

Community and Public Health Advisory Committee Minutes

MEETING DETAILS									
Time and Date	2:00pm, Wednesday, 21 October 2009								
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Auckland								
2	ATTENDANCE AND APOLOGIES								
	<p>Committee Members</p> <table> <tr> <td>Dr Brian Fergus (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Harry Burkhardt</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Seiuli Dr Juliet Walker</td> </tr> <tr> <td>Ian Ward</td> <td>Lynda Williams</td> </tr> </table> <p>In Attendance</p> <p>David Hunter – Procure Juliet Middleton – Procure Barbara Stephens – AuckPAC</p> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Taima Campbell – Executive Director Nursing Andrew Coe – Manager PHOs and Primary Care Hilda Fa’asalele – General Manager Pacific Health Sarah Marshall – Planning & Funding Manager Janice Mueller – Director Allied Health Celia Palmer – Clinical Leader, Planning & Funding Ian Bell – Board Administrator</p> <p>Apologies</p> <p>The Chair declared the meeting open at 2:05pm. Apologies had been received from Pat Snedden, Susan Buckland, Rob Cooper and Farida Sultana. An apology for lateness was recorded for Ian Ward.</p>	Dr Brian Fergus (Chair)	Jo Agnew	Harry Burkhardt	Dr Ian Scott	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	Lynda Williams
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3	CONFLICTS OF INTEREST								
	There was no notification of conflicts of interest for any item on the agenda.								
4	CONFIRMATION OF MINUTES 16 SEPTEMBER 2009								
	<p>The problem of data of enrolled people in PHOs did change the denominators for indicators. The need for retinal screening to align with retinal services and other ophthalmology services was noted.</p> <p><u>Moved Jo Agnew; seconded Ian Scott</u></p> <p><i>That the minutes of the Community and Public Health Advisory Committee meeting held on 16 September 2009 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>								

5	ACTION POINTS 16 SEPTEMBER 2009
	The provisional date for Peter Gluckman to attend was 17 February 2010 where he would talk on the impact of inter-uterine conditions on later life.
6	PLANNING AND FUNDING PERFORMANCE
6.1	Planning and Funding Summary Report
	<p>The issue with other regional DHBs on payment for Auckland Regional Public Health Services goes back 3 years relating to capital charge and the MECA settlement when funding was assumed into PBF, with a contribution from each of the three DHBs of \$500k to be made for the service. For the year 2007/2008 this was paid by all DHBs but in 2008/2009 Counties Manukau and Waitemata had advised that they are not paying and ADHB was endeavouring to have it put into IDFs for 2010. The manager was engaged with the DHBs asking them what services they wanted withdrawn if they are not going to fund. A letter was also being drafted to the Director General of Health who it was hoped would intervene. The issue was public health funding which had not had FFT for next year which had resulted in a reduction of 17 staff and if the two DHBs would not fund there would need to be a further reduction of 15. The MoH was aware of the funding pressure in Public Health. The reductions would be the total removal of public health promotion activity such as smoking cessation, nutrition etc.</p> <p>H1N1 had, nationally, more admissions with more severity which resulted in more people in ICU so it was serious. There was higher incidences of complications particularly for Maori and Pacific and had resulted in the purchase of more ECMO machines. A second wave of the flu was expected. A Mortality Review Committee was being set up to review the flu deaths.</p> <p>Ian Ward joined the meeting at 2:22pm.</p> <p>There was contingency planning for the second wave and while there were normal flu annual peaks and troughs, H1N1 was addressed using national resources managing beds across the country. There was some evidence of people changing their behaviours by isolating themselves.</p> <p>The measles outbreak turned out to be of low impact with 13 cases in the Auckland Regional Public Health Service area. With the funding issues there would be reduced capacity of ARPHS to respond to outbreaks. Health of Older People had an outlier issue and there had been a meeting last week with a letter to the provider detailing ADHB's concern for them to correct their service and provide evidence to that affect. Other providers had increased the level of service which was putting pressure on that provider.</p> <p>ACC had threatened to withdraw funding from the Auckland Sexual Abuse Help Foundation which was a small under funded service who had had a history of problems with funding. ADHB funded a telephone response and ACC counselling. Extra funding had been provided for 6 months to keep them going as they are a necessary service. The Chair and Carol Stott had met with the Associate Minister to secure funding until the end of January while looking at other paths to fund. The amount of money sought \$150k.</p> <p><u>Moved Ian Scott; seconded Ian Ward</u></p> <p><i>That the Community and Public Health Advisory Committee recommends the continued support for the Auckland Sexual Abuse Help Foundation service.</i></p> <p><u>Carried</u></p> <p>With financials there was concern at overrun in rest homes and private hospitals as while the dollars were known immediately the volumes were reported with a six weeks lag and it was known that there was some volume increase. While \$2.2m of extra funding had been put into price there still seemed to be a gap with one issue being that the total pool was distributed by PBF but ADHB's share of the services was higher than PBF. PBF is appropriate if services are on the average but if not then there needed to be some adjustment for example ADHB experienced higher rates of homeless, rest homes, cancer services etc. due partly to medical migration.</p> <p>While there was a universal newborn hearing screening programme it was important that services</p>

	<p>could intervene if screening warranted it. There would be a report back.</p> <p>One of the overall strategies being adopted was devolution to primary care and promoting self management of health.</p> <p>The question of choice between suppliers of Community Laboratory Services was raised following an article in the newspaper with defined sectors for each supplier. There was no settlement process between the suppliers and while it recognised that there may be some confusion the decision at this point was to have the defined areas of activity for each and concentrate on fixing the system. The question of whether a patient could go to the alternative supplier and pay for tests was to be clarified.</p>
6.2	Planning and Funding Indicators Exception Report
	The graph on percentage of mental health providers audited over a three year cycle was graphed over three years with the aim of 91% over that period when the graph would then revert to zero.
6.3	Planning and Funding Indicators
	<p>The number of healthy housing projects - health and social referrals was accumulative over the year.</p> <p>The increase in immunisations to 80% was noted which may be a result of the measles outbreak.</p>
7	IMPROVEMENT ACTIVITIES DAP Projects Report
	The report was noted.
8	MAORI HEALTH ADVISORY COMMITTEE AND PACIFIC HEALTH ADVISORY COMMITTEE
	<p>Pacific Health Advisory Committee</p> <p>The Committee had focused on the summit held on 1 October 2009 with 200 people attending which was an overwhelming turnout considering that it was the day of the tsunami striking Samoa and Tonga. The event was from 1:30pm to 8:30pm so that there was a rolling attendance. Data was gathered and analysis would be done by the consultation team to go into the Strategic Plan from which would be derived a Pacific Island Strategic Plan.</p>
9	PAPERS
9.1	The Health of Asian People in Auckland City
	<p>Sarah Marshall presented to the Committee outlining that Asians were the second biggest population group in Auckland and these could be divided into two groups; South Asian and North Central Asian.</p> <p>South Asian were principally Indian with a young population and when migrating were selected for having good health but were later experiencing high prevalence of diabetes due to lifestyle implications and genetics. This followed the pattern of rural to city migration in western countries with these factors becoming apparent 10 years after migration with a subsequent higher rate of complications i.e. higher rates of heart disease.</p> <p>North Central Asians were mainly mainland Chinese who were relatively young with a high number of 20-24 year olds due to the high number of students. Physically they were relatively healthy but were lower users of services including cervical screening and mammography and had a high abortion rate. There were mental health issues with depression in older people.</p> <p>MEELA were Middle Eastern, Latin, South American and African being principally refugees from Middle Eastern countries and Africa. There was a quota of 750 refugees per annum. Asylum seekers were outside the quota but were eligible for public health funded services and as a small group were particularly vulnerable. There were 15 primary practices that could cater for asylum seekers who had relatively high rates of infectious diseases, disability, traumatic stress and depression with women specifically having difficulties including least access to English. ADHB</p>

	<p>did work with the Auckland Regional Settlement Strategy. Funding for refugees and migrants was through PBF. It was noted that 1 of the 7 people being promoted for health careers through the A+ Trust and First Foundation was from the refugee and migrant population.</p> <p>Sarah was thanked for her excellent report.</p>
9.3	Primary Care EOI Update
	<p>In the appendices were the 2 EOI summaries. ADHB had been working with the PHOs however at a late stage Pacific withdrew from the consortium and promoted their own EOI. There also was a third submission from a home based organisation and while ADHB had not seen the proposal they had endorsed the organisation. The DHB will be heavily involved in the business plan as they are still responsible for their population. The PHO collective had been very good.</p> <p>The timeframe was expected to be a response in a few weeks with a business case to be developed by March for implementation in July 2010. Implementation would be over a 3 year period. The setting of targets were difficult but impacted on the quality of the patient journey and to cut the number of transactions was good for the patient. The central role of the GP was the patient's point of contact into the health system. Procure commented that the whole approach was exciting including the three DHBs and all PHOs working together to get better, sooner, more convenient and less going to hospital. The cooperation had been excellent and there was real opportunities within the same amount of money. The Pacific would have an MoU with the PHO group.</p>
9.2	Resolving Homelessness in Auckland City
	<p>Garry Smith headed the intersectorial group with aims of preventing more becoming homeless and helping the 160-200 designated as homeless to return to an appropriate environment. This was being managed by the Auckland CEO Group and had been assisted by Sarah Marshall. There would be a memorandum of understanding of the partnership of the collaborating organisations recognising that health has social determinants such as high unemployment and there needed to be access to healthcare to assist in employment. The focus on the small and invisible population was to raise awareness and all parts of the organisation needed to be involved. When the project started some of the organisations did not speak to each other and this gap was being overcome with data being shared, utilising resources and being smarter rather than involving more money. Auckland PHO was providing some funding and the City Mission could be used as an address as required for enrolment in the PHO with clinics being run by a GP and nurse practitioners and also physiologists coming to the clinic. The hope is to have a sexual health clinical. This population had had a high use of ED and since the project and clinics had started the status of health was much improved.</p> <p><u>Moved Ian Scott; seconded Jo Agnew</u></p> <p><i>That the Community and Public Health Advisory Committee recommends that the ADHB approve the signing of the Memorandum of Understanding: an inter agency approach for any rough sleeping in Auckland City.</i></p> <p><u>Carried</u></p>
11	GENERAL BUSINESS
	<p>Tsunami Response</p> <p>All DHB responses were being coordinated through Counties Manukau with the response of volunteers being in the 100s putting their names forward with the coordinator matching need with roles. ADHB was providing support for their Pacific people through pastoral support and had also had a number of patients from Samoa. Juliet Walker advised that the volunteer support from New Zealand was great and that the New Zealand Army had been fantastic.</p>

	NEXT MEETING
	The meeting closed at 4:30pm The next meeting is scheduled for 2:00pm, Wednesday 18 November 2009 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Auckland
CONFIRMED CHAIR: DATE:	