB for susceptibility to developing an anxiety or depressive disorder and are more likely to experience unmet need for a General Practitioner.

Local utilisation data shows most Tangata Whaiora residing within Auckland DHB who have a severe and enduring mental illness access specialist mental health services delivered by mainstream services. Conversely, there is a small percentage of adult Tangata Whaiora who chose to access Māori mental health services. It is well documented that Māori need to be able to choose whether they use mainstream services, kaupapa Māori services, or both of these (Mental Health Commission, 1998 ; Ministry of Health, 2008). Responsiveness to Māori does not only apply to kaupapa Māori or Māori-specific programmes and

services: the entire health system and all parts of the mental health and addiction continuum must take the lead in confronting this challenge (Ministry of Health, 2008).

For Pacific people they equally experience mental health problems at a higher rate than the general population, and the most common problems are anxiety, mood disorders, and substance misuse. Pacific people have low rates of healthcare provider contact too but this low rate continues even for more serious disorders. The Pacific population is culturally diverse, has a young age profile and Pacific youth are more likely than older Pacific people to experience a serious disorder.

For Asian people (a diverse and mixed ethnic group) mental health problems were at a similar rate to the general population and no particular trends emerged from the survey.

For refugees and migrants numbers were not sufficient to identify particular trends but other reports identify problems with depression, anxiety, and post traumatic stress related to the transition experience and past events.

From this outline of need the priority groups are; Māori, Pacific people, and children and young people. Attempting to assess the level of demand required to meet the needs of those requiring services and translate this to capacity is inherently difficult when we know that funding is unlikely to meet the needs of all those requiring mental health or addiction services. Often demand will vary to match capacity especially when we look across the full range of problems, although this is rarely the case for severe mental health or addiction problems.

Māori Mental Health

Effective Māori mental health gains require culturally responsive services, systems, training, education, relationships and infrastructure. To this end it relies heavily on a shared approach from the mental health sector as a whole for a dedicated but integrated Māori approach that draws from but is not limited to western and clinical paradigms.

Orienting the health sector to respond effectively to Māori mental health needs will require the commitment of the wider mental health workforce and advanced competencies for mental health practitioners. Such an approach will also contribute positively to opportunities of potential that a Māori led mental health focus brings. It will also inherently require a shift in thinking and practice (E Ara Tauwhaiti Whakarae 2007).

To achieve Māori mental health gains we must recognise the importance of whānau ora, particularly that whānau ora is an inclusive, culturally anchored approach to provide services and opportunities to whānau across New Zealand. It empowers whānau as a whole, rather than focusing separately on individual whānau members and their problems.

Whānau Ora will work in a range of ways, influenced by the approach the whānau chooses to take. Whānau Ora is not a one size fits all approach. It is deliberately designed to be flexible to meet family needs.

Some whānau will want to come up with their own ways of improving their lives, and they may want to work on this with a hapū, iwi, or a non-government organisation (NGO), including family support, and peer support services. Other whānau will want to seek help from specialist Whānau Ora providers, who will offer them wrap-around services tailored to their needs. ADHBs whānau ora approach must take into consideration all these aspect and ensure that services are designed and delivered to achieve whānau ora.

Pacific Mental Health

In response to addressing the issues and needs experienced by Pacific families and communities with mental health disorders, a series of plans and frameworks has been developed for the Northern region.

The Pacific Mental Health and Addiction Northern Region Implementation Plan 2009-2012, The Regional Pacific Model of Care and Mental Health and Addictions Service Framework and the Leadership Framework for the Mental Health and Addictions sector March 2010, provides a cohesive Northern regional approach that is integrated and is both Pacific family and consumer centred.

The three broad priority areas are outlined below followed by six regional strategies. We believe implementation of the strategies outlined is important and will be instrumental to improving the well-being and good mental health of our Pacific people.

Pacific Regional Priorities

1. Improved access to mental health and addiction services for Pacific communities and families
2. Implementation of the Regional Pacific Mental Health and addictions service framework and
3. Pacific workforce development and improved cultural responsiveness.

Six Pacific Regional Strategies

1. Fostering integration and co-ordination of mental health and addiction services across Pacific communities

2. Strengthening Pacific mental health promotion and prevention initiatives
3. Developing Pacific service access and capacity
4. Strengthening the role of primary health care
5. Improving responsiveness and cultural competence within Pacific and mainstream services
6. Facilitating Pacific workforce development

The ADHB Pacific Health Action Plan 2010 – 2014 and ADHB Youth Health Improvement plan 2010 – 2014 also complement the regional approach with a particular emphasis on fostering linkages between mental health and addictions services and first point of contact settings for Pacific young people and their families.

ADHB Pacific mental health principal areas are:

1. Pacific children and Pacific youth and
2. Pacific Mental Health leadership.

These two key areas fall within the scope of the regional priorities and strategies outlined below.

Section Two: Principles

This strategy aligns with both national and regional mental health and addiction strategies. At the national level the government has reaffirmed the relevance of Te Tahuhu as the strategy for the sector, and Te Kokiri as the plan that operationalises this strategy. Both regional and local strategies are to be consistent with Te Tahuhu and Te Kokiri and work towards their implementation at a local level. In addition the Minister may from time to time highlight particular aspects of the national strategy and look to District Health Boards to focus on specific outcomes. This strategy will respond to these directives through tailored projects that develop a particular part of the mental health or addictions continuum.

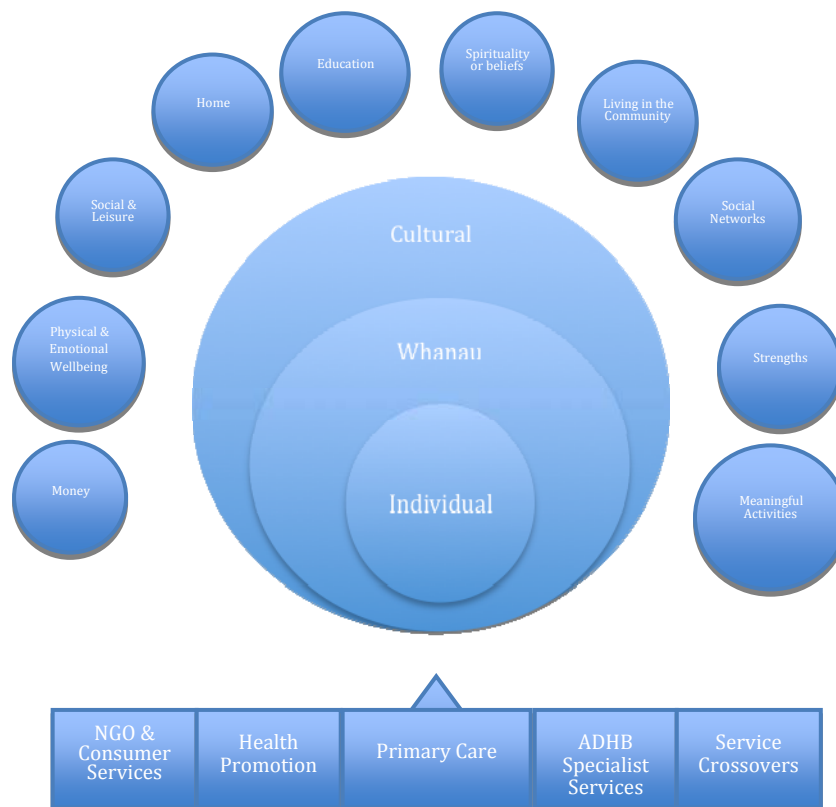
In order to articulate these national and regional plans at a local level we are using the visualisation from the Primary Care Strategy. We see the provision of services as encompassing the whole person but more especially that person and their whānau or family.

An important part of this visualisation is the recognition that much of what can be provided to assist in someone's recovery or wellness and that of their whānau or family, is not limited to mental health or addiction services.

This can be represented in the following diagram, which attempts to show how different elements in a person's life contribute to their recovery.

This does not suggest that health can tackle all these areas but rather that health services are just a small part of what contributes to a person's overall health status. What it may indicate is that whilst health focuses on one specific aspect of a person's status it is important that it has regard to those other components that contribute to a general state of well-being and a person's recovery:

Diagram 1



So, whilst we have an awareness of these other aspects of recovery for this strategy we are focussing on what mental health and addiction services can provide, whilst holding in mind the many connections with other services and people that may contribute to wellness and recovery.

Our 'work ethic' is focussed on the development of a mental health and addictions continuum that utilises an inter-sectoral approach. As a sector we will work together to achieve common objectives across a range of needs, represented in diagram two. Our intention in working this way is that as a sector we better deliver the outcomes required, whether defined by government or consumer.

As part of this sector work we look to the Service Development Group (SDG) to provide sector leadership. Such leadership includes the addition of new services but also the reconfiguration of existing services to better match consumer, whānau, or family requirements, informed by evidence-based best practice models adapted to a local environment.

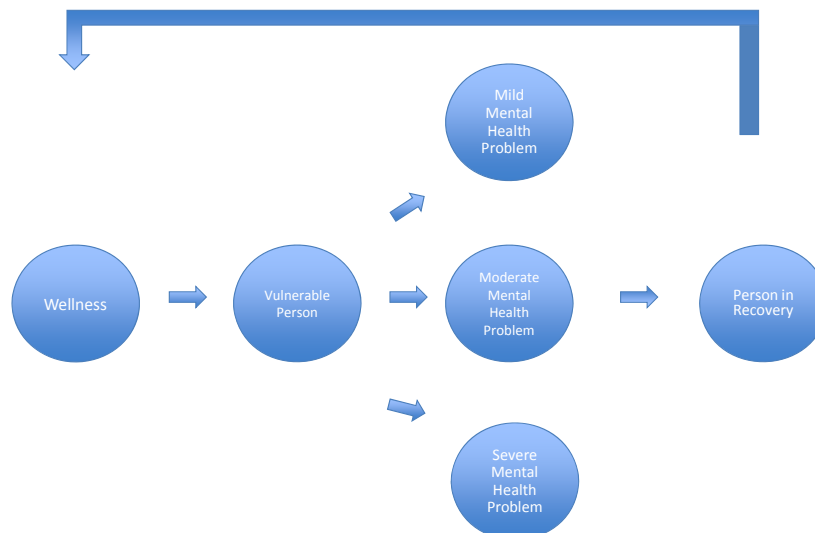
The expectation is that there will be an explicit statement of evidence, effectiveness, and value for money to support a new development or a reconfiguration of services.

We expect an openness, willingness, and preparedness within the sector to do things differently and achieve the best outcomes possible for consumers, whānau, and family.

Diagram two depicts a recovery journey from the point of wellness, to being vulnerable, to experiencing a range of mental health problems, and through to being in recovery and well. Not everyone will have the same journey, and the process may move backwards and forwards before settling for a while in a particular place.

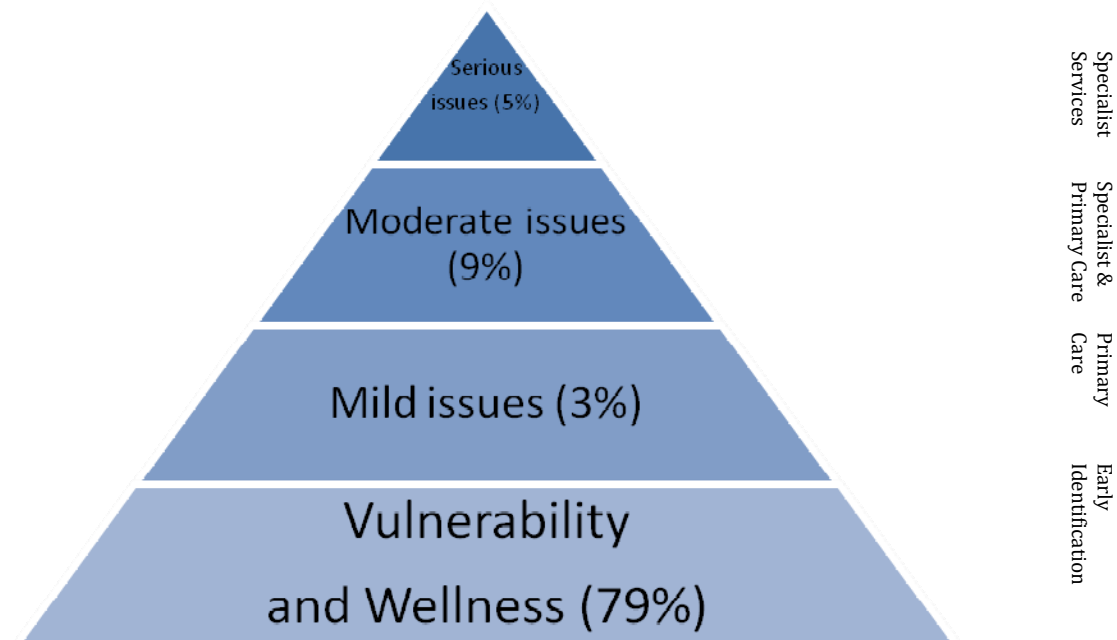
This diagram links to diagram three in attempting to visualise how services might be developed to support a person or their family or whānau, at a particular place in their unwellness or recovery.

Diagram Two



The final diagram in this section provides a view of the 'stepped care model' and maps the services that mental health and addiction facilities might provide to the different stages that someone might be in during their path to recovery or wellness.

Diagram 3



Whilst these two models focus on the individual experience of being unwell and present a simple sequential progression, the strategy acknowledges that mental health and addiction problems are complex and multi-variant. Potentially such problems may include factors connected to: the process of colonisation; poverty; poor education; intergenerational problems; physical health; and stigma.

We also acknowledge that involvement with consumers, family, or whānau is likely to involve multiple providers and that our model of engagement needs to focus on producing an integrated response that is tailored to the people concerned, and flexible in its response to the complexities of people's lives.

On the following pages we now present our strategic goals, the objectives that underpin them, and the actions that will be carried out for them to be achieved. The final section (projects) details the work currently being undertaken to achieve those actions and contribute to our strategy.

Section Three: The Way Forward

Our Strategy for the Mental Health and Addiction Sector

Aim	Objective	Strategic Actions
<p>1. Promotion, Prevention, and Education</p>	<p>Promote a strengths based approach that supports good mental health and prevents addiction.</p> <p>Identify ‘contextual’ and environmental factors that impact mental health</p> <p>Focus on wellness and wellbeing promotion</p> <p>Develop initiatives aimed at facilitating service access for high risk groups, for example Pacific people, Maori, LGBT, including de-stigmatisation programmes</p>	<p>Promote social inclusion</p> <p>Focus on needs of Māori and other specific population groups, e.g. Pacific de-stigmatisation and mental health promotion programme is delivered in Pacific churches</p> <p>Contribute to other projects that promote wellbeing</p> <p>Contribute to activities that reduce stigma associated with mental health or addictions</p> <p>Ensure implementation of suicide prevention action plan</p> <p>Development of a Pacific consumer leadership</p> <p>Develop partnerships with other agencies involved in promotion, prevention, and education, e.g. Mental Health Foundation</p>
<p>2. Build Mental Health and Addiction Services</p>	<p>Identify gaps in the mental health and addiction continuum (Provider Arm, NGO and Primary Care)</p> <p>Develop projects that close these gaps with service reconfiguration or more rarely new programmes and services</p>	<p>To achieve the necessary changes and improve outcomes significant reconfiguration of services maybe necessary as new funding is limited.</p> <p>Building youth health services capacity.</p> <p>Planning and developing services to increase capacity for Older People to reflect changing demographics.</p>

	Aim for improved access to services by removing obstacles	Focus on early identification and intervention for vulnerable groups, e.g. aligning to whānau ora, early access for Pacific and Māori of all ages. Encourage greater NGO and DHB cooperation to avoid duplication
3. Responsiveness of Services	Ensure that all services whether new or existing facilitate access at the earliest possible point of need, especially for specific populations with unique needs and vulnerabilities. Focus on community based models of service delivery Services that are flexible and adaptive	Knowledge in mainstream services of specific cultural and clinical needs Recovery and social inclusion focussed services Mechanisms in place for consumer, whānau, and family feedback, which is then used for making services more responsive When planning or reconfiguring services for Pacific People consider developing services based on Pacific models of health Develop services for Chinese, Indian, and other ethnic communities to facilitate access to mainstream services Improve understanding of mental health and addiction treatment needs of refugee and migrant communities and facilitate access to mainstream services Develop effective partnerships with Manawhenua and Taurahere
4. Workforce for Recovery and Social Inclusion	Foster workforce culture that supports recovery, focuses on social inclusion, is culturally competent,	Promote and support the development of a consumer workforce through service development and reconfiguration

	<p>and has a commitment to quality</p>	<p>Foster a culture of ‘evidence based’ best practice and continuous quality improvement through showcasing, and innovation recognition</p> <p>Support the development of a competent workforce that is: knowledgeable, professional, adaptable, flexible, so that it can readily meet any future needs</p> <p>Develop workforce competency and individual practitioners to meet the needs of Māori</p> <p>Implement workforce development strategies to increase the Pacific and Māori mental health workforce</p> <p>Deliver training in cultural and clinical competencies to support service providers to work effectively with specific cultural groups, e.g. Māori, Pacific, LGBT, Muslims, Asian</p> <p>Support the building of leadership capacity especially for priority groups</p>
<p>5. Māori Mental Health</p>	<p>Focus on broadening access for Māori so that they present earlier to services, they have a choice of provision including kaupapa Māori models of delivery, can actively participate in planning and delivery especially through governance of an Iwi-based solution for service provision</p>	<p>Support the implementation of the northern region Māori mental health plan: Whānau Oranga Hinengaro.</p> <p>Focus on early intervention through identification, and treatment for all age groups</p> <p>Ensure the development of services that provide a choice of treatment delivery, including Iwi based solutions</p> <p>When planning services for Māori consider developing services based on Maturanga Hinengaro and Māori models of health</p>

		<p>Promote the implementation of whānau ora and practices that are whānau inclusive</p> <p>Work towards the delivery of services in settings that are accessible and appropriate for Tangata Whaiora (for example, home, marae, etc).</p> <p>Strengthen the viability and sustainability of kaupapa Māori mental health and addiction services.</p>
<p>6. Primary Care Mental Health</p>	<p>Strengthen the capacity of primary care to promote mental health and wellbeing.</p> <p>Build linkages between primary care and secondary care services to ensure integration.</p> <p>Ensure developments provide equity of access across the community</p>	<p>Support early detection of mental health and addiction in primary care</p> <p>Promote a flexible stepped care approach to delivery of services</p> <p>Ensure systems are in place so that people with severe mental health or addiction problems have their physical health needs met</p> <p>Increase the responsiveness of primary care through workforce development</p> <p>Consider the role of NGOs in primary care mental health and addictions work</p>
<p>7. Addiction</p>	<p>Ensure alignment between addiction and mental health services</p> <p>Support the early identification of addiction problems, including gambling</p> <p>Identify gaps in service provision across the</p>	<p>Work to identify intersectoral opportunities including those with justice services, particularly in relation to Co-Existing Problems (CEP)</p> <p>Support the development of addiction identification in primary care with existing workforce</p> <p>Support the development of</p>

	<p>addiction spectrum and support the development of appropriate services</p>	<p>evidence based choice for consumers across the spectrum, including harm reduction options.</p> <p>Support best practice and evidence based treatment services</p> <p>Support CEP capacity & capability for mental health and addictions workforce including NGO sector</p>
<p>8. Quality Management and Continuous Improvement</p>	<p>Foster learning and evaluation</p> <p>Remove barriers that prevent choice across the continuum.</p> <p>Support the development of provider capability</p> <p>Maximise use of resources, minimise clinical risk and ensure optimal use of workforce capability</p> <p>Use framework of stepped care approach for whole continuum to facilitate right service, right time, and right place.</p> <p>Improve reporting of information</p>	<p>Ensure contracting mechanisms are efficient and produce the outcomes required</p> <p>Use available data to match need, demand, and capacity and ensure competency to deliver as required</p> <p>Foster the sharing of data and information to improve performance throughout the continuum</p> <p>Promote innovative and effective practice together with continuous quality improvement and evaluation</p> <p>Explore long term conditions approach to mental health including self management, e-therapy, stepped care, and peer support to assist maintaining recovery.</p> <p>Explore opportunities (contract requirements) for linking with other services e.g. housing, social services, and WINZ.</p> <p>Use performance reporting to inform service improvements, reconfiguration, and developments across mental health and addiction.</p> <p>Match design and configuration of services to evidence based and best practice models to facilitate</p>

		<p>improvements in services (evidence, effectiveness, and value for money).</p> <p>Support the development of appropriate clinical outcome measures for services</p>
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Core requirements for the reconfiguration of services or the development of new services:

- Reliable outcomes reporting for existing services
- Strong evidence based for the effectiveness of a service or clinical model
- Clear projections that any reconfiguration or change will lead to improved services for consumers and whānau.

Glossary



Community and Public Health Advisory Committee Agenda

MEETING DETAILS		
Time and Date	2:00 p.m. – 5:00 p.m. Wednesday 16 March 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, Dr Lester Levy, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.	
Apologies	Rob Cooper	
In Attendance	Garry Smith, Dr Denis Jury, Taima Campbell, Hilda Fa'asalele, Naida Glavish, Janice Mueller, Ian Bell.	
	Item	Page No
1 5m to 2:05 pm	Karakia	001
2 5m to 2:10 pm	Attendance and Apologies	005
3 5m to 2:15 pm	Conflicts of Interest	007
4 10m to 2:25 pm	Confirmation of Minutes - Wednesday 16 February 2011	017
5 15m to 2:40 pm	Action Points - Wednesday 16 February 2011	023
6 20m to 3:00 pm	Planning and Funding Performance 6.1 Planning and Funding Summary Report 6.2 Planning and Funding Indicators List and Exception Report 6.3 National Targets	027
7 10m to 3:10 pm	Improvement Activities 7.1 DAP Projects Report	049
8 10m to 3:20 pm	Feedback from Maori Health Advisory Committee and Pacific Health Advisory Committee	057
9 20m to 3:40 pm	Review 9.1 Annual Plan 2011-12	059
10 40m to 4:20 pm	Papers 10.1 Community Dialysis 10.2 Mental Health and Addictions Strategic Plan	065

11 10m 4:30 pm	For Information 11.1 Current Consultation Proposals - PHARMAC & 20 DHBs	081
12 10m to 4:40 am	Confirm 12.1 Actions Points for next CPHAC Meeting 12.2 CPHAC Feedback to Board	087
13 10m to 4:50 pm	General Business	089
14 10m to 5:00 pm	Appendices 14.1 Mental Health and Addictions Strategic Plan	091
NEXT MEETING		
	Date and Time: 2:00 p.m. – 5:00 p.m. Wednesday 20 April 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