



Waitemata
District Health Board
Te Wai Awhina

Community and Public Health Advisory Committees Meeting

Wednesday, 9th November 2011

2.00pm

Venue

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

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 12 October 2011

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 12 October 2011 be approved.

(Note: The public excluded minutes of the above meeting are included under separate cover (pink) with Committee members' copies of this agenda. It is suggested that, unless there are any issues which require discussion, approval of the public excluded minutes could be incorporated in the above resolution, without moving into public excluded session).

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community & Public Health Advisory Committees

Wednesday 12 October 2011

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna
commencing at 2.00p.m

PART I – Items considered in public meeting.

COMMITTEE MEMBERS PRESENT:

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

ALSO PRESENT: Dale Bramley (WDHB, Chief Executive)
Debbie Holdsworth (WDHB, Acting Chief Planning and Funding Officer)
Denis Jury (ADHB, Chief Planning and Funding Officer)
Hilda Fa'asalele (ADHB, General Manager, Pacific Health)
Paul Garbett (WDHB, Board Secretary)
Andrew Old (ADHB and WDHB, Medical Advisor – Service Integration)
Jocelyn Peach (WDHB, Director of Nursing and Midwifery)
Janine Pratt (WDHB, Group Planning Manager)
Imelda Quilty-King (WDHB Community Engagement Co-ordinator)
Tim Wood (WDHB Manager Funder NGO)

PUBLIC AND MEDIA REPRESENTATIVES:

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

LEAVE OF ABSENCE: Alfred Ngaro

APOLOGIES: Apologies were received from Lester Levy, Garry Smith, Taima Campbell and Naida Glavish.

WELCOME

The Committee Chair, Lee Mathias, welcomed those present. She advised that Alfred Ngaro will be on formal leave of absence until the elections, as he is a list candidate on the National Party list.

DISCLOSURE OF INTERESTS

The following alterations for the Register of Interests were advised:

- Jo Agnew – no longer Senior Lecturer Nursing, University of Auckland; now Professional Teaching Fellow, University of Auckland
- Susan Buckland – has been appointed a member of the Northern Regional Ethics Committee
- Warren Flaunty – include membership of the Health Practitioners’ Disciplinary Tribunal
- Lee Mathias – no longer Director, Iris Limited
- Robyn Northey – no longer a member of the Northern Regional Ethics Committee

With regard to the open agenda, Agenda Item 3.2 – Submission to the Draft Auckland Plan, Sandra Coney advised of a conflict of interest as a member of the Auckland Council. It was agreed by the Committee that, while Sandra would not take part in discussion on submission content, or the decision on the item, it would be appropriate and useful for Sandra to remain in the meeting room while the item was discussed, to provide information on the Draft Auckland Plan. Warren Flaunty and Christine Rankin also noted their membership of Auckland Council Local Boards, but that this was not an issue in their involvement of consideration of this item (the Local Boards will not be hearing the submissions on the Auckland Plan).

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 14 September 2011 (agenda pages 1-11)

A correction was noted for Item 7 in the minutes: “Matthias” to be corrected to read “Mathias”.

Resolution (Moved Warren Flaunty/Seconded Jo Agnew)

That, with the correction noted at the meeting, the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 14 September 2011 be approved.

Carried

Matters Arising:

It was noted that regular updates on Whanau Ora will be provided in the monthly Primary Care Update from November.

3 DECISION ITEMS

3.1 A Locality Approach for Health Service Planning (agenda pages 13-20)

Dr Andrew Old (Medical Advisor – Service Integration, Auckland and Waitemata DHBs) and Dr Janine Jolly (Localities Manager, Auckland and Waitemata DHBs) were present for this item. They summarised the report.

Matters covered in response to questions and in discussion included:

- There is some existing evidence from the United Kingdom on best practice community engagement in the health sector, and also a growing body of evidence internationally about the value of co-design, in managing community expectations and improving understanding of the health system. The approach being taken in Auckland is an opportunity to gather further evidence.
- Data collection involved building on university research and the partnership with AUT.
- At the moment the focus is on locality health needs assessments, locality health plans and the formation of locality health partnerships, however in terms of looking at the possibility of adapting the Waitemata health link concept for Auckland DHB, the embryonic thinking was a possible model of a single health link for the whole Auckland DHB area (seven local board areas), but ensuring representation from each area. That is only an initial idea and thinking about this is just beginning.
- The importance of engaging with other Government funded activities, such as Whanau Ora, was acknowledged and Andrew Old emphasised the facilitative approach being adopted to bring together existing activities and avoid duplication.
- The locality approach involved both meeting the health needs of local communities and having an impact on the determinants of health, which was a focus of the work with Auckland Council and the other non-Government organisations.
- Communication included Community Links and the Community Links Centre in Glen Innes.

In discussion on this item Rob Cooper referred to a thoughtful paper on Whanau Ora written by Eru Lyndon and it was agreed that this obtained for distribution to Committee members.

Resolution (Moved Tim Jelleyman/Seconded Susan Buckland)

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

That the Boards:

- a) Note the background and progress made to date on developing a locality approach in Auckland DHB.**
- b) Note the linkage with concurrent primary care and community engagement activity, and the actions to align and coordinate across Auckland and Waitemata DHBs.**

Carried

Denis Jury advised that Janine Jolly would be leaving Auckland DHB in a few days time to shift to Wellington. He acknowledged and thanked Janine for her contribution to bringing the locality approach concept to where it is now, a very important strategy for the development of Auckland health services.

The Committee asked that a progress report on the Locality Approach be brought back to it in February or March 2012.

3.2 Auckland Council – Draft Auckland Plan Submission (agenda pages 21-33)

Andy Roche (Policy Analyst, Auckland Regional Public Health Service) and Janine Pratt (Group Planning Manager, Waitemata DHB) were present for this item.

Janine Pratt conveyed an apology from Frank Booth (Service Manager, Auckland Regional Public Health Service). She acknowledged the major role of the Regional Public Health Team and Andy Roche in preparing the draft joint submission and noted that many of the matters requested in earlier submissions to the “Auckland Unleashed” discussion document had already been incorporated by the Auckland Council in the Draft Auckland Plan.

Denis Jury expressed his appreciation of the fresh approach being taken by the Auckland Council and the new enthusiasm being shown to understand the health perspective. The Draft Auckland Plan provided a strong signal for the future on what can be achieved by working together. He also suggested that there may be other ways that health can help city planning, for example by providing information on “near misses” which highlighted issues of safety that the Council could address.

Matters covered in discussion of this item included:

- The child health perspective is well covered in the Draft Auckland Plan and the right questions are beginning to be asked, but it will be important to keep asking those questions as planning progresses.
- Strong satisfaction with the approach the Auckland Council has taken to date in including explicit involvement of the health sector in its thinking and the opportunity this brings for Council resources to be brought to bear on addressing underlying health issues.
- The need to look at strengthening contact at a range of operational levels as well as strategically.

Andy Roche advised that it is hoped to have the draft submission finalised for circulation by Monday, 17 October.

The Committee agreed on the following process for approving the submission:

- (i) The submission will be distributed to all Committee members.
- (ii) Committee members will notify the Secretary for the Committee (Paul Garbett) of their agreement to the submission.
- (iii) The Secretary will notify the Committee Chair of the response from members.
- (iv) The Committee Chair will sign the submission, which will be forwarded to the Auckland Council. (The action taken can be referred to the following meetings of the Auckland and Waitemata District Health Boards for formal endorsement.)

Resolution (Moved Rob Cooper/Seconded Peter Aitken)

- a) **That the report be received and that the Committee notes that submissions on the Draft Auckland Plan close on 25 October 2011.**
- b) **That the Committee notes the further information on the draft submission made available at the meeting.**
- c) **That the process for approving the final submission consist of a “circulated resolution” process, details as agreed at the meeting.**

Carried

Andy Roche confirmed that it is intended to present orally at the hearing of submissions.

3.3 Oral Health (agenda pages 35-46)

Vicki Scott (Programme Manager Youth and Oral Health, Waitemata DHB), Rachel Mattison (Associate Planning and Funding Manager, Primary Care and Oral Health, Auckland DHB), and Sathananthan Kanagaratnam (Clinical Director, Auckland Regional Dental Service) were present for this item.

Sathananthan Kanagaratnam provided a powerpoint presentation on progress in terms of the Oral Health Business Case and oral health issues in the Auckland and Waitemata DHB districts.

Matters covered in consideration of this item included:

- Deep concern at the statistics for child and adolescent dental health
- The very significant disparities in oral health for Maori and Pacific children and adolescents (compared to the rest of the population) remain.
- Oral health historically has not had a high profile in health and it is positive to see that changing.
- It remains an anomaly that for many adults oral health is the one area of health that they can not afford to access.
- The need for greater co-ordination between education and health. An argument raised by some of those schools which decline to have visits by the mobile dental service is that already a number of other mobile services, for example mobile libraries, visit the school and that it would be disruptive to allow more such services. Vicki Scott advised that the decision on whether or not to allow mobiles is sometimes made by the school principal and sometimes the school board. There had been progress on this issue with some schools, but not others. It was also noted that reactions from schools varied markedly, with some principals and school boards really embracing the new dental services enthusiastically. The Committee Chair requested that the Committee be kept updated on this issue and suggested that it may be necessary to consider an approach at the national level (the subsequent resolution refers).
- It was also suggested that it would be worthwhile to obtain more detailed information on what other mobile services visited the schools and possibly look at ideas for rationalisation/co-ordination. It was agreed that an exercise be carried out to establish the number and types of mobile services visiting schools (primary and secondary).
- The Committee endorsed the request from Rob Cooper that presentations which deal with addressing minority needs should highlight these early in the presentation, to emphasise their priority.
- Sathananthan Kanagaratnam advised that approximately 10% of children go to private dental facilities. If children are not enrolled when mobile clinics visit, enrolment forms can be completed on the spot if their parents are available to sign them. In other cases the practice is to inform the school and provide enrolment forms in advance of visits. A small number of children do miss being enrolled.
- The Committee also noted the wider social issues around oral health, including the type of food and drinks being consumed.
- The Committee Chair suggested the possibility of oral health being the next major health issue to be identified following the campaign for immunisation.

Resolution (Moved Pat Booth/Seconded Chris Chambers)

That the Committee notes that the activity under the Oral Health Business Case is progressing to plan and notes:

- i) The significant reduction in arrears in the service delivered by Auckland Regional Dental Service (ARDS).**
- ii) Ministry of Health targets are being achieved or exceeded for the percentage of children caries free at five years of age in the Waitemata and Auckland DHBs.**

- iii) **Arrears rates slightly exceed Ministry of Health targets.**
- iv) **The adolescent oral health utilisation rate has reached 61.5% for Waitemata DHB and 71.8% for Auckland DHB. The District Annual Plan (DAP) target is 60% and 68% respectively for 2010/11.**

Carried

Resolution (Moved Chris Chambers/Seconded Susan Buckland)

(a) That the Committee endorses the:

- i) **Current and planned activity to be undertaken by ARDS across the region to address the Mean Decayed Missing Filled Teeth (DMFT) score at Year 8 which is slightly below Ministry of Health target.**
- ii) **Current and planned activity to be undertaken across the region to reduce inequalities and increasing access to services for high need groups.**

(b) That the Committee requests that presentations that deal with addressing minority needs highlight these early in the presentation, to emphasise their priority.

Carried

Resolution (Moved Sandra Coney/ Seconded Warren Flaunty)

That the Oral Health Programme Managers be requested to discuss the issue of schools declining mobile oral health services with the Ministries of Health and Education, and report back to the Committee on the response received.

Carried

4 INFORMATION ITEMS

4.1 Mental Health Information Paper (agenda pages 47-53)

Howard Dawson (Programme Manager, Waitemata DHB) and Robert Ford (Programme Manager, Auckland DHB) were present for this item.

Howard Dawson introduced the report and referred to the issues related to the Court of Appeal decision concerning payment for sleepover staff. Denis Jury noted the Government's decision to contribute 50% of the cost of back pay for the last six years, and that while there is no direct liability to the District Health Boards as a result of the decision, there is the potential impact from the providers needing to recover their additional costs, and these floating back to costs for District Health Boards when contracts are renewed or new contracts tendered.

Matters covered in response to questions and in discussion of this report included:

- Waitemata DHB plans to phase out residential rehabilitation Level 3 beds (which have sleepover staff) by August 2012.
- The Auckland DHB RFP Process for an Iwi based solution for Kaupapa Maori Services (page 52 of the agenda) very much embraces the Whanau Ora approach.
- With regard to concerns expressed about people with mental health problems in Onehunga, services there include some Level 3 Rehabilitation Services which are well provided for and well staffed. In the case of individuals with mental health

problems who live alone, routine visits are carried out by support services to assess any issues and assist them in meeting their living needs and rehabilitation needs. Once discharged they move to the care of a general practitioner, and they may or may not have a support worker visiting them. Usually if the mental health of someone like this deteriorates, there will be a trigger which brings their case to the attention of Mental Health.

- The differing costs for the two District Health Boards for residential rehabilitation services reflect the distribution of beds and some of the differing requirements of parts of the populations served.

The Committee received the report.

4.2 Community/Consumer Engagement (agenda pages 55-61)

Imelda Quilty-King (Community Engagement Co-ordinator, Waitemata DHB) was present for this item and conveyed an apology from Tony O'Connor (Engagement and Planning Manager, Auckland DHB). Also present were Margaret Willoughby (Rodney Health Link), Tracy McIntyre (Waitakere Health Link) and Deborah Dalliessi (North Shore Community Health Voice).

Matters covered in discussion of this item included:

- Vigorous debate over the merits of the word “consumer” in the context of health services, with contrasting viewpoints for and against.
- Margaret Willoughby referred to the work carried out by Rodney Health Link (page 58-59 of the agenda) and an information pack distributed at the meeting including annual reports and newsletters from the Health Links/ Health Voice.
- Tracy McIntyre referred to the information from Waitakere Health Link (pages 59-60 of the agenda) and highlighted the NGO Open Day at Waitakere Hospital on 31 October. She also extended an invitation to Andrew Old to attend one of their Committee meetings.
- Deborah Dalliessi referred to the information from North Shore Community Health Voice (page 60 of the agenda) and extended an open invitation to all Committee members to feel free to contact them if they had any questions. She noted the substantial increase in the work being done with the District Health Board and that there are now many more levels of engagement than in the past. She advised that they are very aware of localities planning and had been asked to go back to their communities to look at some questions relating to this.
- The Committee Chair noted for the information of the Health Link/Health Voice representatives that Auckland DHB would be considering how it might use the Health Links model.

Resolution (Moved Warren Flaunty/Seconded Max Abbott)

That the report be received.

Carried

5. STANDARD MONTHLY REPORTS

5.1 Primary Care Update (agenda pages 63-69)

Andrew Coe (Group Manager – PHOs and Primary Care, Auckland and Waitemata DHBs) and Stuart Jenkins (Clinical Director Primary Care, Auckland and Waitemata DHBs) were present for this item.

Answers to questions included:

- Discussions are still ongoing with Waitemata PHO about confirmation of their participation in GAIHN. The Committee asked to be kept informed on this. It was noted that the Audit and Finance Committees of both Boards would be considering a report relating to GAIHN at their November meetings.
- Unspent funds – PHO cash reserves (page 69 of the agenda) - it is estimated that the total value may be around \$20M across the region. Work is being carried out in the case of each former PHO to drive down those cash reserves over a two year period and re-invest them in health services for the population. There is still the opportunity to get back funds from organisations no longer in existence and the Committee will be kept informed on progress with that process on a monthly basis.
- Access to Diagnostics (agenda page 67) – in the majority of cases, problems with practices getting connected to the system had been overcome. There are still some issues with non ProCare Practices that use MedTech as their Patient Management System, as detailed in the agenda report. Debbie Holdsworth noted that this is an issue that has concerned Waitemata DHB for some time, and needs to be addressed on a national basis through the National Health IT Board.
- Clinical Pathways (agenda page 68) – in response to questions raised more information will be brought back in the next report about all the levels where pathways is being dealt with and resourcing implications.
- Rheumatic fever – Lee Mathias advised of a new ELISA (enzyme linked immuno assay) being developed for rheumatic fever. A blood test may be possible.
- Weekly Primary Care Reports – in view of the new standard Primary Care report for the CPHAC agenda, it was agreed that it was not necessary to continue to produce these on a weekly basis for e-mailing to Board members. Any information that members should be made aware of quickly could be circulated separately when the need arose.

The Committee received the report.

5.2 Planning and Funding Update (agenda pages 71-75)

Denis Jury (Chief Planning and Funding Officer, Auckland DHB) and Debbie Holdsworth (Acting Chief Planning and Funding Officer, Waitemata DHB) responded to questions relating to the report and provided additional information, including:

- Closure of the Bethany Centre by the Salvation Army – the Salvation Army is still working on what services will replace those that have been provided by the Bethany Centre for young unsupported pregnant women. The Salvation Army is keeping Auckland DHB involved in this issue and the Committee will be kept informed. At this stage there is a possibility of future support being more day support rather than residential support.
- Funding of Sexual Assault Services (agenda page 74) – further to the information in the report, Denis Jury advised that an interim solution had been progressed with the three district Health Boards and other supporting organisations and it can now be assumed that the service will be able to continue in its current form for at least 1-2 years while a more permanent solution is being pursued. The Committee would be kept informed on this and

if there is anything further on Maternity Service Specifications (page 75 of the agenda), although that matter is probably resolved.

- With regard to the additional measures being taken to extend the scope of measles immunisation (page 72 of the agenda), the funding impact for the region is likely to be between \$1.5M and \$2.5M. The respective CEOs will be informing the Finance and Audit Committees at their next meetings.

The Committee received the report.

6. GENERAL BUSINESS

Dale Bramley advised members that:

- Professor Ron Paterson has been appointed by Waitemata DHB to review its clinical quality processes. He is eminently qualified in this area, including previous work as Health and Disability Commissioner.
- Earlier in the day there had been a formal launch of the Bowel Screening Pilot to be delivered by Waitemata DHB. Special thanks were due to the team working to put this programme in place. The Pilot is attracting a great deal of attention in the media.
- Naida Glavish has been appointed to the new joint position Chief Advisor Tikanga for both Auckland and Waitemata District Health Boards. Maori health clinical staff would report both to the relevant clinical manager for clinical matters and to Naida for Tikanga/cultural matters.

The Committee Chair advised that the following principles should apply with regard to responding to requests for information from members. Where the question is a minor or single issue matter, an officer will be allocated to respond directly to the member (not in paper form). Papers will only be produced in response to a request which comes from the Committee as a whole.

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved Lee Mathias/Seconded Warren Flaunty)

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

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

General subject of item to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
<p>1. Confirmation of minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 14 September 2011 with public excluded</p>	<p>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</p> <p>[NZPH&D Act 2000 Schedule 3, S.32 (a)]</p>	<p>Confirmation of Minutes</p> <p>As per the resolution from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.</p>

Carried

The Committee Chair thanked members for their participation.

The meeting concluded at 4.20p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA
DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY
COMMITTEES HELD ON 12 OCTOBER 2011

CHAIR

Actions Arising and Carried Forward from Meetings of the Community & Public Health Advisory Committees as at 31 October 2011

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
WDHB CPHAC 13/4/11	4.3	<u>Interpreter Service</u> – Next Asian Health Service Update to include information on level of service provided, number of times used and cost.	Sue Lim		Included in CPHAC agenda 09/11/11.
CPHAC 10/8/11	3.1	<u>CPHAC Terms of Reference</u> – suggested improvements from Chris Chambers to be considered.	Denis Jury, Debbie Holdsworth		Will be included in review of CPHAC in early 2012.
CPHAC 12/10/11	3.1	<u>Paper on Whanau Ora by Eru Lyndon</u> – to be circulated to Committee members.	Paul Garbett		Requested – will be circulated when received.
CPHAC 12/10/11	3.1	<u>Local Approach to Health Service Planning</u> - progress report requested for February or March 2012.	Andrew Old	CPHAC 14/3/12	
CPHAC 12/10/11	3.3	<u>Oral Health</u> - issue of schools declining mobile oral health services to be discussed with the Ministries of Health and Education and reported back to CPHAC -more detailed information to be obtained on number and type of mobile services visiting schools (primary and secondary).	Vicki Scott, Rachel Mattison Vicki Scott, Rachel Mattison	CPHAC 14/12/11 or 01/02/12 CPHAC 14/12/11 or 01/02/12	Will depend on how quickly response comes from the various parties.
CPHAC 12/10/11	3.3	<u>Presentations dealing with minority needs</u> – request that minority needs be highlighted early in presentation to emphasise their priority.	Debbie Holdsworth, Denis Jury, Paul Garbett, Ian Bell		Noted – to endeavour to anticipate and advise those preparing presentations.
CPHAC 12/10/11	5.1	<u>Clinical Pathways</u> – more information to be provide in November Primary Care Update about all the levels where pathways is being dealt with and resourcing implications.	Andrew Coe (to co-ordinate comment for the report)		Comment included in Primary Care update 09/11/11.

3.1 2012/13 Planning

Recommendation:

That the Community and Public Health Advisory Committee recommends to the Waitemata and Auckland District Health Boards

That the Board:

- 1. Approve the approach to annual planning for 2012/13, including the longer term direction and timetable.**
- 2. Note the suggestion for a joint set of annual plan priorities for Auckland and Waitemata DHBs.**
- 3. Note the draft national planning guidance which has been sent out to members electronically.**

Prepared by: Janine Pratt (Group Planning Manager, Waitemata DHB) and Julie Helean (Planning and Service Development Manager, Auckland DHB)

Glossary

BSMC	- Better Sooner More Convenient
DAP	- District Annual Plan
DHB	- District Health Board
GAIHN	- Greater Auckland Integrated Health Network
HBL	- Health Benefits Limited
LWOM	- Living Within Our Means
NDSA	- Northern DHB Support Agency
NHB	- National Health Board
PHO	- Primary Health Organisation
WDHB	- Waitemata District Health Board

1. Executive Summary

DHBs are required to prepare an annual plan and statement of intent prior to 1 July 2012. We are also required to contribute to the development of the revised Northern Region Health Plan which is being co-ordinated by the Northern Region DHB Support Agency (NDSA) on our behalf. Instructions regarding the plans are released each year by the National Health Board in a suite of policy and guideline documents known as the Planning Package. This package is now available in draft form for DHBs to comment on. The final will be released in November.

A proposed approach to the annual plan, focussed on the increased alignment between Auckland DHB and Waitemata DHB, and the timetable of key activities required to complete the plan, is presented in this paper. This has been developed based on the draft guidance provided by the National Health Board.

Like 2011/12, ongoing discussions will be required throughout the process with the National Health Board, NDSA, BSMC business case partners and other DHBs to ensure the requirements are being met in a way that is appropriate for all stakeholders.

Requirements for the 2012/13 year are very similar to the last planning round, with a few exceptions:

- DHBs are required to complete a new template of activity specifically directed at Living Within Our Means (LWOM)
- There is a requirement to demonstrate progress against national, regional and local workforce development objectives
- Annual Plans are expected to demonstrate increased progress for their Better Sooner More Convenient work within primary health care, with the 2012/13 emphasis being on primary healthcare activity beyond general practice
- There is an increased focus on sustainability and clinical integration.

2. Introduction/Background

The New Zealand Public Health and Disability Act and the Crown Entities Act require the DHB to prepare accountability plans prior to the start of each financial year. These include the Regional Services Plan, Annual Plan, and Statement of Intent, all of which are available to the public on the DHB's website www.waitemataadhb.govt.nz and www.adhb.govt.nz. These plans describe each DHB's longer term direction and the key actions to be undertaken each year in order to achieve the outcomes sought.

2011/12 was the first financial year under the new planning environment which included a regional services plan, rather than a district strategic plan. As we move into the second year of these arrangements, there are increased expectations and specific requirements from the National Health Board with regard to the regional services plan (Northern region health plan NRHP) which were not in place in year 1. These include specific priority areas where the National Health Board requires a regional response which is not currently included in the NRHP e.g. mental health. For the annual plan, there is an increased focus on sustainability, clinical integration and living within our means.

3. Proposed Approach to 2012/13 Planning Round

3.1 Annual Plan

The National Health Board is currently preparing the guidance for the 2012/13 planning round. This includes the annual plan guidelines, operating policy framework, service coverage schedule and reporting requirements (refer to attachment 1 for detailed descriptions of these documents). The drafts were released to the sector on 21 October, with the final versions to be released on 18 November.

Auckland and Waitemata DHB staff have been involved in the development of the annual plan guidance and support the approach being taken, though acknowledge that this continues to be an evolving process and so will require ongoing discussions throughout with the National Health Board, NDSA, BSMC business case partners and other DHBs to ensure the requirements are being met in a way that is appropriate for all stakeholders.

The draft guidance continues the prescriptive approach to the annual plan carried over from 2011/12. This includes a mandatory structure for the document and clear expectations of what is required within each section. The current draft structure is modular and includes:

- Module 1 – Introduction (includes the executive summary and context)

- Module 2 – Strategic Direction (includes national, regional and local strategic direction and key strategies to achieve outcomes sought by the DHB)
- Module 3 – Delivering on priorities and targets (the key actions to achieve the DHB’s outcomes focusing on government priorities, health targets and regional and local priorities)
- Module 4 – Stewardship (includes a summary of the key actions to develop the DHB’s capability and capacity and its ownership responsibilities - this is a Crown Entities Act requirement and this year has an increased focus on workforce)
- Module 5 – Forecast Service Performance (the performance story of what achievement will look like – this is a Crown Entities Act requirement)
- Module 6 – Service configuration (includes a summary of service coverage exceptions and any service changes planned)
- Module 7 – Financial Performance (financial statements and assumptions)
- Module 8 – Appendices
- Summary table of DHB standard reporting measures
- Glossary.

As per 2011/12, only Modules 1, 2, 4, 5 and 7 will be extracted to be tabled in parliament to comply with the Statement of Intent requirements within the Crown Entities Act.

Strategic Direction

In 2011/12, Auckland and Waitemata DHB Boards developed similar sets of Top Ten Priorities and key priority areas for focus. These are listed below in figure 1. For 2012/13, it is proposed that Auckland and Waitemata DHBs build forward on these similarities and develop a joint set of priorities which is used to guide annual planning for both organisations. This recognises the overall strategic direction that is being driven by the Minister of Health through the National Health Board and within the Northern Region Health Plan, which both DHBs are committed to, as well as the increased collaboration between the two DHBs. There are also opportunities to work together on ensuring the ‘look and feel’ of the documents are the same.

Figure 1: 2011/12 Board priorities

Auckland DHB Board priorities	Waitemata DHB Top Ten Priorities
<ul style="list-style-type: none"> • Meet or exceed the 6 national health targets, before December 2011) • Clinical excellence coupled with patient service • Innovative models of care • Clinical leadership • Regional collaboration and integration • Proactive management of emerging issues • Value for money in all we do • Financial discipline • Address the needs of priority populations (children, Maori, Pacific, disabled, older people, “new” New Zealanders) 	<ul style="list-style-type: none"> • Culture • Emergency care • New models of care <ul style="list-style-type: none"> ○ Primary care ○ Whanau ora ○ Readmission ○ Promoting good health • Clinical leadership • Regionalisation through collaboration • Health of older people • Elective surgery • Chronic disease management • Living within our means • Cancer (bowel screening) • Priority populations and service areas (Māori, Pacific, Asian, migrant and refugees, Children and young people and Mental health)

A key consideration for the development of the joint set of priorities is the National Health Board guidance. Information shared with the sector to date indicates the key themes for 2012/13 are sustainability and clinical integration, alongside the following priority areas:

- Utilising Better Sooner More Convenient – clinical integration to support long term financial sustainability across the following areas:
 - Health of older people
 - Mental health
 - Primary care
 - acute demand management, child health, immunisation, cvd/diabetes, tobacco cessation
 - Improved access to services
 - cancer, cardiac, electives
 - Whanau ora.

- With an emphasis on:
 - Regional collaboration and governance
 - Clinical integration
 - Primary and community services
 - Service quality and value for money.

There is an expectation that the national health targets will be updated. These changes have not been shared with DHBs to date, though are expected to reflect the priorities described above.

Statement of Intent

An area that has been an ongoing issue for all DHBs, as it has not met the Office of the Auditor General's expectations, is the statement of service performance within the Statement of Intent. The requirement is for DHBs to tell a performance story, i.e. indicators or measures, which show the public and other stakeholders how the DHB is performing across the breadth of services it funds and provides. Auckland and Waitemata DHBs worked together for the 2011/12 Statement of Intent and reached the 'good' criteria. The statement of service performance and telling the performance story will be a key focus for the planning teams to ensure that a continued improvement is seen by the auditors.

Financial planning

We have been advised by the National Health Board that "at this stage, the sector should expect a similar level of increase to the DHB funding base as last year. HBL (and DHBs) need to find \$60m savings as a contribution."

Therefore the advice to services as they prepare their draft budgets is in line with the previous year, which is revenue growth is expected to be less than the expected cost growth. As such, savings will be required to bridge any funding gap on 'business as usual' budgets. Following receipt of the funding envelope and allocation of this, service changes and volume growth expectations will be modelled into the budgets. Again, revenue growth is expected to be less than expenditure growth. Therefore, to achieve overall breakeven, further savings will need to be identified and/or service configuration or curtailment may need to be considered to ensure the DHBs live within their means.

Auckland DHB / Waitemata DHB Board process

In previous years, the Boards have set aside time to discuss their priorities for the following financial year. For 2011/12, this resulted in specific Board priorities for each DHB. It is proposed that the Boards consider how they would like to establish priorities for the 2012/13 year and whether these could be confirmed via a joint workshop between Auckland and Waitemata DHB Boards, or in some other way.

Management workshop

Last year's planning process at Waitemata DHB included a workshop to develop the detailed plans to be undertaken in the priority areas. The workshop included approximately 100 management and clinical staff from the DHB, PHOs and other community organisations. It provided an opportunity for the different perspectives to be considered in the planning process and was well received by those who attended. Consideration needs to be given to whether a joint Auckland / Waitemata DHB workshop should be held in mid to late January 2012, focussing on the Board priorities, Minister of Health's priorities and any key areas from the regional services plan which require a local DHB plan.

Auckland DHB will progress the Annual Plan development primarily via the Senior Leadership and also the Planning Group, which is a subset of this being focused on the involvement of Healthcare Service Group Leads. Auckland DHB works closely with the Primary Care Business Cases to ensure that primary care has good representation in planning and that primary care plans are well integrated with those of the district health board.

At Waitemata DHB leadership and strategic direction for the development of the 2012/13 annual plan and budget is provided through the Planning Taskforce. The Taskforce's current focus is on ensuring the many planning mechanisms at a national, regional and local level are joined up within the DHB, particularly with regard to service reviews, regional activities, prioritisation of services and the Business Transformation savings programme in preparation for the detailed financial and non-financial planning scheduled for November/December.

Key milestones

As per 2011/12, the draft annual plan is required by the National Health Board in two parts. Financial statements and detailed spreadsheets are required on 2 March to meet the Treasury deadlines, with non-financial narrative due 23 March. The draft Northern Region Health Plan is due 12 March. A proposed detailed timetable is provided in section 8.

3.2 Regional Services Plan – Northern Region Health Plan

The process of delivering the Plan and coordinating all stakeholders is being managed through the NDSA and the Northern Region Health Plan steering group. The detailed timetable and approach for the revision of the Northern Region Health Plan is being prepared based on the draft planning guidance from the National Health Board and will be linked to the annual planning process.

4. Risks/Issues

Alignment between the regional services plan and the DHBs' annual plans will be less of an issue this year as the longer term direction has been confirmed. However, with the delivery of each document only a week apart, there will be little time to ensure all actions are accurately captured in each plan. There is a risk that the DHBs will end up once again with a confused and poorly integrated performance story creating a perception that the region is not working together effectively. The regional services plan processes and the annual plan processes will need to be developed with plenty of time and opportunity for ensuring alignment of actions and measures.

The constricted fiscal environment will place extra pressures on the planning process. The first draft of the annual plan will be expected to contain comprehensive and firm plans to meet financial and performance targets. The processes and structures which support the development of plans are different across the DHBs i.e. Waitemata DHB business transformation team, continued in 2011, will play a significant role in assisting the planning process. At Auckland DHB, a Planning Group, comprised of members of each Healthcare

Service Group, will assist with longer term planning and specify how this translates into annual objectives for the various healthcare services.

5. Costs/Resources/Funding

The costs expected to be incurred as part of the development of the annual plan over and above the cost of staff time, are associated with the proposed Board and management workshops.

The costs associated with the regional services plan in addition to the cost of staff contributing time to this process are not known at the time of writing.

The above costs as currently known and understood will be managed within existing budgets.

6. Proposed Annual Plan and Regional Services Plan Timetable

Note, while this is the proposed timetable, a number of dates and deliverables are fixed i.e. National Health Board milestones and Board meeting dates.

Key Milestones	Date due	Responsibility
Working draft of Planning Package including Annual Plan and RSP guidelines on NSFL website	21 October	National Health Board
DHB feedback on draft Annual Plan guidelines, RSP guidelines, OPF, SCS and DHB Monitoring Framework and Performance measures due to the National Health Board	31 October	DHBs
CPHAC meeting – planning paper discussed	9 November	Group Planning Manager
Release of final Planning Package	18 November	National Health Board
Sector Workshop (practical implementation of guidance)	24 November TBC	National Health Board / DHBs
Board workshop	TBC	Planning Managers
ELECTION	26 November	
Funding Package to be released (timing influenced by formation of new Government)	ASAP following confirmation of detail	National Health Board
Briefing paper distributed including key messages from funding envelope	ASAP following confirmation of detail	Chief Financial Officers
Minister’s Letter of Expectations released	January 2012	National Health Board
Confirmation of Planning and Funding Package detail taking into consideration election outcome <ul style="list-style-type: none"> A workshop will be arranged to facilitate this 	January 2012	National Health Board

Key Milestones	Date due	Responsibility
Content developed Regional work to ensure alignment over common content Planning team provide advice as required Ongoing discussions with National Health Board	December / January	Planning Teams Finance Teams
DHBs notify National Health Board of service change proposals	Late January	DHBs
WDHB – Audit & Finance Committee – update / briefing on annual plan	1 February	Chief Financial Officer / Group Planning Manager
ADHB / WDHB Joint CPHAC - update / briefing on progress of respective annual plans, including overall structure and format	1 February	Planning Managers
ADHB – Board. Progress on the Annual Plan with financials as available	15 February	Chief Financial Officer
WDHB – Board – Approval of draft Annual Plan Financials and review of draft 1 of the narrative	22 February	Chief Financial Officer Group Planning Manager
Draft Annual Plan financials and production plan information submitted to National Health Board	2 March	DHBs
ADHB Audit Committee - Approval of draft Annual Plan Financials	TBC	Chief Financial Officer
Approval of Regional Service Plan	TBC	
Submission of our draft Regional Service Plan	12 March	NDSA
WDHB – Audit & Finance Committee – Approval of draft Annual Plan narrative	14 March	Chief Financial Officer / Group Planning Manager
ADHB / WDHB Joint CPHAC - Approval of draft Annual Plan narrative	14 March	Planning Managers
Complete draft Annual Plans and Statement of Intent (SOI) submitted for National Health Board review	23 March	DHBs
ADHB Board Meeting. Draft Annual Plan as update	28 March	
National Health Board review of drafts and issues resolution with DHBs	April / May	National Health Board / DHBs
ADHB – Audit Committee	18 April	Chief Financial Officer
National Health Board feedback on draft documents to DHBs	27 April	National Health Board
Report to the Minister outlining key issues and innovations	27 April	National Health Board
WDHB – Audit & Finance Committee – Approval of draft Annual Plan financials	2 May	Chief Financial Officer

Key Milestones	Date due	Responsibility
ADHB / WDHB Joint CPHAC – update / briefing on annual plan	2 May	Planning Managers
Final draft RSPs submitted to NHB	7 May	NDSA
ADHB – Board - Approval of Final Annual Plan	9 May	Planning Manager
WDHB – Board – Approval of Final Annual Plan	16 May	Chief Financial Officer / Group Planning Manager
Final draft Annual Plans and SOIs submitted to National Health Board	18 May	DHBs
National Health Board advice to Minister with recommendations for approval or decline of Annual Plans and RSPs	4 June	National Health Board
Letters to DHBs indicating approval or changes required	15 June (earlier if possible)	National Health Board
Final Annual Plans and RSPs signed by Minister / signed SOI extract to Bills Office / Workforce Strategy to be finalised hereafter.	On or before 30 June	National Health Board / DHBs

7. Conclusion

The 2012/13 planning round will be similar to 2011/12, with a few changes to emphasis in the priorities and a focus on clinical integration and sustainability. The process we are suggesting will potentially complicate the planning process by increasing the conversations and activity between the two DHBs in the preparation of the annual plan. However, this process will be able to build upon the relationships and increasing collaboration and integration between Auckland and Waitemata DHBs including CPHAC, primary care and Maori health. It will also formalise ‘joined-up’ planning activity which has been occurring informally to date.

The key challenges will continue to be ensuring that local DHB annual plans reflect the regional agreements, specifically the regional services plan actions and the DHB’s contributions to the BSMC business case annual plans, while maintaining commitments to local priorities, all within the funding envelope.

The approach described in this paper has been based on the draft guidance provided to DHBs, this will be reviewed once the final guidance and funding envelope has been made available in December. Any substantive changes will be advised to the Board and CPHAC.

Attachment 1 – Definitions of key terms and documents

Term	Definition
Annual Plan	Document prepared by each DHB describing the DHB's strategic direction, goals and key actions to be taken in the year. Provides accountability to Parliament and the public for DHB performance.
GAIHN - Greater Auckland Integrated Health Network	The Network comprises 11 PHOs and the three metropolitan Auckland DHBs who are committed to working together to achieve better health outcomes, better patient experiences and better use of money.
Health Targets	Six national performance measures specifically designed to improve the performance of health services. The targets reflect important priorities and focus accountability and effort on achieving progress.
Intervention logic	A framework for describing the relationships between resources, activities and results.
NDSA - Northern Region DHB Support Agency	Shared services agency joint venture owned by the three Auckland Metro DHBs (Auckland, Counties Manukau and Waitemata), for areas of service provision identified as benefiting from a northern regional (including Northland DHB) solution.
Northern Region Health Plan	Key strategic document for the northern region DHBs (Northland, Waitemata, Auckland, Counties Manukau), also known as the Regional Services Plan.
Operating Policy Framework (OPF)	Set of mandatory requirements as well as policy and guideline principles that outline the operating functions of District Health Boards.
Reporting requirements	The Ministry of Health's DHB performance monitoring framework.
Service Coverage Schedule	Document setting out the range and nature of services that a DHB must ensure are delivered to its population.
Statement of Service Performance	The Crown Entities Act requires DHBs, as Crown Entities, to provide audited statements of objectives and performance indicators and measures which report on the DHB's performance.

4.1 Asian Health Support Services Update

Recommendation:

That the report be received.

Prepared by: Sue Lim (Asian Health Support Manager, Waitemata DHB)

Glossary

ARSS	- Auckland Regional Settlement Strategy
DHB	- District Health Board
NDSA	- Northern District Support Agency
PHIS	- Primary Health Interpreting Service
PHO	- Primary Health Organisation
WATIS	- Waitemata Auckland Translation and Interpreting Service

1. Executive Summary

This is a response to the outstanding action from the Waitemata DHB April CPHAC meeting to report back in November 2011 on Interpreter Services and the level of service provided, number of times use and cost.

2. Waitemata DHB Asian Health Support Services manage Waitemata Auckland Translation and Interpreting Service (WATIS)

Secondary Care Interpreting Service:

WATIS provides a 24 hour 7 day a week service covering up to 84 languages for all the Waitemata DHB mainstream services on a fee for service basis.

The following is the interpreting utilisation (face to face and telephone interpreting) and costs (face to face, telephone interpreting, Tele-Assignment and Appointment confirmation) for period July 2010-June 2011 (12 months) by service group:

Service Group	Utilisation (no of episodes)	Costs
Child, Women and Family	953	\$ 91,293.96
Corporate	15	\$ 2,235.00
Hospital Operations	90	\$ 9,084.46
Medical and Older Adult	2554	\$ 250,001.44
Mental Health Services (including Forensics and CADS)	1289	\$ 123,311.46
Surgical and Ambulatory	6120	\$ 554,804.67
Total	11021	\$ 1,030,730.99

Primary Health Interpreting Service (PHIS)

WATIS also provides a more time restricted service (Monday to Friday 8am to 7pm) to primary health care services funded by the NDSA Auckland Regional Settlement Strategy (ARSS) Contract. The service primarily provides telephone interpreting service and only

provides face to face interpreting services based on specific service guidelines stipulated by the contract. All general practices and PHOs belonging to Waitemata DHB have registered for the service. ARSS has been contracted to further rollout to the wider primary health care services such as PHO allied health services, community pharmacies, community laboratories, community radiology services, accident and medical clinics, independent midwives, Plunket, and many others specified by a contract variation. This wider rollout is staged and has completed 80% of the rollout.

The following is the interpreting utilisation (face to face and telephone interpreting) and costs for the period July 2010-June 2011 by service group.

Service Group	Utilisation (no of episodes)
A&M Clinics	5
Community Laboratory	78
Community Pharmacy	3
Family Planning	15
GP Practices	271
Independent Midwives	3
Other	1
PHO Services	9
Plunket services	42
Retinal Screening	171
Grand Total	598

This service received funding of \$155k from NDSA ARSS for 2010-2011. The funding is ring-fenced with a claw-back clause requiring the return of any under utilisation.

4.2 Key Performance Measures – Auckland and Waitemata DHBs Progress Report

Recommendation:

That the report be received, noting the new approach to reporting and that any improvements to the key performance indicators report be discussed at the meeting for incorporation in future reports.

Prepared by: Janine Pratt (Group Planning Manager, Waitemata DHB) and Julie Helean (Manager Planning and Service Development, Auckland DHB)

Glossary

ADHB	- Auckland District Health Board
ALOS	- Average length of stay
CVD	- Cardiovascular disease
EDS	- Electronic Discharge Summary
ESPIs	- Elective services performance indicators
FDNH	- First Do No Harm
KPI	- key performance indicator
YTD	- Year to date

1. Executive Summary

This new report for 2011/12 provides progress information against a suite of measures relevant to each DHB for quarter one, 2011/12, including:

- Ministry of Health – non-hospital Health Targets quarterly reports
- Ministry of Health – non-hospital Indicators of DHB Performance quarterly reports (non-financial)
- Statement of Intent – a selection of statement of forecast service performance measures

Each measure is supported by commentary, a description of the indicators where required, trend graphs where available and Ministry ratings and feedback.

2. Background

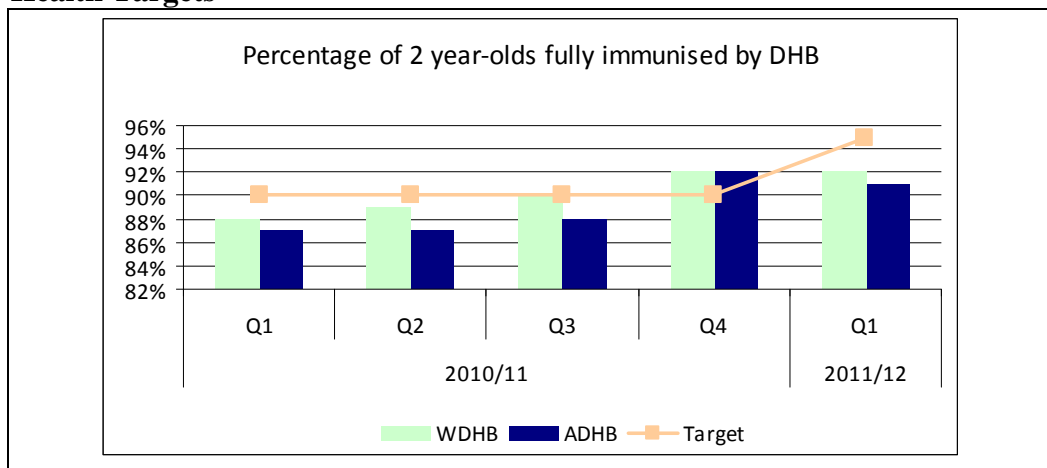
2011/12 has seen a new approach to the annual plan format along with increased emphasis on regional collaboration. Accordingly, previously separate Waitemata and Auckland DHB reports have been reviewed and integrated in line with this collaborative approach. The purpose of bringing this information together is to present a full suite of accountability measures with trend information and commentary to give CPHAC an overall picture of organisational performance across the two DHBs. This information is summarised in the monthly Organisational Scorecard and Board Priorities Performance report for Waitemata DHB. Auckland DHB will continue to receive a detailed monthly update of performance against health targets and other Board priorities.

Measures presented here concentrate on performance. The suite of measures is taken from the DHBs' respective Annual Plans and also from a few cornerstone indicators contained within

our Statements of Intent. Measures that focus on wider population health gain are more usefully reported over longer intervals i.e. six monthly or even annually. Work is underway to further develop the right set of indicators to bring to the respective committees of the Boards. There may be some changes made over time as the two DHBs begin the process of aligning progress reports.

3. Key Performance Measures

Health Targets



Both DHBs are aiming to further improve immunisation coverage through:

- Ensuring all declines that are entered on to the NIR are true declines
- Working with the Outreach Immunisation team to ensure children are immunised on time
- Working with the Auckland Social Sector Leaders Group
- Participating in the Immunisation Operations Group which identifies and seeks to resolve issues related to immunisation rate performance

Additionally ADHB is also undertaking practice audits to improve data integrity. WDHb has undertaken this activity in the past and has since put in place processes to ensure that mistakes in practice data are picked up early.

Maori, Pacific and Asian immunisation rates were all equal to or above 'other' ethnicities for both DHBs.

Health Targets (continued...)

<p style="text-align: center;">% of people with diabetes attending free annual check: Get Checked in the last 5 years by DHB</p> <table border="1"> <caption>Data for % of people with diabetes attending free annual check</caption> <thead> <tr> <th>Quarter</th> <th>ADHB (%)</th> <th>WDHB (%)</th> <th>ADHB Target (%)</th> <th>WDHB Target (%)</th> </tr> </thead> <tbody> <tr> <td>Q1 2010/11</td> <td>~48</td> <td>~58</td> <td>~60</td> <td>~50</td> </tr> <tr> <td>Q2 2010/11</td> <td>~55</td> <td>~65</td> <td>~60</td> <td>~50</td> </tr> <tr> <td>Q3 2010/11</td> <td>~55</td> <td>~65</td> <td>~60</td> <td>~50</td> </tr> <tr> <td>Q4 2010/11</td> <td>~52</td> <td>~62</td> <td>~60</td> <td>~50</td> </tr> <tr> <td>Q1 2011/12</td> <td>~60</td> <td>~70</td> <td>~60</td> <td>~50</td> </tr> </tbody> </table>	Quarter	ADHB (%)	WDHB (%)	ADHB Target (%)	WDHB Target (%)	Q1 2010/11	~48	~58	~60	~50	Q2 2010/11	~55	~65	~60	~50	Q3 2010/11	~55	~65	~60	~50	Q4 2010/11	~52	~62	~60	~50	Q1 2011/12	~60	~70	~60	~50	<p>Overall, Get Checked results are meeting targets for both DHBs. The DHBs will continue to work proactively with the PHOs to raise the performance in this area.</p> <p>Supported self management programmes should impact positively on diabetes management and long term condition management in general, along with other support (such as the LTC coordinators) to encourage better primary care diabetes management.</p> <p>Note: CVD data is not yet available.</p>
Quarter	ADHB (%)	WDHB (%)	ADHB Target (%)	WDHB Target (%)																											
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<p>Smoking – primary care (when available)</p>																															

Indicators of DHB Performance: Northern Regional Health Plan progress report



Northern Region Health Plan

Implementation Progress Report

Quarter 1 - July to September 2011

Contents

1. Summary
2. Progress for top 10 commitments
3. Progress summary across the workstreams
4. Risks and scope change
5. Development plans
6. Budget

Appendix A: National health targets

Appendix B: Retinal screening

1. Summary

The first quarter of 2011/12 has focused on mobilising the implementation plan set out in the Northern Region Health Plan. There was a need to finalise budgets and provide further information to Boards which has impacted progress in some areas. On the whole though good progress has been made around foundation activities in this quarter and the cancer and CVD workstreams are progressing initiatives with direct impact on patient outcomes.

As is to be expected when a new work programme is developed, some changes have been considered and endorsed by workstreams as they undertake more detailed planning. In particular: some changes to patient outcome measures have been agreed in diabetes and cardiac. This is due largely to issues associated with collecting data in a consistent and sustainable way across the four DHBs and primary care.





Key achievements this quarter include:




- Cancer services have agreed prioritisation criteria for colonoscopy and all gastro units in the region are implementing these to achieve regional consistency
- The First Do No Harm workstream has agreed the methodology and measures which are aimed to show improvements to patient safety in our hospitals and rest homes and has put in place two key training events for mid October
- The Radiology Network has developed a comprehensive capital and asset plan which takes into account expected demand patterns and the capital impacts over the next 5 – 10 years
- Advanced Care Planning has developed a business case for workforce training as a foundation for future activity.

An overall summary of progress for each work stream is outlined below.

2. Progress for the top 10 commitments





The table below shows progress against the top 10 commitments















 On track	 Some concerns regarding progress to target	 Not achieved or declining performance	 target discontinued
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	Commitment	Status	Notes
1	Achieve and maintain the Minister's Health Targets	See Appendix A	
2	Reduce the number of harmful falls in our hospitals by 20%	Baseline to be set in Q2	The methodology to measure baseline has been agreed in Q1. The results are expected to commence in Q2
3	Reduce the number of patients who have pressure injuries in hospital or aged residential care by 20%	Baseline to be set in Q2	The methodology to measure baseline has been agreed in Q1. The results are expected to commence in Q2
4	Ensure 50% of patients with lung cancer will have first surgical treatment within 14 days of multidisciplinary meeting	37.5%	Note: 57% of primary lung cancer patients had surgery as first treatment within 14 days from the time the referral was received by the cardiac surgical team. ¹
5	70% of patients admitted with acute coronary syndrome will go from 'door to catheter laboratory' within 72 hours		Result not available in Q1.
6	Increase to 80% the number of high needs diabetes patients with microalbuminuria / proteinuria who are taking ACE/ARB		Result not available in Q1.
7	Undertake retinal screening on 4,500 additional people in metro Auckland area		See Appendix B. While the results for this quarter were less than the average required to meet the target, DHBs are expected to increase numbers when the new IS management system is implemented in Q2/3.
8	For each DHB train 2 more specialist nurses and 3 diabetes nurse specialists as prescribers		Priority for network in Q2
9	Complete Whanau Ora Assessment for targeted population		Result not available in Q1.
10	500 patients will have discussion regarding Advance Care Plans		71 patients have had ACP discussions. Actions on track to increase number.

¹ The difference in the results is due to the short time lag between the MDM decision and referring the patient to the wait list.

3. Progress summary for the workstreams

 Initiative on track to time, cost, quality and business benefit	 Some concern regarding progress to plan	 Not achieved or stopped due to reasons of change of plan or resource availability	 initiative discontinued
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Workstream	Foundation	Patient outcome results	Process results	Achievements	Challenges
The 3 priority areas					
First, do no harm				<ul style="list-style-type: none"> \$1.3m budget approved Methodology to measure baseline agreed Key programme appointments made Stocktake of current activity completed IHI training courses organised for October 	<ul style="list-style-type: none"> Delayed recruitment of team Clinical Leader and Programme Director commencing mid April.
L&Y -Cancer				<ul style="list-style-type: none"> Radiotherapy service model and contract completed All Gastro Units are using regional prioritisation criteria for colonoscopy Lung cancer pathway alignment to national standards 	<ul style="list-style-type: none"> SMO medical oncologist availability
L&Y - CVD		 Measures changed		<ul style="list-style-type: none"> Clinical director recruited KPI framework & prevention strategies agreed A number of working groups have been established to progress specific initiatives e.g. STEMI, PCI, cardiac nurses and CVD risk assessment Guideline development well underway 	<ul style="list-style-type: none"> Slow implementation of Acute Predict at ADHB
L&Y Diabetes		 Measures changed		<ul style="list-style-type: none"> Project Manager recruited Indicator set developed NZ Guideline accepted with minor modifications 	<ul style="list-style-type: none"> Clinical Lead position advertised Stock take pending Changes required to patient outcome measures
L&Y Health of older people		None identified except FDNH		<ul style="list-style-type: none"> Project Manager recruited Methodology and targets agreed for patient safety initiatives (falls reduction causing serious harm & decreased pressure injuries) 	

Workstream	Foundation	Patient outcome results	Process results	Achievements	Challenges
Informed Patient Advance Care Planning	●	●	●	<ul style="list-style-type: none"> Workforce training business case drafted Project plan drafted Communications material developed 	<ul style="list-style-type: none"> Some delays in development and sign off of project plan
Informed Patients Whanau Ora					No Quarter 1 report available
Services					
Laboratory	●		▲	<ul style="list-style-type: none"> Development of long term strategy progressing Joint Laboratories Advisory Group established and progressively taking a wider role in reviewing clinical practice and monitoring of KPIs 	<ul style="list-style-type: none"> A wider range of laboratory stakeholders need to have the opportunity to comment on potential future direction for laboratories which means a longer timeframe is required to complete this work
Radiology	●		●	<ul style="list-style-type: none"> Initial draft of radiology asset and capital plan completed Engagement with national network 	<ul style="list-style-type: none"> Clinical leader role advertised Asset and capital plan work needs to be integrated into regional capital planning
Vulnerable services			▲	<ul style="list-style-type: none"> After hours plan for acute care agreed Actions underway for 4 other services 	<ul style="list-style-type: none"> Two MoH mental health projects underway to review forensic and intellectual disability No MoH action to resolve maternity workforce shortage, but issue relieved with lower birthrate Regional action planned to resolve acute spinal and MaxFax workforce issues needs to be resolved
Service reviews (WDHB and ADHB)			▲		Delayed quarter 1 update provided – see appendix C
IS	●		●	<ul style="list-style-type: none"> Regional PAS: - Current state complete and future state planning underway to determine compatibility with iSoft Regional Population Information – discussion draft completed Regional clinical workstation, CDR and resilience workstream scoping progressing 	Mobilisation has taken some time but good progress is now being made Business case to support IS investments required and needs to be integrated with regional capital and assets work.

Workstream	Foundation	Patient outcome results	Process results	Achievements	Challenges
Workforce	▲		●	<ul style="list-style-type: none"> Regional Clinical Leadership Group established and functioning Regional Training Hub established within ARRMOs and relaunched as NoRTH Regional dataset developed to support workforce planning 	<ul style="list-style-type: none"> Clarification of workforce initiative accountability and deliverables is needed Reporting lines to be confirmed
Capital and assets	●		▲	<ul style="list-style-type: none"> Initial consolidation work undertaken and agreed plan developed to complete and validate regional collation Collation of national guidance 	<ul style="list-style-type: none"> Scope change driven by MoH methodology and national stock take processes Delays in collation of summary detail of strategic projects IS capital not fully reflected in DHB capital intentions
Service Devolution					
Long Term Support for Under 65 year olds with long term conditions (LTSCHC)	▲		●	<ul style="list-style-type: none"> Devolution completed smoothly with no major patient or provider issues Regional risk pool sharing approach agreed Regional Review Panel established with focus on cases over \$80k Working group established to: <ul style="list-style-type: none"> Ensure a consistent regional approach to determining client eligibility and appropriate placement Undertake client profiling to inform future decision making and service development 	<ul style="list-style-type: none"> Awaiting correct financials from MoH, delaying reconciliation Awaiting policy decisions on key issues such as national review processes

4. Development plans

The focus in the first quarter has been on mobilising the 2011/12 implementation plan with more limited work undertaken on the development areas identified in the 2011/12 plan. These areas are:

Child health	Confirmed that this remains a priority to progress for inclusion on 2012/13 plan
Workforce	Considerable work has been undertaken around the establishment of the Northern Region Training Hub. This now provides a good platform from which to leverage the region's considerable training and intellectual capability, particularly in areas of priority for the region.
2012/13 health plan	Work on 2012/13 will start in Quarter 2 when guidance is provided from NHB on regional planning expectations for 2012/13. The region needs to deliver on current commitments before adding additional priorities in a resource constrained environment. It is therefore envisaged that the 2012/13 Plan will largely build on the current plan with work programmes reviewed and extended as appropriate. Additional initiatives will be added in a comparatively small number of areas as agreed with the Northern Region Health Plan Steering Group

5. Risk Management

The key NRHP risks are summarised below.

Risk ID	Description	Business Unit	Inherent Classification Baseline risk	Residual Classification Risk left after controls in place	Controls
1.	Information systems <i>Critical to support many of the proposed changes in models of care</i>	Health Alliance	High	Medium	The healthAlliance work programme has its own reporting lines and risk management controls.
Actions: No action required. Controls under healthAlliance management. NRHP to stay in the information loop.					
2.	Workforce <i>Time is needed to grow the workforce to work in new fields but limited funding within current capacity</i>	Clinical Leadership Group to assess	High	High	Controls are in place in individual DHBs and workforce entities such as NoRTH.
Actions: Steering Group and Clinical Leadership Group to agree: <ul style="list-style-type: none"> KPIs and deliverables for the NRHP initiatives, and the processes to deliver and manage these initiatives What information is needed for initiatives which are not directly managed by the NRHP e.g. NORTH and DHB specific initiatives 					
3.	Recruitment of support for networks <i>Delay in recruitment may delay progress</i>	NRHP Steering Group	High	Low	<ul style="list-style-type: none"> Recruitment process has resulted in key positions being filled Workarounds in place for other positions
Actions: No action required.					
4.	Interdependencies with BSMC business cases <i>The cumulative change agenda is significant and will require careful management</i>	NRHP Steering Group, GAIHN NHC, Alliance Health Plus	Medium	Low	<ul style="list-style-type: none"> Alliance Leadership Team in place Cross-over membership between NRHP and BSMC Networks comprise primary care clinicians
Actions: ALT and NRHP Steering Group to regularly test the cumulative change impact					
5.	DHB commitment <i>DHB leadership must commit and participate in monitoring and decision making processes.</i>	DHBs Executive Management NRHP Steering Group	High	Low	<ul style="list-style-type: none"> NRHP Steering Group in place comprising of senior executives Budgets approved
Actions: No action required					
6.	National leadership of vulnerable services <i>Maternity and Forensic and ID Mental Health are not on NHB agenda</i>	NHB	Medium	Medium	Controls in place for the MoH programme of work. Regional agreements in place to respond to peaks in births
Actions: Continue to lobby NHB					

6. Financials

The 2011/12 budget was finalised in Quarter 1 and delegations within this were agreed. A phased budget has been developed for the 2011/12 financial year. The phasing of the First Do No Harm budget should be viewed as indicative only at this stage and will be reviewed in Quarter 2 as part of the more detailed planning work that will be undertaken for the campaign.

The budget for Quarter 1 was comparatively low at \$135,000 reflecting the fact that the work would initially be undertaken by people in posts and already budgeted for and that no major training events were scheduled for this first quarter. Actual expenditure was slightly below the Quarter 1 budget.

	Quarter 1			Year to Date			Year End Forecast***		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Overall NRHP Costs									
First Do No Harm									
FTE Costs	-	-	-	-	-	-	730,000	730,000	-
Other Costs	-	-	-	-	-	-	555,000	555,000	-
Total FDNH	-	-	-	-	-	-	1,285,000	1,285,000	-
							-	-	-
Other NRHP Activity									
FTE Costs	124,710	125,000	290	124,710	125,000	290	599,710	600,000	290
Other Costs	9,455	10,000	545	9,455	10,000	545	249,455	250,000	545
Total Other NRHP	134,165	135,000	835	134,165	135,000	835	849,165	850,000	835
							-	-	-
Total NRHP Costs	134,165	135,000	835	134,165	135,000	835	2,134,165	2,135,000	835

During the first quarter there were some changes agreed to budgets with the Steering Group that will impact both the first and subsequent quarters. These were as follows

- The \$150k budget established for external assistance with regional spatial, capital and asset planning was reallocated to the core FTE budget as the focus of work is not on spatial planning (where external expertise would have been required) and the work is being undertaken “in house”
- Additional funding of \$86k was agreed for Advance Care Planning increasing the budget from \$150k to \$236k. This was necessary as HWNZ has not committed to any funding, whereas the initial budget bid has been based on a 50/50 share of training costs. This additional budget request has been accommodated by reallocation of the core NRHP implementation budget.

In addition commitments were made to IHI training for FDNH and Advance Care Planning training which will occur in Quarters 2 and 3 respectively.

The DHB revenue contributions towards these costs are as outlined below.

	First Do No Harm	Other NRHP Costs	Total
Northland	-	16,368	16,368
Waitemata	-	41,725	41,725
Auckland	-	35,030	35,030
Counties Manukau	-	41,041	41,041
All DHBs	-	134,165	134,165

Appendix A: National Health Targets

Q1 National Health Targets

	Electives	ED Waits	Hospital smoke free	Diabetes HBA1C <8	Diabetes Annual Checks	CVD Risk Assessment	Combined CVD and Diabetes	Immunisation	Radiotherapy Treatment
Northland		86%	100%	71%	70%			81%	100%
Waitemata	99%	93%	96%	69%	58%	80%	69%	92%	100%
Auckland	99%	92%	80%	75%	60%	79%	71%	92%	100%
Counties Manukau	108%	96%	89%	56%	81%	80%	73%	89%	100%
Regional average	102%	92%	91%	68%	67%	80%	71%	89%	100%
<i>Target</i>	<i>increase</i>	95%	95%	<i>increase</i>	<i>increase</i>	90%	<i>increase</i>	95%	100%
Previous result Q4 2010/11	107%	94%	86%				72%	89%	100%

Notes

- Some Northland DHB results will not be available until 7th November. These will be reflected in the Q2 report. This includes Electives, CVD and Diabetes measures.

Appendix B: Retinal Screening

2010/11 Baseline

Waitemata	12,812
Auckland	6,500
Counties Manukau	10,491
Total 2010/11	29,803
Target additional for 2011/12	4,500
Annual target 2011/12	34,303
Average required / quarter	8,576

Q1 Results 2011/12

Waitemata	3159
Auckland	1468
Counties Manukau	2490
Total Q1	7117
<i>Variance to average</i>	<i>- 1,459</i>

Appendix C: Service Reviews

Project name	Service reviews	Report compiled by	Jo Brown, Ngaire Buchanan	Quarter	1 September 2011
Summary	Waitemata and Auckland DHBs have agreed to review arrangements for services provided to the Waitemata population in the 2011/12 year. These services include Gestational Diabetes, Ophthalmology, Vascular Surgery, Paediatrics, Respiratory (Long Term Oxygen Services), Cardiology and Renal. In addition to these services there is agreement to review regional arrangements for Second Trimester termination services.				
Scope changes	Note that the Vascular Surgery discussion relates to the provision of interventional radiology services associated with secondary services already provided at Waitemata There are no other scope changes to report.				

Deliverables completed	<p>Proposals to develop local services at Waitemata for Gestational Diabetes and Long Term Oxygen have been completed and changes to current arrangements confirmed.</p> <p>Planning for next phase in Renal and Cardiology service developments have commenced and bilateral discussions between the clinical teams are occurring. Preliminary work has been completed to assess the Interventional Radiology demand associated with secondary services provided at Waitemata.</p> <p>Clinical Directors of Paediatric Services at Auckland and Waitemata are working together to confirm future direction for clinical services planning for Paediatrics for both DHB populations.</p>
Tasks behind schedule	Bilateral discussions regarding the Ophthalmology Service review have not commenced.
Issues and mitigation	Waitemata will initiate Ophthalmology discussions with ADHB by end of November.
Focus for next quarter	<p>Progressing Ophthalmology service review.</p> <p>Initiating regional discussion relating to Second trimester termination of pregnancy services.</p> <p>Confirming plans for interventional radiology services for the Waitemata population.</p> <p>Confirming changes to arrangements for Cardiology services for the Waitemata population.</p> <p>Progressing implementation of the Long Term Oxygen service and Gestational Diabetes services.</p>

Decisions and/or issues to be raised to Steering Group (or other) <i>Specify the issue and decision required</i>
Nil

Statement of forecast service performance measures

Indicator	Results	Commentary																											
Oral Health: Arrears rates	<p style="text-align: center;">Arrears rates by DHB</p> <table border="1"> <caption>Arrears rates by DHB</caption> <thead> <tr> <th>Year</th> <th>Quarter</th> <th>ADHB (%)</th> <th>WDHB (%)</th> <th>Target (%)</th> </tr> </thead> <tbody> <tr> <td rowspan="4">2010/11</td> <td>Q1</td> <td>11.5</td> <td>12.0</td> <td>10.0</td> </tr> <tr> <td>Q2</td> <td>10.5</td> <td>11.0</td> <td>10.0</td> </tr> <tr> <td>Q3</td> <td>11.5</td> <td>11.5</td> <td>10.0</td> </tr> <tr> <td>Q4</td> <td>12.8</td> <td>11.8</td> <td>10.0</td> </tr> <tr> <td>2011/12</td> <td>Q1</td> <td>13.5</td> <td>12.0</td> <td>10.0</td> </tr> </tbody> </table>	Year	Quarter	ADHB (%)	WDHB (%)	Target (%)	2010/11	Q1	11.5	12.0	10.0	Q2	10.5	11.0	10.0	Q3	11.5	11.5	10.0	Q4	12.8	11.8	10.0	2011/12	Q1	13.5	12.0	10.0	<p>Arrears data provides information regarding the percentage of children who are overdue for an assessment. The oral health services provided by ARDS are becoming increasingly accessible and available leading to the number of children overdue for their scheduled examination decreasing. There are specific geographic areas that have particularly high arrears rates which impacts on the overall results. This can partly be attributed to the implementation of the Oral Health Business Case i.e. old clinics closing awaiting the opening of new facilities. The improvement in arrears since 2009 can be attributed to an increase in oral health clinicians, improved productivity and improved, reliable data collection.</p>
Year	Quarter	ADHB (%)	WDHB (%)	Target (%)																									
2010/11	Q1	11.5	12.0	10.0																									
	Q2	10.5	11.0	10.0																									
	Q3	11.5	11.5	10.0																									
	Q4	12.8	11.8	10.0																									
2011/12	Q1	13.5	12.0	10.0																									
Oral Health: enrolments	<p style="text-align: center;">New enrolments of children in Auckland Regional Dental Service</p> <table border="1"> <caption>New enrolments of children in Auckland Regional Dental Service</caption> <thead> <tr> <th>Year</th> <th>Quarter</th> <th>ADHB</th> <th>WDHB</th> </tr> </thead> <tbody> <tr> <td rowspan="4">2010/11</td> <td>Q1</td> <td>2,200</td> <td>3,500</td> </tr> <tr> <td>Q2</td> <td>3,500</td> <td>3,800</td> </tr> <tr> <td>Q3</td> <td>3,000</td> <td>3,500</td> </tr> <tr> <td>Q4</td> <td>3,000</td> <td>4,000</td> </tr> <tr> <td>2011/12</td> <td>Q1</td> <td>2,800</td> <td>3,800</td> </tr> </tbody> </table>	Year	Quarter	ADHB	WDHB	2010/11	Q1	2,200	3,500	Q2	3,500	3,800	Q3	3,000	3,500	Q4	3,000	4,000	2011/12	Q1	2,800	3,800	<p>The Auckland Regional Dental Service has placed a particular emphasis on enrolling pre-school children. One of the key functions of this service is to build relationships with Well-child providers in the area to encourage early enrolment in the service and early referrals from other providers when appropriate. The coordinators visit some early childhood centres in targeted areas.</p>						
Year	Quarter	ADHB	WDHB																										
2010/11	Q1	2,200	3,500																										
	Q2	3,500	3,800																										
	Q3	3,000	3,500																										
	Q4	3,000	4,000																										
2011/12	Q1	2,800	3,800																										

Statement of forecast service performance measures (continued...)

Indicator	Results	Commentary																				
Community laboratory	<p style="text-align: center;">Number of community based lab tests by provider</p> <table border="1"> <caption>Estimated data for Number of community based lab tests by provider (2010/11)</caption> <thead> <tr> <th>Quarter</th> <th>Diagnostic Medlab</th> <th>Labtests</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>~100,000</td> <td>~650,000</td> <td>~50,000</td> </tr> <tr> <td>Q2</td> <td>~100,000</td> <td>~650,000</td> <td>~50,000</td> </tr> <tr> <td>Q3</td> <td>~100,000</td> <td>~650,000</td> <td>~50,000</td> </tr> <tr> <td>Q4</td> <td>~100,000</td> <td>~500,000</td> <td>~50,000</td> </tr> </tbody> </table>	Quarter	Diagnostic Medlab	Labtests	Other	Q1	~100,000	~650,000	~50,000	Q2	~100,000	~650,000	~50,000	Q3	~100,000	~650,000	~50,000	Q4	~100,000	~500,000	~50,000	<p>The decrease for Metro Auckland DHBs is due to claims from Labtests Auckland not being completely loaded into the Labs datamart. The outstanding claims for April 2011 to June 2011 (~437,000 tests) will be captured retrospectively.</p>
Quarter	Diagnostic Medlab	Labtests	Other																			
Q1	~100,000	~650,000	~50,000																			
Q2	~100,000	~650,000	~50,000																			
Q3	~100,000	~650,000	~50,000																			
Q4	~100,000	~500,000	~50,000																			
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Quarter	Auckland	Waitemata																				
Q1 (2010/11)	~5,800	~6,500																				
Q2 (2010/11)	~5,500	~7,000																				
Q3 (2010/11)	~4,800	~7,200																				
Q4 (2010/11)	~4,800	~7,500																				
Q1 (2011/12)	~4,800	~8,000																				

Statement of forecast service performance measures (continued...)

Indicator	Results	Commentary																																	
PHO enrolment	<p style="text-align: center;">Total DHB population enrolled in any PHO</p> <table border="1"> <caption>Estimated data for PHO enrolment chart</caption> <thead> <tr> <th>Quarter</th> <th>WDHB (%)</th> <th>ADHB (%)</th> </tr> </thead> <tbody> <tr><td>Q4 2006/07</td><td>91.5</td><td>93.5</td></tr> <tr><td>Q2 2007/08</td><td>92.5</td><td>90.0</td></tr> <tr><td>Q4 2007/08</td><td>94.0</td><td>92.5</td></tr> <tr><td>Q2 2008/09</td><td>94.0</td><td>90.0</td></tr> <tr><td>Q4 2008/09</td><td>94.0</td><td>91.5</td></tr> <tr><td>Q2 2009/10</td><td>93.5</td><td>92.5</td></tr> <tr><td>Q4 2009/10</td><td>94.5</td><td>92.5</td></tr> <tr><td>Q2 2010/11</td><td>94.0</td><td>93.5</td></tr> <tr><td>Q4 2010/11</td><td>94.5</td><td>93.5</td></tr> <tr><td>Q1 2011/12</td><td>95.0</td><td>93.5</td></tr> </tbody> </table>	Quarter	WDHB (%)	ADHB (%)	Q4 2006/07	91.5	93.5	Q2 2007/08	92.5	90.0	Q4 2007/08	94.0	92.5	Q2 2008/09	94.0	90.0	Q4 2008/09	94.0	91.5	Q2 2009/10	93.5	92.5	Q4 2009/10	94.5	92.5	Q2 2010/11	94.0	93.5	Q4 2010/11	94.5	93.5	Q1 2011/12	95.0	93.5	<p>1 July 2011 saw the introduction of Waitemata’s 2 PHO policy. The six PHOs that were in place prior to this time amalgamated into one of two PHO entities: ProCare Networks Ltd or the new Waitemata PHO. It appears as if this process may have improved local knowledge around the benefits of enrolling with a PHO which could explain the increase in enrolment numbers as well as the ongoing improvement with PHOs around enrolment policy.</p>
Quarter	WDHB (%)	ADHB (%)																																	
Q4 2006/07	91.5	93.5																																	
Q2 2007/08	92.5	90.0																																	
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Q1 2011/12	95.0	93.5																																	

5.1 Primary Care Update

Recommendation:

That the report be received.

Prepared by: Andrew Coe (Group Manager Primary Care, Waitemata and Auckland DHBs)

Glossary

ALT	- Alliance Leadership Team
BFG	- Better Sooner More Convenient Primary Care Funding Group
BSMC	- Better sooner more convenient primary health care
COPD	- Chronic Obstructive Pulmonary Disease
DAP	- District Annual Plan
DHB	- District Health Board
FFP	- Flexible Funding Pool
HP	- Health Promotion
HUHC	- High Users Health Card
IFHC	- Integrated Family Health Centre
PHO	- Primary Health Organisation
PPP	- PHO Performance Programme
SALT	- Service Alliance Leadership team
SIA	- Services to improve access
TIA	- Transient Ischaemic Attacks
TPK	- Te Puni Kokiri

1. Introduction

This report gives an overall update on matters relating to Primary Care for October 2011. It includes:

- Progress on the implementation of Better, Sooner, More Convenient (BSMC) primary health care
- Progress on the three business cases
- Whanau Ora
- Progress on the regional annual plan projects to improve primary/ secondary system efficiency.

2. Implementation of Government's BSMC Primary Care Strategy

2.1 Regional Progress to Date

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

2.2 Progress with PHO Consolidation

There are no more planned PHO mergers that the DHBs are aware of. North Waikato PHO, which operates in CMDHB, is still expected to join the National Hauora Coalition but it is not submitting its register as expected for quarter 3 and discussions are continuing.

3. Business Cases

3.1 GAIHN

Funding

A CPHAC paper was presented in September outlining GAIHN's Investment Proposal. The paper requested that CPHAC notes the investment sought by GAIHN. CPHAC agreed with the proposal in principal but requested that Auckland and Waitemata DHBs' Audit & Finance Committees sign-off the funding request. A paper has been written for the Audit & Finance Committees, which will be presented at their November meetings. The paper also considers the funding implications if Waitemata PHO were to withdraw its partnership from GAIHN. The quantum being sought by GAIHN is \$475K from Waitemata DHB and \$310K for Auckland DHB.

The GAIHN Alliance agreement has been signed by Auckland PHO, East Health and ProCare. The agreement is currently going through Auckland DHB's internal sign-off process. As Waitemata PHO has still not yet confirmed their partnership in GAIHN, the agreement has been signed without their inclusion. Waitemata PHO can be added into the GAIHN Alliance agreement at a later date if necessary. Once the agreement has been signed by all parties, Sector Services will be instructed to prepare the PHO Variation and maximisation of Care Plus can begin. The Ministry of Health will however only release the maximised Care Plus funds once the ALT has agreed on how this funding will be spent and that the DHB has contracted appropriately for this.

A Transition Plan for the Regional Annual Plan Projects to GAIHN has been developed and is being implemented. The Transition Plan was circulated to BFG via email for sign-off.

Concern has been raised across the Regional Governance table around the governance of the business cases due to confusion around Ministry and DHB involvement. GAIHN currently only has funding to sustain it until 30 November if current outstanding invoices are paid.

3.2 National Hauora Coalition (NHC) (ADHB only)

Regular meetings between NHC, Counties Manukau and Auckland DHBs are ongoing. These occur on multiple levels. Monthly operational meetings occur between CMDHB, ADHB Programme Managers and NHC Auckland locality operational management. These focus on supporting NHC through the contractual aspects such as alliance documentation, transition plans and act as a conduit for the partner DHBs. Weekly strategic meetings are held between the NHC CEO and CMDHB executive/senior leadership team, helping to shape the long term strategic vision of the organisation.

Auckland DHB is continuing to provide the monthly reporting through to Counties Manukau DHB due to staff extended leave.

NHC and DHBs have met during the last quarter to agree the process for setting targets at both a local and national level for the PPP as well as for the setting of baseline data and measurements for implementation plan targets. There has also been some confusion in the role of the MoH and DHBs' level of governance in this process. The NHC has put together a paper for the partner DHBs to consider how they propose to set targets nationally. This is on the

understanding that there is to be improvement for those PHOs who may be already above the proposed target. The proposal shows the NHC baseline data amalgamated from the historical PHOs and it is expected that a national target will be set from this data, with local targets set between DHBs and locality providers. The payments will be paid on a national level and distributed to the providers in an appropriate and agreed methodology. The partner DHBs have agreed this in principle and the NHC are to circulate proposed targets which have been generated by the PPP methodology as well as a snapshot of the whanau ora dashboard which PPP have designed for them.

ALT Membership: The first workshop to re-establish the NHC ALT was held on 27 October and hosted by He Kamaka Oranga at Auckland DHB. It is intended that the first official meeting of the newly established ALTs (Auckland and Midland) will occur in early November.

SALT Establishment: NHC has held preliminary meetings to determine Mama Pepi Tamariki (Mothers Babies and Children) and Oranga Ki Tua (Long Term Conditions) programmes in readiness for SALT establishment. SALT membership will be determined concurrently with the ALT membership process.

3.3 Alliance Health + (AH+) (ADHB only)

AH+ have appointed a new Clinical Director, Dr. Siobhan Trevelyan. Siobhan will be responsible for strengthening the clinical leadership and network within AH+. To support Siobhan with this key role, CMDHB has generously offered the clinical secondment capacity of Dr Siniva Sinclair (public health physician).

AH+ were asked to present to the Whanau ora Business case panel, which consisted of representatives from MoH, TPK and independent advisors, in Wellington in September. The meeting was very positive, with special mention of how AH+ articulated the importance of merging both strategies of BSMC and Whanau ora together to avoid duplication and realise the service delivery approach. The outcomes are due in October but there was no update at the time of this report.

AH+ has consolidated and is now working on a strategy of growth. AH+ has been approached by interested parties to join the PHO and is exploring opportunities to diversify its portfolios i.e. provider development, service delivery, social service provision.

AH+ was successful in progressing to the RFP stage for a Pacific provider development ROI issued by the Ministry of Health which was submitted on 7 October. AH+ have contracted Quality Health Partners to support this development.

The Mt Wellington Integrated Family Health Centre (IFHC) was officially launched on 20 October 2011 by the Prime Minister.

Southseas IFHC plans have been signed-off and the refurbishments were due to start in October. AH+ is working with the provider collective to establish six demonstration sites across its provider collective which includes IFHC developments. This gives AH+ an opportunity to oversee how the providers will translate the navigation functions into practice. It is hoped that after three months of implementation the action research will generate some learning and recommendations for AH+ to consider in terms of what form and shape navigation functions will take.

Each of the nurse led services is in the process of submitting a nurse led plan to help inform AH+ nurse led plan. This plan will be used to identify synergies and special projects (including resource requirements) across the nurse led network that will enhance current nurse led initiatives. AH+ is aiming to have a plan completed in quarter 2, 2011.

AH+ is actively participating in the Metro-Auckland Afterhours Task Force space at a regional level. There have been several meetings with the Chair of the Taskforce as well as a follow up meeting with Synergia to gain a good understanding and background of developments to date in the afterhours project. AH+ have been part of the later involvement of the AHA taskforce and has agreed to contribute up to \$1.41 per enrolled service user (along with NHC) towards reduced copayments for the priority group. AH+ and NHC have signalled intent to formalise their alliance in relation to this work programme, given its effect on the high needs populations served.

3.4 Flexible Funding Pool

Out of the three business cases within the metro Auckland area, only AH+ has the ability to move to a flexible funding pool (FFP) as it has completed all the necessary alliance documentation. AH+ have confirmed that the health promotion (HP) and services to improve access (SIA) components of PHO funding which will move to FFP are currently being used to:

- Maintain SIA and HP programmes that were in place prior to formation of AH+ - some SIA projects have ceased which we are pending further detail on
- Contribute to the Afterhours alliance
- Contribute to Business Case deliverables e.g. nurse led clinics, development of AH+ infrastructure.

On the establishment of a functioning ALT, an evaluation of current SIA and HP programmes will be undertaken which will lead to alignment of services through the FFP process.

4. Whanau Ora

The Auckland and Waitemata DHB Maori Health teams are working more closely together to collectively make progress on primary health care. The two DHB Maori health committees merged in August to form a joint committee, Manawa Ora. One of the initial pieces of work is to make progress on regional components in the business cases, an initial stock take in preparation for Whanau ora and BSMC (see table below).

Provider, Coalition or Network	MoH - BSMC	TPK – Whānau Ora
National Hauora Coalition	Has a BSMC business case	Has members a part of Whānau Ora
Alliance Health Plus	Has a BSMC business case	Is a Whānau Ora Collective Network
Te Whānau o Waipareira Trust	Is a provider within the Greater Auckland Integrated Health Network business case	Is a member of a Whānau Ora Collective Network – National Urban Māori Authority
Ngāti Whātua o Ōrākei Health Services	Is a provider of the National Hauora Coalition	Is a member of a Whānau Ora Collective Network – Ngāti Whātua o Ōrākei Māori Trust Board
Pacific Island Safety and Prevention Project	Not involved with BSMC	Is a Whānau Ora Collective Network

There are differences between those whanau ora providers delivering under the BSMC and the work emerging within Whanau ora Te Puni Kokiri (TPK). A presentation at the Maori Health Gains Advisory Committee from TPK this month will contribute to the models and processes and the advice offered to providers with BSMC towards achievement of Whanau ora in this operational year.

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

5.1 Regional Afterhours

A communications and marketing plan has been developed by a Media/PR agency engaged to manage the communications process, branding and circulation.

A formal Alliance and entity will not be established to manage the afterhours initiative. A Partnership Group will be established as the formal governance. This will operate under Alliancing principles with representation from all partner groups, including clinical representation and links to the BSMC business cases. Terms of reference for the Partnership Group and subgroups have been developed to clarify their roles and responsibilities.

DHBs have undertaken extensive work to reconcile the overall afterhours funding and how existing contracts will transition to the new contracts under the initiative. CMDHB will be the lead DHB for the new reduced co-payments component and will contract with the Accident & Medical Providers Consortium. A contract has been developed with input from all three DHBs legal advisors and draft documentation has been sent to Sector Services to prepare the contract

documentation for a 1 November start date. Overnight contracts will continue to operate under individual DHBs and their relevant A&M providers. CMDHB has also developed Deeds to cover those parties and service components that fall outside of the CMDHB contract. It is proposed that any disputes will be referred in the first instance to the Partnership Group for a recommendation and this will be considered by the DHBs before taking any remedial action.

Service KPIs are being developed with significant DHB clinical input, to inform the service evaluation in March 2012 and throughout the life of the initiative. The KPIs are based on those that were originally developed in the ARAHN proposal. There is agreement to report at NHI level so that DHBs have the ability to undertake detailed analysis of the whole afterhours system to evaluate its effectiveness and impact on the utilisation of ED services as well as value for money of the reduced co-payments for eligible groups. It has transpired that some of the A&M data that was used to undertake the original utilisation modelling included some inaccuracies, so it has been agreed to re-measure the baseline utilisation so that further utilisation analysis can be undertaken against an accurate base. A 1-day clinical event is also being planned to develop clinical indicators that can operate across primary and ED services.

Eligible patients for reduced co-payments have been defined as those that are enrolled with a participating PHO who are under-2, 65 and over, CSC or HUHC card holder, or live in a Quintile 5 area (NZ Deprivation index). However, Auckland domiciled people who have a valid CSC or HUHC that are not on the current register, and all children under-6, will also be eligible.

The DHB overnight services review will start once the contract is in place. Legal advice has been obtained to ensure that Waitemata DHB and Auckland DHB will each be able to retain its share of any savings from the overall after hours funding in the event that it can deliver overnight services more cost effectively from its EDs. This will be included in the Collaborative Agreement between the DHBs to avoid any doubt in the future.

Risks

- Not enough quality data to inform the Afterhours evaluation in March 2012: This is a low risk now, given agreement for NHI level data reporting. It will also be mitigated by careful selection of KPIs so that relevant data is captured.
- The Afterhours network will attract people away from their GP medical home because it is cheaper and/or more convenient for patients. This will be mitigated by monitoring GMS claw backs for relevant patient categories to assess the impact on general practice.

5.2 Access to Diagnostics

The roll-out of ProExtra to CMDHB is progressing well. As at 18 October, 56 CMDHB practices have been trained and installed and ProCare are on track to achieve 65 practices trained and installed by 31 October 2011.

The Clinical Triage Criteria was endorsed by the Regional Radiology Group at their August meeting and the Clinical Governance Group produced a final draft ready for programming into ProExtra. A formal quote for the programming work is expected in early October. In September the GAIHN Project Director and Chair confirmed the programming costs involved with updating the Clinical Triage Criteria in ProExtra will be covered by the GAIHN reserves in the interim of receiving the funding from the DHB partners. The updated Clinical Triage criteria was provided to the eReferrals team in early October to build a mock up and circulate to the Clinical Governance Group for review.

5.3 Minor Skin Surgery – Skin Lesions

A satisfaction survey is being sent to all patients who are referred to the GP scheme from 1 July 2011 to 30 September 2011. As at 18 October 2011, 62 surveys have been returned and feedback is extremely positive. Patients agree they are provided with a quality service, and that general practice is a convenient place for their surgery. Some specific comments include “This was a most satisfactory operation in every way – close to home and not having to travel across town to hospitals” and “Every part of the procedure was excellent. I was impressed and pleased”.

As at 30 September 2011, 223 of the 300 target volumes have been achieved, leaving a variance of -77. However the referral numbers vary month to month and we expect to see an increase in the referrals numbers as the scheme becomes more known and the confidence in the system increases.

5.4 Clinical Pathways

The COPD and TIA Business Cases have been worked up and approved by the Active Clinical Network and ALT. Five more pathways have been approved for development. These are Congestive Heart Failure, Gout/Metabolic Syndrome, Cellulitis, Depression and Chronic Kidney Disease. Additional resourcing requirements have been identified to fully implement these pathways and appropriate project structure and support will be required to deliver on their objectives. Funding required as requested in Business Cases.

In summary, COPD and TIA require significant funding and time to implement. They will not be implemented this financial year unless funding is released.

5.5 Summary of Annual Plan Targets

Initiative		Regional Volumes		Targets	
		Month (October)	YTD (to end Sept 2011)	YTD (to end Sept 2011)	To end Jun 2012
Acute Demand / POAC		1,362	6,902	6,667	20,000
Access to Diagnostics	DAP Target 1 The rate of referrals that do not meet the clinical triage criteria from GPs to radiology are less than or equal to 20% by the end of June 2012 (currently up to 35%).	13.8% ¹	15.6%	33%	20%
	DAP Target 2 The volume of DHB-funded GP-requested diagnostic radiology procedures performed in the community will increase by 10% across the Metro Auckland DHBs, on 2010/11 volumes by 30 June 2012.	1,464 ²	3,928	2,727	10,396
Minor skin surgery		63 ³	223	300	1,200 ⁴

6. Localities and Clinical Networks

The West Auckland Network has been established with the support of Sapere. As of the middle of October, it has convened four times. Terms of Reference, Role and Responsibilities and a Network charter have been developed and agreed by its members.

Sapere are currently undertaking a scoping study in West Auckland. The report will

1. Investigate future models of care and associated service and site configuration options for New Lynn.

¹ September figures are provided

² September figures are provided

³ September figures are provided: Volumes are based on the referrals sent out during the month for Waitemata DHB and Auckland DHB and actual procedures completed for CMDHB.

⁴ Community based skin lesion procedures during 2011/12

2. Develop / refine population based demand and work force/facility (supply) estimates for key components of the proposed service configuration.
3. Develop operational cost estimates for the service configuration options and develop preliminary capital cost estimates for the site configuration options.
4. If possible, identify how clinical networks will develop to support primary care activity.

Work on developing the New Lynn IFHC is continuing and is expected to open in early-2013. The GP developers have approached Waitemata DHB with an offer for the DHB to co-locate and integrate services into the IFHC. Waitemata DHB is currently scoping up its requirements and discussing lease terms and conditions. A report will be produced at the end of January 2011. The Sapere Group has also been selected by the Ministry of Health as an expertise consortia and it will be assisting with the New Lynn IFHC development.

Te Whanau O Waipareira Trust has developed a large Whanau Ora Centre in Henderson. Waipareira services have been consolidated into Whanau House and are now being delivered from the centre. Waitemata DHB has approved a range of initial services that will be co-located and integrated into Whanau House during 2011/12 and the transfer of these services has begun. A range of additional services have been identified and will be scoped during 2011/12 for implementation from July 2012.

Synergia /Tuia Consortia have been selected by Ministry of Health as the consortia to enhance progress towards IFHC developments in central Auckland and are currently undertaking an initial scoping exercise. The initial stage of the assignment will involve investigating the issues of the Auckland Clinical Network, and seeking to identify what the best approach to establishment would be.

A Clinical lead has been appointed to the North Network as well as the appointment of an Implementation Support Group to support the networks development.

7. Other

7.1 Unspent Funds

The Ministry of Health wrote to all District Health Boards (DHBs) regarding the management and use of PHO cash reserves becoming part of the DHB's Operating Policy Framework (OPF) reporting requirements for 2011/12. The DHBs are now required to report to the Ministry on individual PHO cash reserves and agree forecast expenditure plans with those with significant and increasing PHO cash reserves by 20 October each year.

Auckland and Waitemata reported with all the available information to the MoH at that time and are intending to follow up where accounts were not available and submit further information by 20 December 2011.

PHO	Cash Reserve as at 30.06.11	Expenditure plan submitted	Follow up required
Auckland PHO	Nett Cash Balance: \$199,760	Yes	
Alliance Health +	Reported by CMDHB as host DHB		
Coast to Coast PHO	Accounts not yet available	No	After AGM on 1 November 2011

PHO	Cash Reserve as at 30.06.11	Expenditure plan submitted	Follow up required
Harbour Health PHO Ltd	Only 09/10 available at this time -\$97,949		
HealthWEST	\$837,299	Discussion around transitional arrangements	18 November 2011
National Hauora Coalition	New PHO	No	By CMDHB as host for 2012 reporting
ProCare Networks Ltd	The information provided by ProCare was not sufficient to identify the cash balances	No	The MoH and DHB has requested from ProCare their statement of financial performance as at 30 June 2011
Te Puna	Accounts not yet available	No	
Waitemata PHO	New PHO		For 2012 reporting
Waiora Charitable Trust	Accounts not yet available	No	1 November 2011

7.2 Measles

The metro Auckland region approved a primary care action plan to respond to the sustained community transmission of measles. The response is basically an enhanced immunisation campaign targeting anyone born after 1969 that is unsure of their immunity to get vaccinated. It has also resulted in a change to immunisation schedule for children by bringing the 15 month measles, mumps and rubella vaccine back to 12 months and for the second dose to be given anytime 28 days afterwards as opposed to the normal schedule of 4 years old. The potential costs have been scoped to be around \$1.5-2.5 million, however this has had to be based on a variety of assumptions. Communication is the key to the uptake of the campaign. There has been limited response to the first wave of communications through radio, print media and primary care themselves and so a second wave utilising radio and supported by posters and flyers for practices is going to be launched within the next two weeks.

5.2 Planning and Funding Update

Recommendation:

That the report be received.

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

Glossary

ACH - Auckland City Hospital
ACP - Advance Care Planning
DHB - District Health Board
GP - General Practitioner
IDF - Inter-District Flow
NGO - Non-Government Organisation
PHO - Primary Health Organisation

1. Summary

This report updates the Committees on Auckland and Waitemata DHBs' Planning and Funding activity for the month. Primary Care has been moved to a separate regular report (refer separate paper).

2. Summary of activities in common

2.1 Planning

Please refer to the separate paper titled '2012/2013 Planning' for a full update.

3. Waitemata DHB Update

3.1 Funding

The Funding and Planning Team received approval at the October Audit and Finance Committee meeting to reconfigure delivery of mental health packages of care, community support and some residential rehabilitation services. The new model of contracting and service delivery is based upon support hours delivered instead of the current model of purchasing FTE and beds. The service reconfiguration will allow for more flexible, transparent and consistent allocation of support services, tailored to individual needs. The service reconfiguration will also enable the enhancement of services through the establishment of three housing co-ordination roles and two employment consultant roles. Planning is now underway with three providers to pilot the reconfiguration of Level 3 and Level 4 residential rehabilitation services. The Waitemata DHB Service Co-ordination Team will assess all 39 residents of these providers and recommend whether or not they would benefit from the service reconfiguration. If not, some services will remain as they are.

A new housing insulation programme Warm Up Waitemata will insulate 500 homes in 2011/12. Warm Up Waitemata has been made possible due to the support of EECA, Autex Industries Ltd, The Insulation Company and other third party funders. This programme will target older people over 65 years, pregnant women and families with children under 14 years. To be eligible, families must have a community services card, live in their own or a rented home (not a Housing New Zealand house) and the house built prior to 2000. Waitemata is working with Counties Manukau DHB to implement this programme.

The Healthy Lifestyles Team has worked in collaboration with Auckland DHB to produce a 50 page Nutrition Guide for health professionals. The guide includes assessment tools and information on how to assess and manage nutrition / weight management needs across a range of conditions. The guide is being distributed to GPs, primary care nurses and other interested professionals in secondary care. The first training session on how to use the guide was held with a group of practice nurses in October. Further training is being planned over the next six months for various forums and cell groups. The guide is also available electronically on the DHB staffnet and internet.

3.2 Funder Finance

Funder Non Government Organisations (NGO)

The September core result for Funder NGO was \$68k favourable to budget for the month and \$166k favourable for the year to date. Included in this result is expenditure to Auckland DHB for the settlement of PHO enrolment based service costs resulting from GP practices changing PHO membership after IDF budgets had been finalised. These payments are covered within the Funder NGO budgets.

Utilisation trends relating to NGO demand services are all tracking as expected and within budget. Home Based Support Services expenditure was previously noted as being unusually high in August, but is now within expected levels year to date. These services are sometimes prone to inconsistent claiming by providers which then affects month on month expenditure comparisons.

Funder Inter District Flows (IDFs)

The September core result for Funder IDFs was on budget for the month and for the year to date. Coding for Medical and Surgical inpatient services is completed for July and utilisation is within budget. As previously noted a six to eight week lead time is required for coding completion. Also, as advised in the NGO section above, the changes in IDF costs resulting from movements in PHO practice memberships and/or enrolments growth are accounted for and covered within NGO budgets.

Funder Consolidated

The September consolidated core result for Funder was \$68k favourable to budget for the month and \$166k favourable for the year to date.

4. Auckland DHB Update

Lifting the Health of people in Auckland City

4.1 Engagement and Consultation

The DHB's Public Consultation and Engagement Policy is being reviewed to bring it into line with new legislation and wider policy imperatives and opportunities. A draft policy will be presented for CPHAC to review in December.

An invitation has been received and accepted to lead the evaluation of the effectiveness of the Auckland Homeless project. The goal of the inter-agency project is to improve systems and services to prevent clients becoming homeless as well as providing homeless people with a pathway out of homelessness.

The methodology and outcomes from research examining patients' journeys from home to the point of admission into an ACH ward will be presented at the upcoming national tertiary services conference. Work has begun to build a research programme that will examine the research findings in more depth and to translate the findings into action.

A report is being prepared about an Advance Care Planning (ACP) workshop held with patients and bereaved family members. The outcomes will inform the development of ACP tools and guidelines and the topics raised will be further examined in the project's future community engagement activity.

The pre-admit process project (looking at standardising the pre admit processes patients currently experience within Auckland DHB) is running a survey to investigate and compare the experience of patients continuing to flow through the non-pilot pre admit clinics vs. patients flowing through the pilot pre admit clinics.

Community dialysis units' patients and carers are being asked to report on their experience of care in the units and how the units compare to the old facilities. Their input will help the project team understand how patients are benefiting from the new units and what further improvements could be made from patients' points of view.

4.2 Child, Youth and Women's Health

Maternity Service Specifications

The Ministry of Health has published a suite of new draft maternity services service specifications. Both Auckland DHB and Counties Manukau DHB had indicated concerns regarding a proposed change to the definition of post natal care that could have major capacity implications for DHBs whose systems depend upon transfer of women and babies to a primary maternity facility for post natal care. The Ministry of Health has acknowledged these concerns and agreed changes and on this basis Auckland DHB and Counties Manukau DHB have agreed to endorse the service specifications. Both Auckland DHB and Counties Manukau DHB concerns have been largely allayed by the agreed amendments. The Ministry has also agreed to a change to the definition of a post natal stay suggested by Auckland DHB which will have the effect of allowing flexibility around the length of post natal care depending on a woman's need and choice.

4.3 Health of Older People

Residential care

The Seaside Sanctuary closure is underway, with 12 of the 20 residents having been relocated to new facilities off Waiheke without incident. Of the seven residents that remain, two have identified placement preferences and these are being progressed. For the remaining five, a small group home on Waiheke is being explored following clinical approval for each of the residents, and discussion with families and carers. Auckland DHB is working up a tender document to put to the market seeking small group home providers, and Seaside Sanctuary has agreed to leave one wing of the facility running whilst this process is undertaken and appropriate alternatives are developed. This is potentially an exciting opportunity for the population of Waiheke, as a clinical panel has been convened to review new referrals for Rest Home care on the island for suitability for small group homes into the future. Media and community attention remains high but weekly updates on progress from Auckland DHB seem to be reducing the one off reactive responses.

Dementia Day Care

This tender is now complete with negotiation underway with the preferred provider. This has been an extraordinarily positive outcome, with Selwyn Village committing to taking on all residents as well as staff from the Meadowbank service, including the transport service and the current driver. The continuity that this will provide is highly valued by the families of dementia clients. From November the service will operate from Selwyn heights in Hillsborough, with an assurance that a property in the Eastern suburbs will be secured as a priority. All transport issues will be managed in the interim for Eastern bays residents, however an analysis of the current client group has revealed that many travel from central Suburbs each day. The evaluation panel has therefore also agreed that the second placed proposal will be accepted to deliver an additional 15 places in Onehunga using new CFA funding for respite care from 1 July 2012.

4.4 Mental Health

Te Whetu Tawera

With the temporary closure of six beds at the mental health inpatient unit (Te Whetu Tawera) we have approached NGO community providers with specific requirements to explore the possibility of extending their service provision. We currently have one NGO provider delivering five “alternative to admission” or crisis respite beds in the community. This service has been operational since June 2011 and is working well. This provider does not have capacity to increase its number of beds and so we approached several residential service providers and one agreed to open vacant houses and operate them on an ‘as needed’ basis as an alternative to admissions service.

Such services work with people who are relatively unwell and who might otherwise access an inpatient bed. They provide a high level of care and support including access to NGO clinical staff to manage risk. The new provider of this temporary service is well established and does deliver high level rehabilitation services, but this alternative to admissions service is a new area for them. As part of the development and delivery of the service the new provider is working very closely with our established alternative to admissions NGO, such that referrals will continue to be processed through the current provider and once they are full they will direct any overflow to the alternative provider and offer support and guidance. This support will extend to offering backup overnight clinical support to the new service as well as other assistance for client care as needed. This temporary service will be available until at least early March when Te Whetu is expected to be fully operational again.

4.5 Changes to the CVD/Diabetes Target

With effect 1 January 2012, the current Better diabetes and cardiovascular services health target will be replaced by a new national target called “More heart and diabetes checks”.

The target will measure the number of completed cardiovascular risk assessments for all eligible persons within the last five years (which includes a diabetes check). The target goal is 90 percent. Data will be sourced from the PHO performance programme.

To assist DHBs in working towards this health target, interim goals have been set over the next two years. The first step is for DHBs to achieve at least 60 percent by 1 July 2012, then 75 percent by 1 July 2013, and full achievement of the national target goal by 1 July 2014.

The overall goal to improve the care and outcomes for people with Diabetes and / or Cardiovascular disease or at risk of developing CVD is well supported. The targets are agreeable in principle, however the time frames will be a challenge, primarily for the following reasons:

- The changes to the reporting systems using PHO Performance Programme have not been tested or even conveyed to PHOs and as with the smoking target, there have been significant challenges to getting this correct and mitigating confusion in the sector.

- The systems changes required are not documented nor clearly established and as a consequence the communication to primary care cannot begin, i.e. there is no detail with which to create a conversation. The timing leading up to Christmas and New Year is a time where changes cannot be implemented due to this time being primarily used to review existing problems and solutions, undertake upgrades, etc.

As such, it is not possible to understand the actual implications or improvement strategies that will be required to achieve the suggested target goals until the details are supplied by the MoH. At that time a comprehensive review and discussion can be undertaken that will then inform Auckland DHB on what activities will be required in order to meet the targets.

What will be important is to ascertain if the system will be able to report by DHB rather than PHO (as is current). This currently will have significant issues on driving change as in the example of NMHC, the outcome is the combined achievement and there is no way to see Auckland DHB's performance within that reporting. This will be reflected in many of the other indicators, for example smoking.

