Community and Public Health Advisory Committees Meeting

Wednesday, 13th February 2013

2.00pm

Venue

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

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

Well Being to All.

AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
13th February 2013

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna **Time: 2.00pm**

COMMITTEE MEMBERS
Lee Mathias - Committee Chair (ADHB Deputy Chair)
Warren Flaunty - Committee Deputy Chair (WDHB Board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Deputy Chair
Jo Agnew - ADHB Board member
Peter Aitken - ADHB Board member
Judith Bassett – 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
Gwen Tepania-Palmer – WDHB Board member
Tim Jelleyman - Co-opted member
Eru Lyndon - Co-opted member

MANAGEMENT
Dale Bramley - WDHB, Chief Executive
Ailsa Claire – ADHB, Chief Executive
Debbie Holdsworth - WDHB, Acting Chief Planning and Funding Officer
Denis Jury - ADHB, Chief Planning and Funding Officer
Naida Glavish – ADHB and WDHB Chief Advisor, Tikanga
Paul Garbett - WDHB, Board Secretary

Leave of Absence: Rob Cooper

Apologies:

AGENDA

KARAKIA

DISCLOSURE OF INTERESTS

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that might give rise to a conflict of interest with a matter on the agenda?

Items to be considered in public meeting

All recommendations/resolutions are subject to approval of the ADHB and WDHB Boards.

2.00pm *(please note agenda item times are estimates only)*

1 AGENDA ORDER AND TIMING

PRESENTATIONS:

2.00pm Te Aka Ora, Vulnerable Families Forum - Waitemata DHB Health Excellence Awards
2.15pm Self-Directed Care Strategy Development Processes – Ailsa Claire (Chief Executive, Auckland District Health Board) 12

2 CONFIRMATION OF MINUTES
2.45pm 2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 21/11/12 1

3 DECISION ITEMS
2.15pm 3.1 Self-Directed Care Strategy Development Processes .... (Presentation) 12

4 INFORMATION ITEMS
2.50pm 4.1 Better Public Services 17

5 STANDARD MONTHLY REPORTS
3.00pm 5.1 Primary Care Update 21
3.15pm 5.2 Planning and Funding Update 61

3.30pm **6 GENERAL BUSINESS**

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Professor (Adjunct) of Leadership – University of Auckland Business School Co-Director – New Zealand Leadership Institute Deputy Chair – Health Benefits Limited Independent Chairman – Tonkin & Taylor Chair – Auckland District Health Board Chair – Waitemata District Health Board Chairman – Auckland Transport	01/11/12
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Board Member – Health Workforce New Zealand Board Member, AUT Millennium Ownership Trust Chair – Social Services Online Trust Board Member – The Rotary National Science and Technology Trust	28/09/11
Jo Agnew	Professional Teaching Fellow – University of Auckland Casual Staff Nurse – Auckland District Health Board	12/10/11
Peter Aitken	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd Owner – Pharmacy New Lynn Medical Centre	18/09/12
Judith Bassett	Nil	09/12/10
Pat Booth	Consulting Editor – Fairfax Suburban Papers in Auckland	24/06/09
Susan Buckland	Self employed – Writing, editing and public relations services Professional Conduct Committee member – Medical Council of New Zealand Professional Conduct Committee member – Occupational Therapy Board Member – Northern Regional Ethics Committee	12/10/11
Chris Chambers	Employee – Auckland District Health Board (wife employed by Starship Trauma Service) Clinical Senior Lecturer – Anaesthesia Auckland Clinical School Associate – Epsom Anaesthetic Group Member – ASMS Shareholder – Ormiston Surgical	20/04/11
Sandra Coney	Elected Member – Chair, Parks Committee, Auckland Council	02/05/11
Rob Cooper	Board Member – Auckland District Health Board Board Member – Waitemata District Health Board Chief Executive – Ngati Hine Health Trust Advisory Board Member – James Henare Research Centre, University of Auckland	19/09/12
Warren Flaunty	Member of Henderson – Massey, Rodney and Upper Harbour Local Boards, Auckland Council Trustee - West Auckland Hospice Trustee - Waitakere Licensing Trust Shareholder - Metlifecare Shareholder - EBOS Group Shareholder – Pharmacy Brands Ltd Shareholder – Westgate Pharmacy Ltd Chair – Three Harbours Health Foundation Trustee – Trusts Community Foundation Ltd	18/07/12
Lee Mathias	Managing Director – Lee Mathias Ltd Director – Midwifery and Maternity Providers Organisation Ltd Shareholder/Director – Pictor Ltd Director – John Seabrook Holdings Ltd Governance Advisor – AuPairlink Ltd Council member – NZ Council of Midwives Chair – Tamaki Transformation Transitional Board Chair – Health Promotion Agency Board Governance Advisor – Health Vision Ltd	18/09/12

Robyn Northey	Project management, service review, planning etc. – Self employed Contractor Board member – Hope Foundation Northern Region Trustee, A+ Charitable Trust	18/07/12
Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Member – The Families Commission Director – The Transformational Leadership Company	02/02/11
Allison Roe	Shareholder – Optimisewellbeing.com Founding member – Breast Health Foundation Director – Spiritus NZ Trustee – Allison Roe Trust Founder – Takapuna 2020 Community Group Board member – North Shore Hospital Foundation	28/03/11
Gwen Tepania-Palmer	Chairperson – Ngatihine Health Trust, Bay of Islands Life Member-National Council Maori Nurses Alumni – Massey University MBA Director – Manaia Health PHO, Whangarei Board Member – Auckland District Health Board	18/10/12
Co-opted Members		
Dr Tim Jelleyman	Clinical Director, Paediatrics (Child Health Service) Member, Active Clinical Network (ACN) for the Greater Auckland Integrated Health Network (GAIHN) Project	08/09/10
Eru Lyndon	Ngati Whatua o Orakei Corporate Ltd Honorary Research Fellow – Auckland University Member – AUT Business School Industry Advisory Committee Te Mata a Maui Law	12/08/11

Auckland and Waitemata District Health Boards

Community and Public Health Committees

Member Attendance Schedule 2012

NAME	FEB	MAR	MAY	JUNE	JULY	AUG	OCT	NOV
Lee Mathias (ADHB / WDHB combined Committees Chair and ADHB Deputy Chair)	✓	✓	✓	✓	✓	✓	✓	✓
Warren Flaunty (ADHB / WDHB combined Committees Deputy Chair)	✓	✓	✓	✗	✓	✗	✓	✓
Dr Lester Levy (ADHB and WDHB Chair)	✓	✓	✓	✓	✗	✓	✗	✓
Max Abbott (WDHB Deputy Chair)	✓	✓	✓	✗	✓	✓	✓	✓
Jo Agnew	✓	✓	✓	✓	✓	✓	✓	✗
Peter Aitken	✓	✓	✓	✓	✗	✗	✓	✓
Judith Bassett	-	✓	✓	✗	✓	✓	✓	✓
Pat Booth	✓	✓	✓	✓	✓	✓	✓	✓
Susan Buckland	✓	✓	✓	✓	✓	✓	✗	✓
Chris Chambers	✓	✓	✓	✓	✓	✗	✓	✓
Sandra Coney	✓	✗	✓	✓	✗	✓	✓	✓
Rob Cooper	✗	✗	✗	✗	✗	✗	✗	✗
Robyn Northey	✓	✓	✓	✓	✓	✓	✓	✗
Christine Rankin	✓	✓	✗	✗	✓	✓	✓	✓
Allison Roe	✓	✓	✓	✓	✓	✓	✓	✓
Gwen Tepania-Palmer	-	✓	✓	✗	✓	✓	✓	✗
Co-opted members								
Dr Tim Jelleyman	✓	✓	✓	✗	✓	✓	✓	✓
Eru Lyndon	✓	✗	✓	✓	✓	✓	✓	✓

✗ absent
^ leave of absence
** attended part of the meeting only*
 # absent on Board business

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 21st November 2012

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 21st November 2012 be approved.

Note: A correction has been made to the minutes that some members will have seen previously. The first bullet point now shown under item 3.5 was previously included in item 3.3.

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 21 November 2012

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

COMMITTEE MEMBERS PRESENT:

Lee Mathias (Committee Chair) (ADHB Deputy Chair)
Warren Flaunty (Deputy Committee Chair) (WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair)
Max Abbott (WDHB Deputy Chair)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Susan Buckland (ADHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member) (present from 2.36p.m)
Christine Rankin (WDHB Board member) (present until 4.02p.m)
Allison Roe (WDHB Board member)
Tim Jelleyman (Co-opted member)
Eru Lyndon (Co-opted member)

ALSO PRESENT: Ailsa Claire (ADHB, Chief Executive)
Denis Jury (ADHB, Chief Planning and Funding Officer)
Debbie Holdsworth (WDHB, Acting Chief Planning and Funding Officer)
Andrew Old (ADHB, Medical Advisor – Funding Division)
Jocelyn Peach (WDHB, Director of Nursing and Midwifery)
Janine Pratt (WDHB, Group Planning Manager)
Carol Stott (ADHB, Strategy and Planning Manager)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Marty Rogers (ADHB and WDHB, Manager Maori Health Gain, Planning and Funding)
Leani Sandford (ADHB, Interim General Manager, Pacific Health)
Tim Wood (WDHB, Group Manager, Funder NGOs)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Lynda Williams, Auckland Womens Health Council
Anne Curtis, Health Link North
Tracy McIntyre, Waitakere Health Link
Lorelle George, Waitemata PHO
Gaylene Sharman, HealthWest
Aroha Hudson, HealthWest
Alastair Sullivan, White Cross Healthcare
Carmel Vyas, ProCare PHO
Adrian Collier, Pfizer
Vivien Twyford, Twyfords NZ

APOLOGIES: Apologies were received and accepted from Jo Agnew, Rob Cooper, Robyn Northey, Gwen Tepania-Palmer, Dale Bramley and Naida Glavish, with an apology for late arrival from Sandra Coney.

WELCOME Lee Mathias welcomed those present.

KARAKIA Allison Roe read to the meeting the English translation of the karakia.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no declarations of interest with regard to the agenda.

PRESENTATION: Derek Wright, Recovery Solutions (formerly Challenge Trust)

Derek Wright was welcomed to the meeting. He provided a power point presentation covering the changes made to the organisation and its new strategic directions for 2012-2015, centred on improved community wellbeing and participation and covering:

- Aligned culture and values
- Innovative client services
- Growth and consolidation of services
- Exceptional stakeholder relationships
- Strong capability and capacity

Derek Wright also detailed the performance indicators that will be used in measuring performance and the roadmap for achieving the various targets. In the course of his presentation he noted that their ambition is to double the size of the organisation over the next three years, but with an approach that looked more at partnerships rather than mergers. They were also looking at extending involvement in providing social housing and generally trying to create a continuum of care.

In answer to a question, Derek Wright advised that staffing changes during the upheavals at Challenge Trust had been at senior management level and the rest of the organisation had remained quite stable. What they were seeking at management level was a balance of health experience and business experience.

The Committee Chair thanked Derek Wright for his presentation.

1. AGENDA ORDER AND TIMING

Items were taken in the order listed on 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 10 October 2012

(agenda pages 1-8)

Resolution (Moved Warren Flaunty/Seconded Judith Bassett)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 10 October 2012 be approved.

Carried

Matters Arising:

ADHB/WDHB Collaboration Governance Group Minutes – the Board Chair advised that because these minutes involved some issues of employment, it would not be appropriate to include them in Board papers; however arrangements could be made to send them to Board members individually on a confidential basis. The Committee agreed with this suggestion.

3 DECISION ITEMS

3.1 2013/14 Annual Plan Update (agenda pages 9-14)

Janine Pratt (Group Planning Manager, WDHB) was present for this item and summarised the report. She noted that since the report had been written, some joint feedback had been provided to the Ministry of Health on its requirements and that a number of staff members would be attending a meeting the following week where there would be a lot more advice from the Ministry on the planning package and Annual Plan requirements.

Matters discussed included:

- The Committee Chair raised the need to think about clearly defining what is meant by "equity" and "fairness" in the Annual Plan, as ideas of what fairness means differ. In relation to this the Board Chair spoke of the need to have a decision making framework based on robust principles to avoid subjective decisions.
- The challenge posed by the fact that the funding situation is unlikely to improve for a number of years needs to be enunciated in the Annual Plan.
- The desirability of conciseness in the document having to be balanced against the Ministry's expectations of sufficient detail in the Plan to assure progress can be checked.

Janine Pratt advised that the final timetable for the Annual Plan process had not yet been received, but it was usually due at a date in the period from 12 to 25 March. It is hoped to get a draft to CPHAC before the document is submitted. By the 13 February CPHAC meeting date, there should be a good idea of what the document is going to include.

Resolution (Moved Lee Mathias/Seconded Tim Jelleyman)

That it be recommended to the Auckland and Waitemata DHB Boards:

That the Board:

1. **Note the expected priorities for 2013/14.**
2. **Note that the approach to developing annual plans ensures we fulfil all our accountability requirements as DHBs.**
3. **Note that ideally the annual plans will be informed by a logic framework which is consistent across both DHBs.**
4. **Note that the planning and accountability documents across Auckland and Waitemata DHBs will use exactly the same format and style. Where content is common to both DHBs, this will be presented, for each DHB, using identical text.**

Carried

3.2 Auckland and Waitemata District Health Boards' Healthy Food Environment Policy (agenda pages 15-30)

Kate Sladden (Planning and Funding Manager ADHB) was present for this item.

Lee Mathias introduced the report, noting that the proposed policy will fit into a much wider approach to promoting a healthy environment from Auckland and Waitemata DHBs.

Kate Sladden commented that what can be achieved through environmental change is really significant. The paper to this meeting reflected the earlier paper to CPHAC in July 2012, but gave more detail about what had been achieved to date, for example with vending machines. It also detailed the proposed principles and statements to be contained within the policy.

2.36p.m – Sandra Coney present.

Matters covered in discussion of the proposed approach included:

- The need to include something about using the hearts and minds of staff to promote the policy, noting that the health boards are amongst the biggest local employers.
- With regard to what is supplied at vending machines, it was suggested that a realistic approach is needed to meeting the needs of people in the middle of the night, when no other food sources may be available – or else considering other food sources to vending machines.
- The approach is intended to provide an example to other large organisations of what can be done.
- Support for the underlying principle of attempting to influence people towards more healthy eating habits.

Resolution (Moved Lee Mathias/Seconded Max Abbott)

That it be recommended to the Auckland and Waitemata DHB Boards:

That the Board:

1. **Endorse the principles and statements for the Healthy Food Environment Policy.**
2. **Support the actions to achieve Policy implementation.**

Carried

3.3 Rheumatic Fever Prevention and Intervention Programme in Auckland and Waitemata DHBs (agenda pages 31-46)

Carol Stott (Strategy and Planning Manager, Auckland DHB), Tim Wood (Group Manager Funder NGOs, Waitemata DHB), Alison Leversha (Community Paediatrician, Auckland DHB), Richard Aickin (Director of Child Health, Auckland DHB), Fionnagh Dougan (GM, Starship Hospital) and Chrissie Picken (Chief Advisor, Population Health, Ministry of Health) were present for this item.

Alison Leversha introduced the report, noting that the principles of the programme had been determined, but that the specifics of how they are to be delivered are being worked out. A housing working group, a health promotion working group and a primary care working group are involved in this.

In answer to a question, Chrissie Picken advised that the Ministry of Health is broadly in support of the integrated co-funded approach proposed in the report.

Matters covered in discussion and response to questions included:

- Rheumatic fever is a red flag for everything not working for children in our communities. There is a strong awareness that involvement in this issue also provides great opportunities to look at skin sepsis and other issues.
- Concern that the people who tend to get access to programmes such as assistance with insulation are those cleverer at accessing such programmes and not those with the greatest needs.
- Support for the fact that Maori and Pacific health providers had been included in the engagement strategy.
- Richard Aickin confirmed that it is quite beyond the capacity of clinicians dealing with children in hospital to assess their housing situation. They do ask those questions and can put families in touch with agencies that can assist them.
- Sandra Coney advised that an Auckland Council report had shown that a significant percentage of houses are now better insulated as a result of the various insulation assistance schemes. She also advised that a Council Working Party is currently working on issues such as future minimum house sizes, minimum room sizes and rules concerning healthy homes and insulation.
- As noted on page 33 of the agenda, a throat swabbing programme in high-risk schools in the Auckland DHB area is likely to only reach 35% of vulnerable children and in Waitemata DHB less than 10%. The problem is that unlike Counties Manukau DHB where a lot of the children experiencing rheumatic fever are from the lowest decile schools, for Waitemata and Auckland DHB the incidence is quite complicated and more broadly spread. That is why a different approach is needed.
- The possibility of involving pharmacies is being thought about and will be discussed with those involved in such a programme in Tokoroa.

Resolution (Moved Judith Bassett/Seconded Chris Chambers)

(a) That the report be received.

(b) That it be recommended to the Auckland and Waitemata DHB Boards:

That the Board:

Endorse the proposed prevention and intervention programme for Auckland District Health Board and Waitemata District Health Board, for the reduction of Acute Rheumatic Fever in our populations.

Carried

3.4 Auckland After Hours Initiative – Update (agenda pages 47-70)

Dr Ian Scott (Chair, After Hours Project Partnership) presented this report. Kim Marcus from Synergia was also present for the item.

Ian Scott summarised key points from the Executive Summary of the report (pages 52-53 of the agenda) and in particular the three indicators of 12,000 additional patient visitors to the eleven network A&Ms after hours; 27% increase in the proportion of children under six able to access free after-hours care at an A&M within a 30 minute drive; and 55 more GP practices connected to the HML Telephone Triage Service. He also noted the level of co-ordination that had not previously existed, including the PHOs and the Emergency Departments at all of the hospitals.

Ian Scott stated that the new system had made it a lot cheaper for the vast majority of those people needing to access after hours care. For the DHBs there had been a significant reduction in the rate of increase in emergency departments since September 2011. In the view of those involved in the project, an excellent service is being provided and one that is well received by many of the patients. Ian also referred to the limited funds that had been available to spend on communications and suggested that to change the behaviour of a large number of people there was a need to spend much more than the budget of $150,000.

Matters covered in discussion and response to questions included:

- Concern at the non-availability of free after hours services for under six year olds at A&Ms in the Auckland DHB area, for example a family in Glen Innes needing to travel to Otahuhu for that. Ian Scott advised that the problem had been that ProCare PHO had insisted that A&Ms should not undercut general practitioner charges. After discussion of the issues and the current situation in the Glenn Innes/Tamaki/Orakei areas, it was suggested that it an appropriate recommendation be made to the Boards on this issue.
- In answer to a question, Ian Scott said that an area he saw with potential for improvement is the high number of people who come to emergency departments from residential care facilities, many of whom could have their needs met by the after hours service at the A&Ms. This issue could be driven by the after hours partnership as there is an ability to come up with an excellent affordable response for residential care without sending patients to hospital.
- Ian Scott said that a key issue is how to affect the attitude of GPs, some of whom had a limited view of their responsibilities. GPs are being paid to provide a 24 hour service, a principle that was tested in a court hearing in South Canterbury not long ago.
- Ian Scott advised that one issue with communicating to the public about the After Hours Service is that they had found that not one Emergency Department in the region had put their posters up, and only some had their pamphlets available. He considered that the DHBs could be promoting the service much more. The Committee agreed that a report should be brought back to it on strengthening communication to the public about how to access urgent care.
- The interim evaluation of the initiative (led by Auckland University and overseen by the Clinical Subgroup of the After Hours Network) is due in December, with the final report due in March 2013.
- In discussion of the proposed resolution, the Auckland DHB Chief Executive noted that in considering proposals relating to residential care it would be important to bear in mind work being carried out by GAIHN.

Resolution (Moved Lee Mathias/Seconded Peter Aitken)

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

That the Board:

1. **Note the progress made on improving access to after hours care through the Auckland After Hours Health Care Network.**
2. **Note the proposal to investigate further with GAIHN opportunities for other avenues to access urgent care (particularly relating to residential care).**
3. **Note that a University of Auckland led evaluation is due to report in December 2012 (interim) and March 2013 (final) to inform future direction.**
4. **Request that a report be brought back to CPHAC in the next few months on strengthening public communications on how to access urgent care.**
5. **Request that ways of improving accessibility to free after hours care for under six year olds be investigated where it does not exist, such as at East Tamaki.**

Carried

3.5 Combined Auckland and Waitemata DHBs Child Health Improvement Plan (agenda pages 71-119)

Carol Stott (Strategy and Planning Manager, ADHB), Dr Richard Aickin (Director of Child Health, Auckland DHB), Dr Alison Leversha (Paediatrician, Auckland DHB) and Tim Wood (Group Funding Manager, WDHB) presented this report.

Richard Aickin introduced the report.

Matters covered in discussion and response to questions included:

- Concern that there is not more emphasis on child abuse and child neglect in the report.
- A concern was expressed that the Plan did not highlight a health leadership role in reducing child abuse. There was an extensive discussion of the issue of child abuse including its relationship with neglect, poor living conditions, poor nutrition and other social and economic factors. It was noted that often the families involved are disconnected from society, unable to cope with a whole range of issues. Lee Mathias advised of an initiative in Sydney involving nurses as case managers and having a personal health orientation, which is achieving good results. Ailsa Clare also advised of a nurse led parenting programme in the United Kingdom. The discussion generally supported the view that only a multi-sectoral approach can address such a complex issue, but that the health sector has a responsibility to play its part actively.
- It was suggested that the plan focuses on women and mothering, but should also target the role of men in households, whether birth fathers or step fathers.
- Carol Stott advised the Plan showed the strategy, but it is intended to develop an implementation plan to give it practical effect.
- On page 18 of the Plan (page 95 of the agenda), the wording of clause 1 (under Prevention) needs re-wording.
- There was a discussion as to whether or not the objective on page 26 of the Plan (page103 of the agenda) "Fewer young people commit suicide" should be: "No young people commit suicide". Alison Leversha advised that the view of the Child Youth Mortality Review Group is that the issue is inordinately complex and a zero target did not appear achievable. Some youth suicides occur with young people who have never been visible to mental health services.
- Eru Lyndon provided a Maori perspective on child health improvement. The colonisation process had lead to Maori being dependant on the good will of others. The more recent Maori experience had been that when supported to take ownership they had started to see positive results. The way forward is to invest significantly into Maori health providers and to start doing things that Maori know will work. Richard Aickin noted that the Plan supported this approach, although to achieve it the Boards may need to stop doing some other things. The Board Chair advised of efforts through the Maori Health Gain Advisory Committee to build capacity into Maori providers. It just needed a place to start, but releasing capital to that would be critical.
- On page 33 of the Plan (page 110 of the agenda) it was agreed that an additional indicator be included: "Breastfeeding: %exclusively breast feeding at 6 months".

Resolution (Moved Lee Mathias/Seconded Allison Roe)

That it be recommended to the Auckland and Waitemata DHB Boards:

That the Board:

1. **Note that the feedback from CPHAC (18 July 2012) has been considered and the plan has been updated.**
2. **Approve the Combined Auckland and Waitemata DHB Child Health Improvement Plan (including minor amendments agreed at the CPHAC Meeting of 21 November 2012).**

Carried

4. INFORMATION ITEMS

There were no information items.

5. STANDARD MONTHLY REPORTS

5.1 **Primary Care Quarter 1 2012** (agenda pages 120-147)

Andrew Coe (Group Manager Primary Care) and Stuart Jenkins (Clinical Director Primary Care) were present for this item.

The Committee Chair confirmed that she liked the new format for the report.

Stuart Jenkins updated the report with regard to localities development. He advised that the Clinical Governance Group had met on 20 November, which was the first time the PHOs had come along with data based on practices, definitely a step forward. They are keen to involve Counties Manukau and are also trying to simplify and align clinical governance groups. They aim to focus integration activity in primary care through governance structures.

Stuart Jenkins advised that in the West they were working towards Phase 2 of implementation. Work will concentrate on practice re-engineering, to make practices more efficient and able to take on more activity. To date this work has been within the New Lynn and Henderson IFHCs, but will shortly begin with the third IFHC. It is expected that this work will lead to more practice amalgamation in West Auckland, which is critical. Work is continuing around clusters, with a meeting to take place in New Lynn in November and hopefully meetings in December in Henderson and Massey. The process for appointing Clinical Directors for the Northern and Central localities is proceeding, and funding is being sought from the Ministry of Health to fund activity in the Central locality.

With regard to the More Heart and Diabetes Checks target (pages 125-126 of the agenda), Andrew Coe advised that a difficulty had been that each DHB – Auckland, Counties Manukau and Waitemata had a different way of dealing with the issue and they had ended up with three different programmes. For Auckland DHB there had been an issue with ProCare not accepting the national health target, which was why the Ministry of Health had been involved to support progress. ProCare had now moved forward on this. Overall though, what is needed for this target is a joined up planning process. With regard to this, Tim Wood noted that one of the issues is the different level of funding DHBs put into this target, for example for diabetes checks. While they might plan together, there would still be a fundamental issue concerning funding levels. Ailsa Clare advised that there are a number of vehicles available to address this. Strengthening GAIHN is one. The issue has to be that if a strategy and process is agreed, there also needs to be agreement on resourcing.

With regard to movement of practices between PHOs, Andrew Coe advised that they were collectively working on a paper for the Audit and Finance Committees in the New Year about how to manage these in a better way. The needs of the general practices have to be balanced against how services are allocated through PHOs and the distortions that practice shifts can cause.

The report was received.

5.2 **Planning and Funding Update** (agenda pages 148-152)

Marty Rogers, the new Manager Maori Health Gain, Planning and Funding, was welcomed by the Chair and the Committee.

The section of the Auckland DHB update relating to Funding of Sexual Assault Services (page 150 of the agenda), services provided by the Auckland Sexual Abuse Foundation (HELP) was clarified by Denis Jury and Carol Stott. The long term counselling service for victims is funded through ACC. The crisis service has two parts: a call out service funded by the DHBs and a telephone support line and crisis counselling service funded by government agencies. HELP had expected a certain amount for the services funded by the government agencies and that expectation had not been met, which was why it was proposing to shift to more limited hours. There had been some lack of agreement between the government agencies involved. Auckland DHB had been a strong advocate for these services. Carol Stott was asked to keep CPHAC members informed of developments concerning this issue, outside the meetings cycle.

In answer to questions, Tim Wood advised that ProCare had not yet determined which 15 to 20 pharmacies across the Waitemata DHB District would deliver the Pharmacy Smoking Cessation Programme (page 148 of the agenda). It had been decided that it would be more efficient to have ProCare co-ordinate the process rather than having numerous small contracts between the DHB and the pharmacies. An open, transparent process is being followed.

The report was received.

6. GENERAL BUSINESS

There was no general business.

The Committee Chair thanked those present for their participation in the meeting.

The meeting concluded at 4.40p.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 21 NOVEMBER 2012

____CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 4th February 2013

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 29/08/12	4.2	'Well Child' - An update report on the 'Well Child' programme and its target achievements	Denis Jury	CPHAC 20/03/13	A short briefing was taken to the August ADHB Board meeting based on MoH summary data for ADHB Well Child Tamariki Ora services. It is anticipated having a full Well Child report at the March CPHAC meeting, based on receipt of full reports from the MoH.
CPHAC 10/10/12 21/11/12	3.1	ADHB/WDHB Collaboration Governance Group – minutes to be provided to Board members for information. Agreed at November meeting to circulate to individual members on a confidential basis.	Vicki Buchanan		Actioned.
CPHAC 21/11/12	5.2	Issue with Funding of Auckland Sexual Abuse Foundation by government agencies – CPHAC members to be kept informed of developments outside of the meetings cycle.	Carol Stott/Denis Jury		Actioned. Progress with resolution of funding issues advised by e-mail 18/12/12. Also covered in February CPHAC Planning and Funding Update.

3.1 Presentation: Self-Directed Care Strategy Development Processes

Recommendation:

That the Auckland and Waitemata DHBs Community and Public Health Advisory Committees recommend to the Auckland and Waitemata DHB Boards:

That the Board notes the Self Directed Care Strategy Development processes and that both Waitemata and Auckland DHBs work together to populate the outcome.

Prepared by: Ailsa Claire (Chief Executive Officer, Auckland District Health Board)

This paper is designed to explore the next steps to developing the Auckland wide community strategy for self directed care.

This is based on principles of participation and engagement of all concerned and will be an ongoing iterative process. We will have to collectively focus on developing a culture of trust and power sharing with the population and between the partners based on agreed outcomes, learning from Whanau Ora and creating synergies with it.

'Self directed care means the system working together as one to achieve change, not only of the system but also of the hearts and minds of those who work within it.'

This paper describes a set of steps that we need to take. The narrative below the heading **is illustrative only and should not be seen as a proposal.**

Having agreed the steps to be taken we will then all work together to populate the outcome.

Steps to a self directed care model

1. Describe the outcome, example

Supporting the people of Auckland to maximise their health and well being we will ensure:

- people will control and be empowered to maximise their own health and well being and enhance the quality of their life
- people will have different beliefs about their health or their role in care
- services will be free flowing and based on patient need and the outcomes people want for themselves and their communities
- people will have rapid and convenient access to high quality cost effective evidence based services
- a focus on health inequalities
- a focus on key programmes which will help prevent early death and long term illness and distress eg:
  - CVD
  - Cancer
  - Obesity
  - Mental health
  - Alcohol related harm

- People are served by a professional, well trained and accountable workforce
- Focus on and reward for quality and innovation

2. **Describe and agree self directed care and self care and its synergies with Whanau Ora for example**

- My plan /my shared care plan
- Information about my health, people like me, treatment, treatment options and the quality of care
- A trusted person to help, care navigation
- Control of care, decision making, choice, telecare etc
- Access how I want it, digital by default
- Service response to my plan which is local, focused on me and integrated
- Respect and dignity at all times and trust in me.

3. **Focus on patient stories –** and keep the focus on what it feels like and what people want for themselves, keep the moral high ground and the shared objective.

4. **Determine the population focus** - communities of interest and/or geographic areas which are a logical local delivery focus. Population base that is big enough to allow for allocation of resources to the locality (potentially all resources). Initially all resources utilised at a locality level could be part of a locality budget but ultimately all services utilised by the locality could be included with possible exception of tertiary services.

5. **Describe the resources currently utilised by the locality** and the resource need based on the criteria agreed to target health inequalities. Should describe all resources utilised in area and define the social capital of the people.

6. **Identify the partners at DHB and locality level and agree the partnership arrangements (leadership and how to manage this programme and develop the strategy).**

7. **Agree the partnership model and processes with the community including community governance approach.**

8. **Describe role and function of primary care services and access and care coordination points for example**

- Population focus with targeted population based interventions
- Locality linkages to ensure population access to extended services and subspecialisation within primary care
- Care navigation based in primary care settings
- Services accessed via primary care or direct access eg access to talking therapies
- Attached or locality/population based staff eg district nurses, rapid response services
- Access to diagnostics and near patient testing
- Telecare and telehealth
- Extended access
- Multi modal consults (video, phone, email)
- Interdisciplinary practice and model
- Extended teams in primary care eg, clinical pharmacist, health care assistants, extended scope nurses
- Clinical partnerships with community pharmacy
- Partnership with residential homes
- End of life care
- Clear access and coordination points for non enrolled populations
- Active case finding, registers
- open communication and transparency about services, their performance and strengths and weaknesses

9. **Agree the model of coordination and integration at a local level.** Already we have different models developing some of which use primary care practices as the coordination point others of whom do not. Given agreement about the outcome different models should be encouraged to fit local situations.

10. **Agree what needs to be different in secondary care** initially and how secondary care services are to be accessed by localities and how secondary care will support localities? How do we create a system instead of secondary and primary care? For example,

    - Staff trained in supporting my plan, motivational approaches
    - Open referrals and follow up
    - Services close to me, telecare and telehealth
    - Two way digital communication
    - Service integration

11. **Agree underpinning principles and support processes for example:**

    - cultural change based on trust and partnership
    - OD programme eg everyone trained in motivational interviewing
    - participation and engagement processes
    - open transparent two way communication between population and people who serve them
    - care navigation
    - costed care pathways with financial and care control devolved as far as possible
    - integrated patient information systems
    - integrated training
    - community educators
    - telecare and telehealth
    - e-clinical pathways
    - e-benchmarking, (Atlas of variation)
    - predictive risk modelling
    - insight based service design
    - open data and transparency of data
    - peer education models

12. **DHB wide and locality intelligence. Public health analysis at locality level so all localities can answer**

    - How healthy? Reducing health inequalities and improving health outcomes now and in the future
        - How healthy /unhealthy is my population in relation to my benchmarks?
        - What are the determinants of health?
        - How much is the local population going to change in the future?
        - Who would benefit most from a disease management programme?
        - What proportion of disease in this area is avoidable?
        - What diseases kill the most people and which are the biggest burden?
        - What causes patients the most distress?
        - What are the preventable conditions contributing to our premature mortality?
        - Who is at the greatest risk of disease /acute admission to hospital?
        - Who are the sickest people and where do they live?

- What is really happening in this system? Information at the right time and to the right person to protect the vulnerable and to ensure the right care is given.

  - Is demand really going up?
  - What is the demand today for urgent care?
  - What are the current flows and pathways and are people using the right ones? Where are the bottlenecks?
  - To what degree do patients make informed decisions about their care?
  - How much variation is there in our service offer?
  - What are patients telling us about what is going on in the system?
  - How much random variation in activity do we observe?

- How Much? Improved financial information including budgeting and planning so we know we are spending on the right things with the right provider

  - How much are we spending on what?
  - How much is focused on health inequalities?
  - What is the cost of our care pathways?
  - Where is there financial variation?

- How do we compare? challenge the current state through benchmarking and comparison in order to improve clinical outcomes

  - Where is the clinical/activity/cost variations local, national international best practice? Are we delivering national standards of care for patient experience quality and outcome?
  - How do we compare for value from money, outcomes and productivity against similar areas/best practice over time?

- Are the providers who serve our population delivering what they agreed?

- How could things be better?

  - What are our patients telling us?
  - What is the impact, cost of changing a pathway of care? What are our drivers for change? Have we engaged our stakeholders?
  - Do we need to procure services from other providers or work in partnership with stakeholders?

- What difference have we made?

  - Have we improved health outcomes?
  - Have we reduced inequalities? How do patients rate their experience of our services? Did we meet our targets and sustain them?

- What are our future plans?

  - What are the barriers that exist that prevent change?
  - Given the budget how do we prioritise?

13. **Identify potential delivery mechanisms**. What models of service delivery exist or could be developed in a locality. Anticipated that these will be different in different localities based on existing models, need and population preference. Must be capable of meeting common objectives and the community governance model agreed with the local population.

14. Agree outcome based and benefits realisation measurement

Ensure everything we do has a clear outcome and measurable benefit eg We will reduce the prevalence of smoking by x by date .

15. Agree processes to support maximum devolution of decision making and Resource.

16. Open and explicit resource allocation process at all levels based on

- health outcomes, greatest benefit for all
- facilitation of self directed care and self care
- clinical effectiveness use of sound evidence base
- quality, use of quality standards
- affordability, live within resources.

4.1 Better Public Services

Recommendation

a) **That the report be received.**

b) **That the Committee notes the current activity aligned with the Government Better Public Services Programme.**

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

Glossary

DHB - District Health Board
HSGs - Healthcare Service Groups
NHB - National Health Board

1. Executive Summary

DHBs are expected to engage and invest in three of the Government's Better Public Service Result Areas; increased immunisation rates, reduced rheumatic fever rates and reduced number of childhood assaults (white paper on vulnerable children). This paper summarises the specific expectations, progress to date and mechanisms for keeping the CPHACs updated on an ongoing basis.

2. Background

Auckland and Waitemata DHBs are expected to make a difference through the Better Public Services programme which aims to deliver better results and improved services for New Zealanders. This whole of Government programme was launched in 2012 and reinforced in the Minister's Letter of Expectations for 2013/14 and has three key policy focuses:

- **Results** – getting traction on the results that matter most
- **Performance** – strengthening leadership, culture and capability
- **Citizen** – better services and value for money.

2.1 Result Areas

From a DHB perspective, we are expected to deliver on three of the ten "**Results** Targets"

- **Immunisation**
- **Rheumatic fever**
- **Child physical abuse**

Summary from Better Public Services website
http://www.ssc.govt.nz/bps-supporting-vulnerable-children published 3 July 2012

Immunisation

The target for immunisation is "Increase infant immunisation rates to achieve and maintain 95% coverage of eight-month-olds fully immunised with the scheduled vaccinations by 2017". To achieve this result, it is proposed to:

- Support every pregnant woman to have a named GP before birth
- Ensure every baby is registered with a GP before they are two-weeks-old
- Pre-call infants for their six-week immunisation when they are four-weeks-old and promptly recall infants who are not up-to-date with immunisations
- Better join-up of two services for families – Well Child/Tamariki Ora and Family Start.

Rheumatic Fever

The target for rheumatic fever is "Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by June 2017". This is described as a "stretch goal". To reach this goal, it is proposed to:

- Provide throat swabbing and treatment to children at high risk
- Raise community and health sector awareness of the disease
- Improve knowledge of rheumatic fever through surveillance and research
- Work across government agencies to address risk factors like housing conditions and hygiene in schools – for example, by ensuring hot water and soap are available.

Overcrowding in housing is also an important health determinant link to reducing rheumatic fever. This point has been made with regards to the importance of how the Better Public Service result areas need to interlink with other intersectoral initiatives like education, housing etc.

Child Physical Abuse

The target is to halt the 10-year rise in children experiencing physical abuse and reduce current numbers by 5% by 2017. This is described by the Government as extremely ambitious. Actions to reduce the number of assaults on children will be developed through the Government's White Paper for Vulnerable Children. These actions could include major changes over time to:

- better screen children for vulnerability
- fully assess the needs of vulnerable children
- better enable frontline workers and communities to communicate concerns about children
- make services more focused on results.

Progress to Date

Immunisation

Both DHBs are meeting the immunisation target of 85% by July 2013. Auckland DHB's result for Q2 was 91% and Waitemata DHB's result was 92%. The CPHACs are regularly provided updates on our achievement against the immunisation target, which is also a health target.

Rheumatic Fever:

In November 2012 the committees were provided an update on the plans to respond to the expectations regarding rheumatic fever. Progress against these plans will be provided to the committees regularly and will be incorporated in the 2013/14 annual plans.

Child Physical Abuse:

In addition to the presentation at the beginning of this meeting, highlighting a Waitemata DHB initiative which focuses on vulnerable children, we plan to provide an update on the DHBs' response to the Government's White Paper at the March CPHAC meeting. An initial review of the implications for Waitemata DHB services was provided to the December 2012 meeting of the Waitemata DHB Hospital Advisory Committee.

2.2 Performance

With regard to the **Performance** focus, there is increased effort being placed on working across agencies to achieve collective interests. The State Services Commission is seeking opportunities and ideas on how the State Services can operate more effectively and efficiently. To date our main focus has been on how we as DHBs can operate more effectively and efficiently, including collaboration with the other DHBs in the region. Moving forward there is an expectation that increased collaboration would occur with other agencies.

We have some activities underway including the establishment of the Auckland Intersectoral Health Group, and the increased DHB presence at the Auckland Social Sector Leaders Group (ASSLG) and Auckland Policy Officer meetings. However the focus of the ASSLG is the Southern Initiative which occurs within Counties Manukau DHB's district. There will be flow-on impacts across the region; however the effort and resources are targeted in the southern area.

There are also specific and discrete intersectoral projects implemented across the metro-Auckland region with a direct impact on patients and clients. These include housing initiatives (eg insulation projects across the region, Healthy Housing in CMDHB etc), Gateway Assessment programme, regional immunisation intersectoral group as part of ASSLG focused on achieving the two year old immunisation target, and the multi-agency strategy for high risk children and youth (mental health), most of which are described in our Annual Plans.

2.3 Citizen

The **Citizen** focus on better services and value for money encompasses engagement with citizens and businesses through to leveraging expertise, best-sourcing and continuous improvement and innovation. As signalled in our annual plans we will need to increase our efforts to transform our DHBs through service integration, new models of care, innovation and service improvement, and collaboration where there are tangible benefits (financial and health outcomes). The signals from Government indicate the tight fiscal constraints are going to increase rather than improve (refer Vote Health four year budget plan[1]), so we will need to continue to implement longer term strategies to continue to maintain our sustainability.

[1] Budget 2012: Vote Health Four-Year Budget Plan

3. Conclusion

Both DHBs have established planning and implementation activities to respond to the engagement and investment expectations of the Better Public Service Result Areas of relevance to the health sector. Each month we will update the CPHACs on further progress towards these result areas.

The performance and citizen focuses of the Better Public Service programme have been included in the Minister's letter of expectations for the past few years, and therefore both DHBs have strategies in place to respond which they are implementing as part of the annual plan deliverables, specifically relating to living within our means and service integration and development.

http://www.treasury.govt.nz/publications/informationreleases/budget/2012/pdfs/b12-2265841.pdf

5.1 Primary Care Quarter 1, 2012

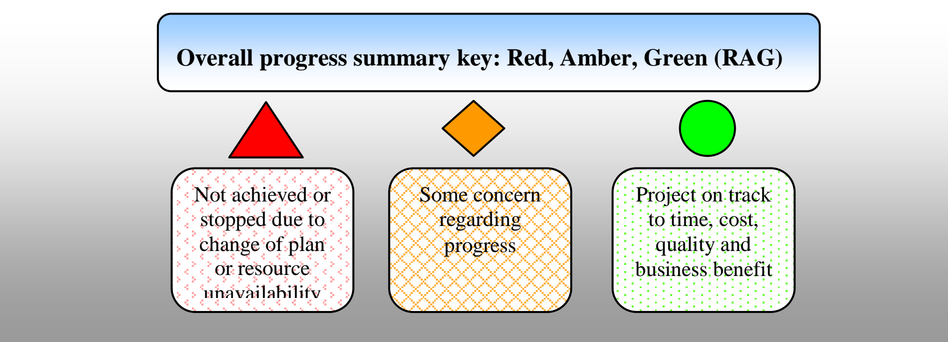
Recommendation:

That the report be received.

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

Glossary

A&M - Accident and Medical Centre
AH+ - Alliance Health Plus
ALT - Alliance Leadership Team
ARC - Aged Residential Care
BFG - Better, Sooner, More Convenient Primary Care Funding Group
BSMC - Better, sooner, more convenient primary health care
COPD - Chronic Obstructive Pulmonary Disease
DHB - District Health Board
IFHC - Integrated Family Health Centre
NHC - National Hauora Coalition
PHO - Primary Health Organisation
PMS - Patient Management System
POAC - Primary Options for Acute Care
PPP - PHO Performance Programme
TIA - Transient Ischaemic Attack



Note: Initiative not yet started

1. Summary

This report provides an update on matters relating to Primary Care for the first Quarter to the end of December 2012.

2. Primary Care Dashboard

The scorecard presented in this report for the first time for primary care and is very much a work in progress.

It is a standardised performance scorecard which aligns to the overall organisational scorecard where possible and shows how each DHB is tracking against a wide range of measures. Given the DHBs' focus on health targets, these are presented first in the scorecard as priority measures. Where appropriate, indicators are presented with performance by ethnicity. For each measure, the green bar reflects how well we are doing against the target for the period presented.

The progress green bar is weighted for each measure based on the degree of concern of any short fall in meeting the target. For the most part, these weightings reflect those used in the overall organisational scorecard, however this element of the scorecard is still work in progress for some of the measures. For example, this weighting is noticeable for Health Targets where the scale is very sensitive so that any variance is deemed to be significant. If performance is achieving or better than target, the bar will display as a solid green line. Where the bar is blank, this reflects very poor performance against the target or where no data is available or no target has been set. We will continue to work with our PHO partners to ensure those areas where we don't currently have the data are populated in future reports.

Auckland and Waitemata DHB Primary Health Care Scorecard

2012/13 Q1

Priority One - Waitemata DHB

Health Targets	Actual	Target	Trend
Better help for smokers to quit (primary care) - Total	35%	90%	▲
Better help for smokers to quit (primary care) - Maori	0%	90%	
Better help for smokers to quit (primary care) - Pacific	0%	90%	
Better help for smokers to quit (primary care) - Asian	0%	90%	
Better help for smokers to quit (primary care) - Other	0%	90%	
More Heart and Diabetes Checks - Total	58%	75%	▲
More Heart and Diabetes Checks - Maori	51%	75%	▲
More Heart and Diabetes Checks - Pacific	56%	75%	▲
More Heart and Diabetes Checks - Other	59%	75%	▲
Immunisation - fully immunised by 8 months - Total	92%	85%	
Immunisation - fully immunised by 8 months - Maori	83%	85%	
Immunisation - fully immunised by 8 months - Pacific	95%	85%	
Immunisation - fully immunised by 8 months - Asian	97%	85%	
Immunisation - fully immunised by 8 months - Other	92%	85%	

Priority One - Auckland DHB

Health Targets	Actual	Target	Trend
Better help for smokers to quit (primary care) - Total	34%	90%	▲
Better help for smokers to quit (primary care) - Maori	0%	90%	
Better help for smokers to quit (primary care) - Pacific	0%	90%	
Better help for smokers to quit (primary care) - Asian	0%	90%	
Better help for smokers to quit (primary care) - Other	0%	90%	
More Heart and Diabetes Checks - Total	53%	75%	▲
More Heart and Diabetes Checks - Maori	63%	75%	▲
More Heart and Diabetes Checks - Pacific	49%	75%	▲
More Heart and Diabetes Checks - Other	68%	75%	▲
Immunisation - fully immunised by 8 months - Total	89%	85%	
Immunisation - fully immunised by 8 months - Maori	81%	85%	
Immunisation - fully immunised by 8 months - Pacific	86%	85%	
Immunisation - fully immunised by 8 months - Asian	94%	85%	
Immunisation - fully immunised by 8 months - Other	90%	85%	

Service Delivery - Waitemata DHB

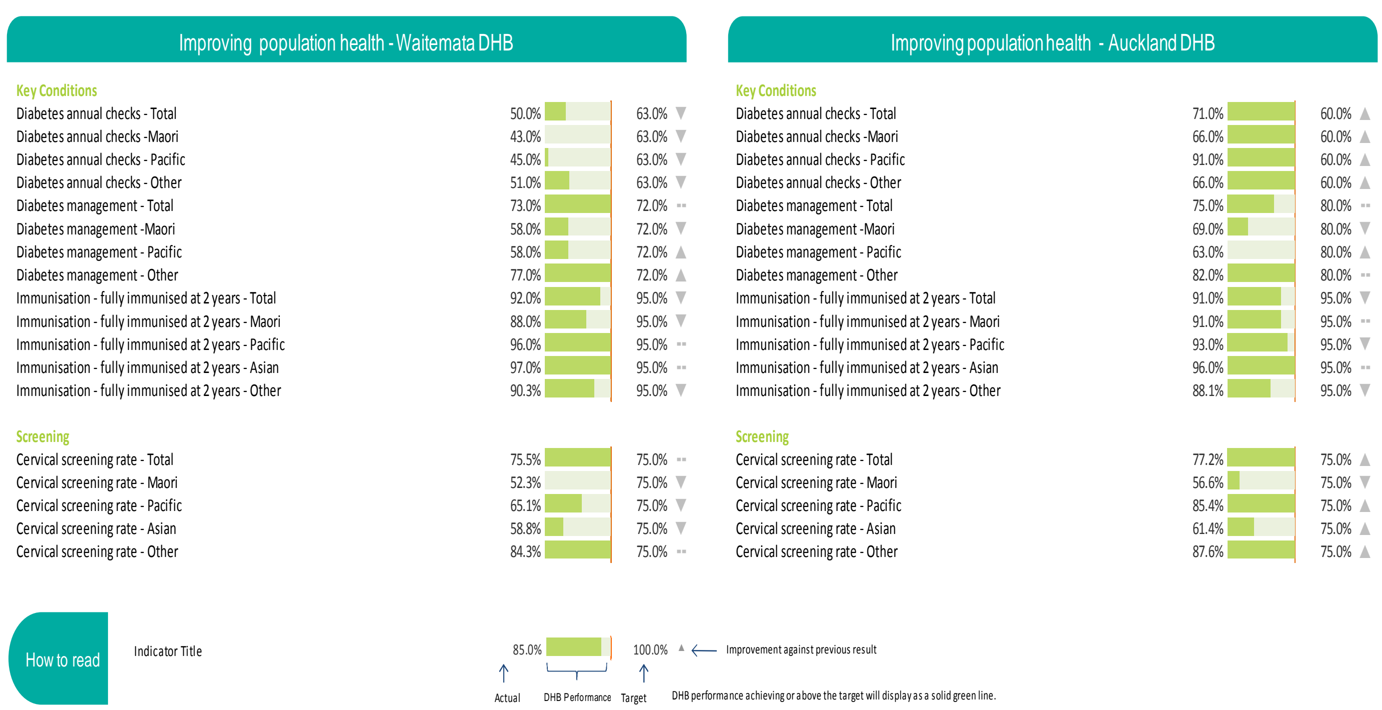
Enrolment	Actual	Target	Trend
PHO enrolment - Total	94%	95%	▲
PHO enrolment - Maori	75%	95%	--
PHO enrolment - Pacific	100%	95%	--
PHO enrolment - Asian	77%	95%	--
PHO enrolment - Other	96%	95%	--

Acute Care	Actual	Target	Trend
POAC Referrals - Total	1854	1538	▲
POAC Referrals - Maori	162	149	--
POAC Referrals - Pacific	140	112	▲
POAC Referrals - Asian	113	289	▲
POAC Referrals - Other	1439	987	▲
% of metro Auckland's population able to access free under 6's after hours services	98%	95%	--

Service Delivery - Auckland DHB

Enrolment	Actual	Target	Trend
PHO enrolment - Total	92%	95%	▼
PHO enrolment - Maori	77%	95%	▲
PHO enrolment - Pacific	100%	95%	--
PHO enrolment - Asian	73%	95%	▼
PHO enrolment - Other	100%	95%	--

Acute Care	Actual	Target	Trend
POAC Referrals - Total	1118	1425	▲
POAC Referrals - Maori	87	111	▲
POAC Referrals - Pacific	207	160	▲
POAC Referrals - Asian	150	429	▲
POAC Referrals - Other	674	726	▲



Improving population health - Waitemata DHB

Key Conditions	Actual	Target	Trend
Diabetes annual checks - Total	50.0%	63.0%	▼
Diabetes annual checks -Maori	43.0%	63.0%	▼
Diabetes annual checks - Pacific	45.0%	63.0%	▼
Diabetes annual checks - Other	51.0%	63.0%	▼
Diabetes management - Total	73.0%	72.0%	--
Diabetes management -Maori	58.0%	72.0%	▼
Diabetes management - Pacific	58.0%	72.0%	▲
Diabetes management - Other	77.0%	72.0%	▲
Immunisation - fully immunised at 2 years - Total	92.0%	95.0%	▼
Immunisation - fully immunised at 2 years - Maori	88.0%	95.0%	▼
Immunisation - fully immunised at 2 years - Pacific	96.0%	95.0%	--
Immunisation - fully immunised at 2 years - Asian	97.0%	95.0%	--
Immunisation - fully immunised at 2 years - Other	90.3%	95.0%	▼

Screening	Actual	Target	Trend
Cervical screening rate - Total	75.5%	75.0%	--
Cervical screening rate - Maori	52.3%	75.0%	▼
Cervical screening rate - Pacific	65.1%	75.0%	▼
Cervical screening rate - Asian	58.8%	75.0%	▼
Cervical screening rate - Other	84.3%	75.0%	--

Improving population health - Auckland DHB

Key Conditions	Actual	Target	Trend
Diabetes annual checks - Total	71.0%	60.0%	▲
Diabetes annual checks -Maori	66.0%	60.0%	▲
Diabetes annual checks - Pacific	91.0%	60.0%	▲
Diabetes annual checks - Other	66.0%	60.0%	▲
Diabetes management - Total	75.0%	80.0%	--
Diabetes management -Maori	69.0%	80.0%	▼
Diabetes management - Pacific	63.0%	80.0%	▲
Diabetes management - Other	82.0%	80.0%	--
Immunisation - fully immunised at 2 years - Total	91.0%	95.0%	▼
Immunisation - fully immunised at 2 years - Maori	91.0%	95.0%	--
Immunisation - fully immunised at 2 years - Pacific	93.0%	95.0%	▼
Immunisation - fully immunised at 2 years - Asian	96.0%	95.0%	--
Immunisation - fully immunised at 2 years - Other	88.1%	95.0%	▼

Screening	Actual	Target	Trend
Cervical screening rate - Total	77.2%	75.0%	▲
Cervical screening rate - Maori	56.6%	75.0%	▼
Cervical screening rate - Pacific	85.4%	75.0%	▲
Cervical screening rate - Asian	61.4%	75.0%	▲
Cervical screening rate - Other	87.6%	75.0%	▲

Summary Performance against targets – Maori Health

Priority One Targets

Good progress is being made with new immunisation target for 8 month olds. While this has been achieved overall for both DHBs, both DHBs are just short of the target for Maori. Performance against this target for Maori is expected to improve in Q3.

The Better Help for Smokers to Quit (primary care) and More Heart and Diabetes Checks targets continue to be a challenge for both DHBs. We are not yet able to provide ethnicity specific data however will continue to work with our PHO partners to populate these fields where we currently have no data.

Heart and Diabetes Checks is a new target for the 2012-13 year. Although Māori in Auckland DHB are below the target, Māori are performing better in comparison to the Overall population.

Service Delivery Targets

Achieving the PHO enrolment target for Māori continues to be a challenge and enrolment rates have again risen for Q1. PHO ethnicity data quality remains an important issue and IS likely to be the cause of the apparent 'under-performance' (i.e. measurement error with misclassification of Māori as non-Māori).

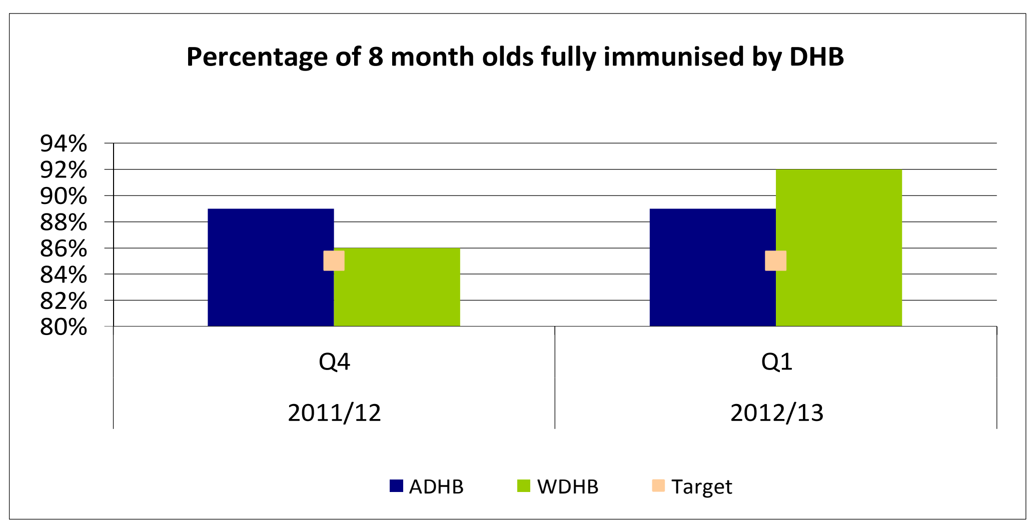
Improving Māori Population Health Targets

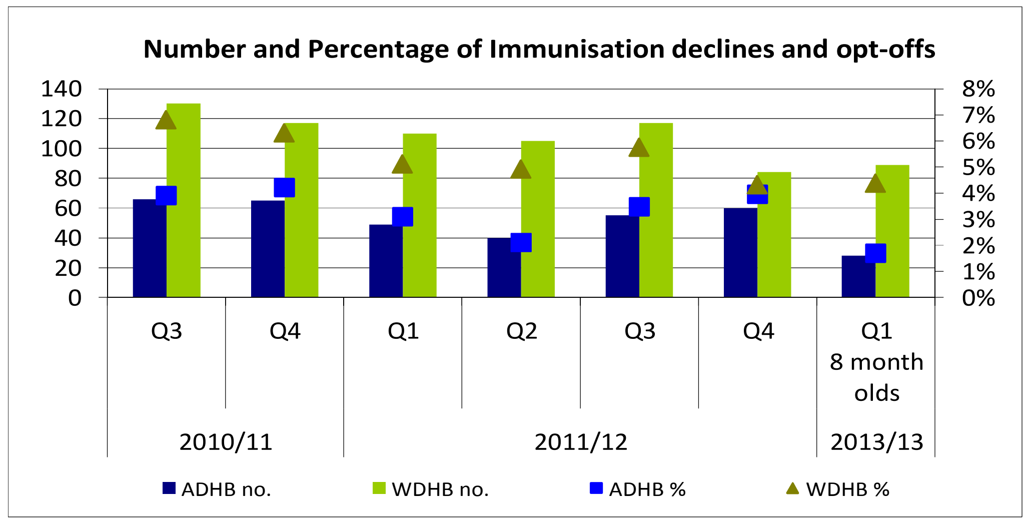
Cervical Screening coverage rates for Māori are well below target for both DHBs and significantly lowers than the rates for the rest of the population. Waitemata DHB is leading the project to correct the ethnicity misclassification.

3. National Targets

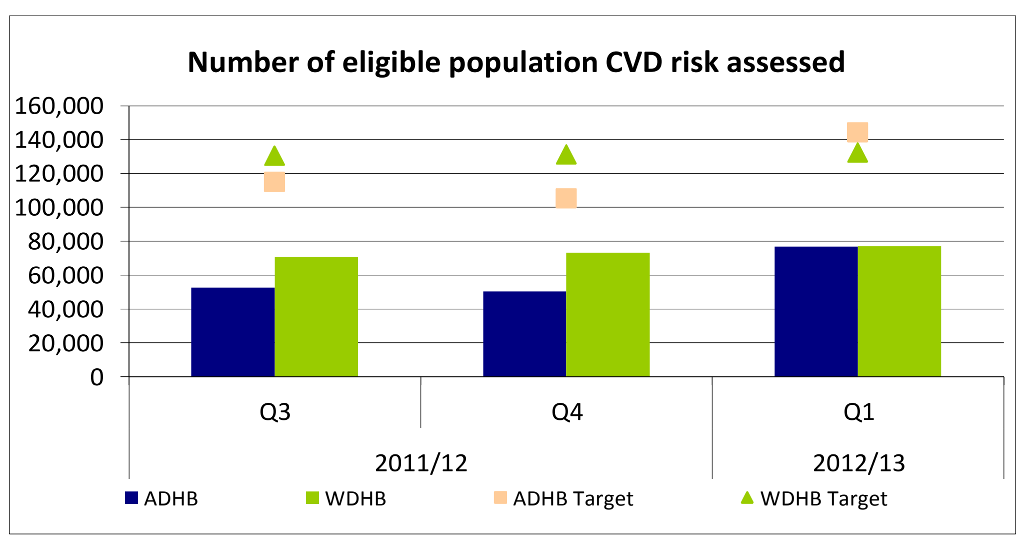
Health Targets	Metro Targets Q2 2012/13	Quarter 2 2012/13*			On track
		ADHB	WDHB	Metro	
Immunisation (8-month olds)	85%	89%	92%	87%	
More Heart & Diabetes Checks	75%	53%	58%	55%	
Smoking – Brief advice	90%	34%	35%	36%	
Smoking- Brief advice for Maternal smokers	90%	not available	not available	not available	

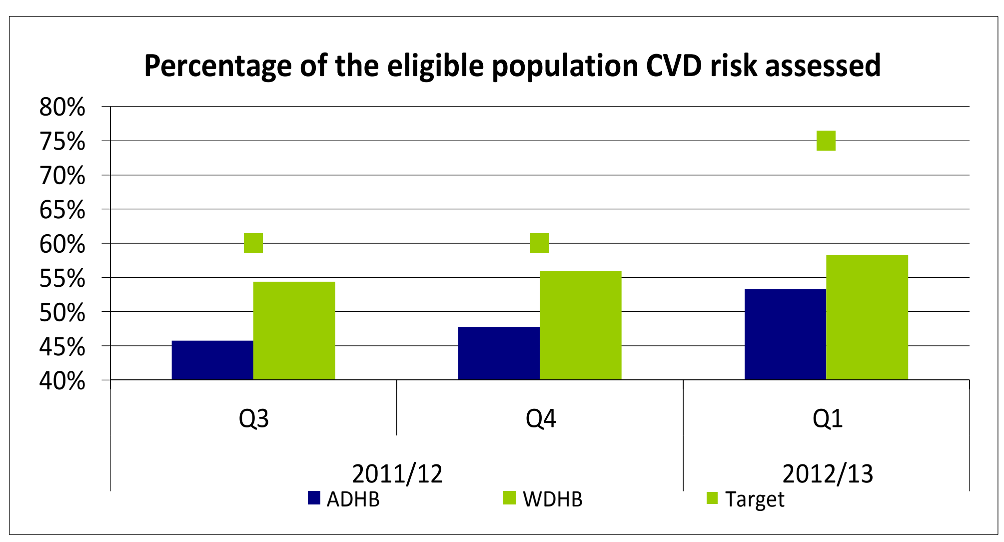
Immunisation Q2 2012/13



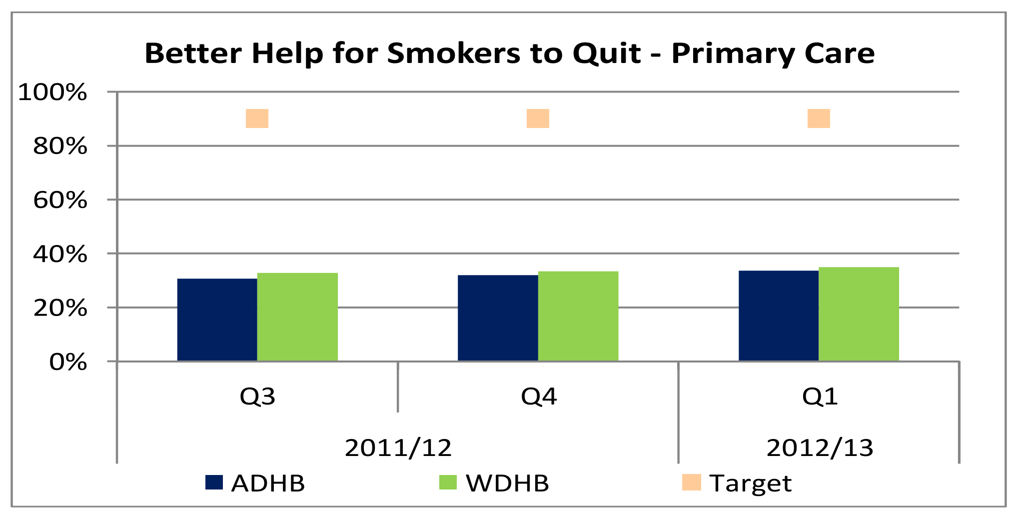


More Heart and Diabetes Checks Q1 2012/13





Better Help for Smokers to Quit – primary care Q1 2012/13



4. DHB Performance Measure: Policy Priority 2 (PP2) Implementation of Better, Sooner, More Convenient primary health care

There are three business cases operating in Metro Auckland: GAIHN, Alliance Health Plus and National Hauora Coalition. The DHBs are partners within these business cases and their progress against their business case deliverables is attached as an appendix. The business case reports are discussed at BFG monthly and any risks identified. The table below is a DHB summary of business case progress to date.

Business Case	Quarterly Report received	On Track	Risks and Future management	Who
GAIHN	Yes		The first quarter of the year has seen the implementation of a new governance structure. New operational management under the direction of the ALT has reworked the annual plan and implemented a more robust project management structure. A new reporting framework and business case framework has enhanced communication and allowed improved planning for the coming year.	BFG
NHC	Yes		Population shifts continue with the movement of practices between PHOs. ADHB has worked with the provider to improve reporting and ensure representation on the ALT. A recent focus has been on improving practice performance against health targets.	BFG
AH+	Yes		Historical governance and operational issues have now been addressed, we look forward to progressing business case deliverables and Whanau Ora deliverables. Significant practice movement has continued. A recent focus has been on improving practice performance against health targets.	BFG

5. Objectives set in our Annual Plan for this financial year

Target area	On track	Comment	Actions	Risks & future management
Diabetes	(green circle)	**WDHB** Both PHOs have implemented the Diabetes Care Improvement Package.	• Quarter two reports are due 20 January 2012. • These will provide up to date data on annual review coverage, good diabetes management and a narrative on the response of practices to the change in service.	
Smoking	(red triangle)	**WDHB** No further PPP data has been released since quarter one 2012/13. The unverified PPP data from Q1 shows that WDHB has achieved 34%.		• The DHBs are currently working with PHOs to ensure that the capture and submission of their Smokefree data is accurate. As PHOs are experiencing difficulties in extracting a full data set from the GP practices' Practice Management System (PMS), this has resulted in the data being unreliable.
Smoking	(red triangle)	**ADHB** No further PPP data has been released since quarter one 2012/13. The unverified PPP data from Q1 shows that ADHB has achieved 33.61%.	• The ADHB Smokefree Pregnancy Service is visiting each general practice to provide them with referral data and brochures. • Also all regional independent midwives have received an email promoting the service. • All ADHB employed midwives are being contacted in the week of 14th January by email. Meetings have been held with the charge Midwives in National Women's Health to ensure that new patients that are admitted are referred if ready to quit.	• As PHOs are experiencing difficulties in extracting a full data set from the GP practices' Practice Management System (PMS), this has resulted in the data being unreliable. • The DHBs are currently working with PHOs to ensure that the capture and submission of their Smokefree data is accurate.

Integration Activities

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
Community dialysis	◆	**Renal Services to** • Work with a Maori primary care provider to design, devolve and deliver Adult Haemodialysis services in a community setting, • Work with a Pacific primary care provider to design, devolve and deliver Adult Haemodialysis services in a community setting and • Work with primary care providers to design, devolve and deliver Adult Haemodialysis for patients who are unable to home dialyse (Community Home Haemodialysis) • Implement a new model of care which will integrate kidney disease prevention, early intervention, and chronic kidney disease management services	• Partnership with Maori provider is delayed as we need to proceed to tender to finalise costs. The Board of the Maori provider has responded positively to the proposal for an interim agreement, and consequently we have engaged a professional building project manager to speed up the process. • Partnership with Pacific provider for Dialysis unit in Onehunga is delayed as Council has declined use of site for Community Dialysis. We are now refurbishing and reconfiguring the old Greenlane unit in order to enable us to investigate other options, including purchasing our own building/land in the Onehunga area. This option will include working in partnership with a Pacific provider, and the local Pacific provider has indicated they are still keen to work with us.	• Projects are not overdue yet, but are now running behind timetable
POAC	◆	• Increase the safe management in the community of people's acute care needs thus decreasing the number of avoidable Emergency Department presentations and subsequent hospital admissions	• At risk of exceeding budget for WDHB, requires ongoing close monitoring.	• St John transport service to be expanded to include all general practice clinics (currently only A & Ms). • POAC and Aged Residential Care service to be implemented in ADHB facilities April 2013.

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
		• Annual target of 23,473 POAC referrals for 2012/13, 85% of these will avoid needing to go to hospital because of this care • July - Dec 2012 total referrals 10,577. • Monthly average 1,762 (month target 1956). CMDHB total 4,781 (below 6 month target 5,811), ADHB total 2,146 (below 6 month target 2,850), WDHB 3,650 (above target 3,075). Below target for ADHB and CMDHB.		
Regional after hours project		• A Network of at least 10 A&M clinics open until at least 10pm, 365 days per year with reduced co-payments for under 6s, over 65s, HUHC (High Use Health Card), CSC (Community Services Card) and those living in quintile 5	• The one year on report presented to CPHAC in November was well received. • A meeting was held on 13 December to review the preliminary results of the School of Population Health's evaluation of the After Hours Network. • At the November Project Partnership meeting there was discussion regarding Shorecare providing free after hours care from 10pm until 8am.	• Further information on identification on hospital/ED posters and flyers to be undertaken. • The final report by the School of Population Health's evaluation of the After Hours Network is due in March 2013. • Further work with the GPs and PHOs will need to be undertaken to ensure after hours care provided by Shorecare is implemented.
COPD		• Deliver 120 Completed pulmonary rehab programmes in the community by June 2013: (30 in each Quarter) current	• 157 COPD patients have now been triaged to the new community programmes and are no longer sitting on a waitlist. More than 84%	• There will therefore be a need to establish more sites in 2013 following completion of an evaluation.

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
		baseline is approx 100 patients • Implementation of GAIHNs regional pathway for COPD by March 2013 (engage and plan Q2, implementation in Q3)	of these patients waited longer than 6 weeks, more than 55% waited longer than 3 months and in the previous year more than 13% were still waiting at 6 months. The current waitlist as of this month is 25 days. It has been as low as 9 but due to successful promotion of the new community programmes we will see this grow due to the estimated population of COPD patients being 15%. • 123 accepted their first assessment pre class (47 at the Glen Innes Community Centre and 71 at the Mt Albert YMCA and 5 were assessed at Laura Fergusson's Greenlane site due to patient need/request. • 58 patients have completed the programme which includes a pre assessment, twice weekly exercise and self management and post assessments following the course and at 1 and 6 months. A further 38 patients have partially completed the programme and a number awaiting a first assessment. Work is underway to analyse the non-attendees and strategies will be put in place to improve this. • 21 Maori and 15 Pacific Island patients were referred to the programme. A number of Maori and	• Work will also begin in the New Year with the Pacific Island Health Groups to look at ways of establishing Pulmonary Rehabilitation with that population.

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			Pacific people are in the current programmes, therefore we will report on attendance and completion rates for these later. Work continues in the region in order to increase total referrals and increase attendance rates of Maori and Pacific clients through improving awareness among GPs and others. • Five eight week cycles have been completed since February 2012. These are set to continue in the New Year.	
Health of Older Persons	◆	• Support GAIHN - 10% reduction in number of residents from ARC presenting to ED • 2,000 bed day reduction in acute admissions from aged care sector across northern region by June 2013.	• Two GAIHN led workshops with key sector stakeholders identified a range of issues and potential solutions: – Access to medical care, specialist nursing or medical advice, urgent diagnostics and interventions – Patient and family perceptions about the most appropriate care	• Leads have been identified to progress the identified solutions • ALT agreed pilot IV service to commence with Auckland DHB, Q3-4 2013/14, to be reviewed for expansion in 2013/14.
	◆	• 10% reduction of readmission rates for 75+	• The Ministry reported standardised acute readmission rate: • WDHB 16.77 • ADHB 13.95 • ADHB is currently below the target of 14.92%. • WDHB is not on track to reduce to the target of 15.00%. We have been	• Extending the role of the discharge coordinators in ED/ADU at both sites • Targeting those DRGs with high readmissions e.g. COPD. This work will be undertaken in the next 6 months and will include frequent users of ED

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			unable to replicate the Ministry figure and are working to achieve this. This will allow analysis of what is driving this higher than expected result if it found to be the case. • The Integrated Transition of Care Project will be completed by June 13. It targets 'at risk' older patients discharged from the hospital. Although a preliminary review was undertaken, it is too early to draw conclusions. Full evaluation will be completed at the end of the project.	services and integrating the community nursing team with the hospital to better support patients in the community • Continuing to work in aged residential care to support staff to manage their more complex patients • Continue to improve the discharge process and the information given to both patients and care givers (i.e. handover to residential care).
HOP (WDHB only)	(green)	• Prevent 25% of readmissions of high risk groups identified through WDHB's predictive risk model	• Integrated Transition of Care Project (ITCP) is testing the hypothesis that a suite of interventions prior to and immediately following patient discharge will reduce the frequency of acute unplanned readmissions within 28 days. The target population is medical patients age >65 (Caucasian) and >55 (Maori, Pacific) with a calculated risk of readmission ≥20%, determined by a 'predictive risk model.' The project began a developmental phase on 05.12.11, and the 12 month pilot study commenced on 01.04.12. It will report interim findings to the Waitemata DHB Board on 27.02.13.	

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
Child Health		• Support NHC to reduce ASH (Ambulatory Sensitive Hospitalisations) rates for under 2 year olds by 1% (ADHB)	• Working closely to develop strong working relationships between the DHB and NHC senior management. ADHB now has a member on the NHC ALT to progress deliverables within the Annual Plan.	
Sexual Health		• Explore integrated model of care for sexual health services	• The PHO CEOs have discussed how to progress the primary care issues with sexual health services, taking into consideration the work that is currently being undertaken through WDHB service planning and the national value for money review. WDHB is currently reviewing services currently delivered by ADHB. The aim is to develop a more integrated model with primary care which would shift volumes from ADHB hospital based services.	
Radiology		• Aligning radiology costs for POAC and Access to diagnostics and front line processes	• We are starting this process by developing clinical criteria which is almost complete. There are a number of considerations to be worked through before committing to development regarding the front line process and pricing.	• We will be scoping the IT platform development and pricing/service provision will be negotiated once the clinical criteria is in place and once full risk assessment has been made ensuring demand can be managed.
		• A regional target for waiting times for accepted routine community referred radiology.	• The current target is as follows: The Regional Target 2012/13, for waiting times for accepted routine community referred radiology is	• The latest data shows that: **ADHB**: Above target except for MRI **CMDHB**: Above target for

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			75% of accepted referrals for scans within 6 weeks (42 days).	CT, below for MRI and not recorded for US and CR **WDHB**: Above target for CT and MRI and below for US and CR.
Urgent Care	●	• Develop avoidable admissions plan for high risk individuals identified by GAIHN predictive risk algorithm. Set regional target for percentage decrease in growth of bed days for identified individuals.	• The intervention model is being developed as part of GAIHN proposals for 2013/14 to ALT. A regional target growth has not been set.	
Non contact FSAs (ADHB)	●	• Increase non-contact FSAs by 4% each quarter.	• 36% - Somewhat ahead of target of 8% for first six months of year.	
Clinical pathways ADHB	●	• Implementation of GAIHN's regional clinical pathway for depression by June 2013.	• Pathway finalised by the Regional clinical development group in November and presented to the Alliance Clinical Network (ACN) in December for clinical sign off and feedback. ACN requested type/dose of medication to be included for sign-off. Pathway to be amended and resubmitted for sign-off.	
Clinical pathways ADHB/ WDHB		• A dementia pathway, which is regionally consistent wherever possible, will be developed by 30 June 2013.	• A draft Dementia Services Guide for the northern region has been developed and is being circulated for feedback. ADHB has developed an In-Hospital Dementia Project, which screens for cognitive impariment in people over 75 years admitted to the general hospital and	

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			then prompts development of a personalised support plan and care guidelines for those people with cognitive impairment whilst in hospital. This project is being launched early in 2013. Preliminary discussion has occurred with the Shared Care Planning Project with a view to engaging with this project. • Waitemata DHB focus is on development of the Dementia Clinical Pathway premised on earlier recognition and enhanced assessment skills of Dementia by primary care, earlier linking of patients and their whanau with community based Dementia education / support / management services and, for those patients requiring it, earlier referral to the appropriate secondary and/or tertiary care services. A Clinical Reference Group with clinical leaders across primary, community, secondary and tertiary care was convened during November 2012. It will determine the Waitemata DHB Dementia Clinical Pathway by February 2013 (this is an integrated project so refer also to the Health of Older Persons section of the Annual Plan reporting). The Clinical Pathway will be piloted with up to	

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			60 patients by 6 General Practice teams in each of ProCare and Waitemata PHOs from 01.10.13 – 30.06.14.	
Clinical pathways ADHB/ WDHB	(green)	• A child health care pathway based on priority areas identified in the ADHB/WDHB Child Health Plan by June 2013.	• The Child Health working group was established in November. The group has identified West Auckland child health priority areas from national and regional plans. A draft implementation plan for including success measures will be completed by March.	

Primary Care Nursing

Project	On track	Comment	Actions	Risks & future management
Integrated wound care pilot	(green)	• Pilot an integrated model of care for complex lower leg wounds. The two pilot practices in West Auckland commenced enrolling patients in September. Feedback from the patients, Practice Nurses and District Nurses is very positive about the shared wound care undertaken at the General Practice.	• Coordination and consistency of care between the different practices was an issue. • Two actions were implemented from November: 1) to have a key nurse in each practice and 2) to begin monthly meetings involving the key Practice Nurses, the District Nurses and Dietitian to discuss issues and plan improvements to the model of care.	

Project	On track	Comment	Actions	Risks & future management
Workforce development		Nurse Entry to Practice (NETP) Expansion Programme in Primary Health Care. • Fifteen new graduates are working in Primary Care settings on this programme. Eight nurses completed the new graduate programme on the 20th December 2012 and continue to work in their practice settings. • Seven nurses commenced the programme in the September 2012 intake. They are being supported in their Practice settings by the PHC Nursing Development team. • Nine new graduate nurses have been interviewed and offered places to commence the next programme which starts in February 2013. They were recruited through the new national recruitment process, Advanced Choice of Employment (ACE) for new graduate nurses.	• All New Graduates will continue with support from the Primary Care Development team in the NETP programme.	• The ACE process and time frames were difficult for Primary Care employers to work with. Feed back will be given re difficulties with the process for Primary Care.

6. Locality Activities

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
Locality Approach		Locality Plans • Jointly agreed locality plan for Auckland West locality submitted to the Ministry of Health by 31 December 2012 • Jointly agreed locality plans for Auckland Central and Auckland North localities submitted to the Ministry of Health by 31 March 2013	• A draft plan for the West Auckland locality has been completed. The plan is still to be reviewed by the yet to be established locality governance group and the newly appointed Primary Care lead CEO. The Ministry of Health have agreed to an extended February deadline for the submission of the plan. • The WDHB planning team has initiated a North locality and cluster level analysis. • Significant community engagement in the Central network has been undertaken. The appointment of a Clinical Director for the Central Network has been delayed but the planned appointment in January will assist the progression of the plan. However significant work will need to be done in order to meet this deadline. The Central Locality Plan will be therefore constitute a high level framework for the Plan.	• A joint ADHB/WDHB workshop was held in December with relevant, PHO and business cases. This workshop provided a forum and mechanism for the development of the future direction of primary care. Further planning is needed to provide the necessary detail for the locality plans
Integrated Health Networks		• Three Integrated Health Networks in place (2 in WDHB, 1 in ADHB)	• The West Auckland Health Network continues to function at an operational level. • The clinical director role for the North Network is still to be appointed. The role has been re-	• The West Auckland locality steering group has been disestablished. This group will be superseded by an overarching governance group to provide a strategic direction

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			advertised and will close on the 11th of January 2013. Five tentative North cluster areas have been identified and will be confirmed once the North Director is appointed. • The appointment of a Clinical Director for the Central Network has been delayed but the planned appointment in January of this position will help to develop the clinical network and clusters.	from a super district (i.e. Auckland and Waitemata DHB combined) level. The structure and membership of this group is still to be confirmed. The plan is still to be reviewed by the yet to be established locality governance group and the newly appointed DHB CEO lead for primary care.
	(green)	• West Auckland	• The West Auckland Health Network continues to function at an operational level. • Community representation is a key component of the three clinical work streams. A locality update presentation was delivered to the WDHB community engagement forum. • Diabetes work stream established. Main goal of this work stream is to implement a Diabetes Quality Improvement Team (QIT) to gather data and benchmark diabetes care across the West locality. The QIT will also support the general practices to provide better diabetes care. A service level agreement has been completed and the planned recruitment of nurses will occur in Q3. The first ten practices are being	• The West Auckland Health Network will continue to engage with the Waitakere Health Links. • WDHB PHO and Primary Care manager and Clinical Director Primary Care to update the WDHB provider arm on Primary Care activity and plan further integration of clinical services. • Finalise West locality plan and submit to the Ministry of Health.

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			prioritised to receive support from QIT. • The initial six urgent care meetings with key stakeholders have been completed, and a recommendation report is being drafted. This report will provide a basis for activity in 2013. It is expected that the implementation of the recommendations will be a phased approach over a minimum of five years. • The working group has been established and has identified the following child health areas to focus on: asthma, rheumatic fever, skin infections and the interface between maternal, well child and child health providers. The specific success measures are still to be determined by the group.	
	◆ (orange)	• North Auckland	• The clinical director role for the North Network is still to be appointed. The role has been re-advertised and will close on 31st January 2013.	
	● (green)	• Central Auckland	• Online health survey across Central completed and analysis commenced. Survey results presented to Puketapapa Local Board. Community Action Research data available from Tamaki.	• Slow uptake of the online survey delayed availability of survey data for analysis to be completed. Complete analysis of online survey data. • Puketapapa Local Health

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			• Three Local Health Partnership groups meeting in two local board areas. Draft Terms of References completed by two Local Health Partnership groups in Maungakiekie-Tamaki. Wellbeing community expo and forum supported in Puketapapa. • A service review has been undertaken in Great Barrier with a plan outlined for co-design of services. A clinical director will be appointed in January. • Central locality health needs and service mapping undertaken.	Partnership group is meeting but will be formally established in February. • Engagement with Great Barrier Island community to commence review and co-design of the Island's health system will occur next quarter. • The recruitment of a Clinical Director will help to advance work on the Central Locality Plan. • Initial work to identify cluster groups and a plan for engagement with service providers in defined areas.
	Green	• 4 clusters in place (WDHB only)	• A GP cluster meeting was held in New Lynn in November. Massey and Henderson cluster meetings will be early in 2013. The WDHB planning team has initiated a North locality and cluster level analysis. Five tentative North cluster areas have been identified and will be confirmed once the North Director is appointed.	
Integrated Family Health Centres	Green	• 4 Integrated Family Health Centres operational across Auckland and Waitemata DHBs by June 2013	• New Lynn IFHC on schedule to open in April 2013. • Whanau house will be fully functional by February 2013.	

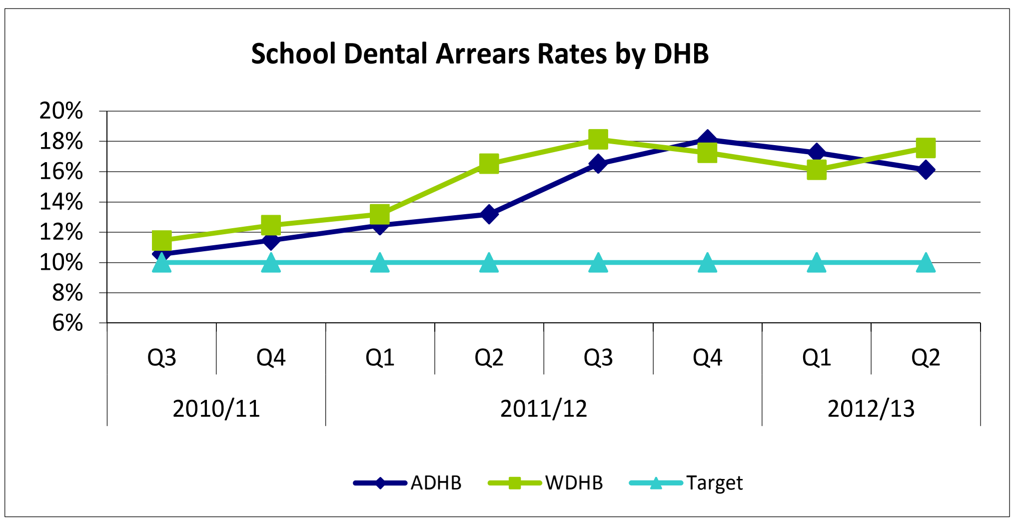
Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
			• ADHB, Alliance Health + and the Tongan Health Society discussed the current key health needs and issues and possible models and services that could be implemented at Onehunga IFHC. • The current model being piloted at Mt Wellington IFHC focuses around an existing GP medical centre.	
		• Whanau House in Henderson delivering new models of integrated care by June 2013 (engagement with surrounding practices in Q1, developing a new model of care in Q2 and implementation in Q3/4).	• New models of care have been discussed for Paediatric services being delivered in WH. Engagement with Whanau ora services have been undertaken to ensure a smooth transition of care for their clients.	
		• New Lynn Integrated Family Health Centre operational and delivering new models of care in line with West Auckland's locality plan by 2013-14	• New models of care have been discussed for Paediatric services being delivered in New Lynn IFHC. Paediatric and Diabetes work streams in West Auckland are providing a project plan as to the delivery of care and what it will look like.	
		• Co-design process in place to explore new models of care within the development of Waiheke Integrated Family Health Centre by June 2013.	• Initial meetings are underway in Waiheke to progress IFHC development and community engagement.	• Planned community engagement and a service review in Waiheke.

Objective	On track	DHB Annual Plan deliverables	Actions	Risks & future management
		• Implementation of new models of care in collaboratively agreed priority areas within Alliance Health + Integrated Family Health Centres (engagement with surrounding practices in Q1, developing a new model of care in Q2 and implementation in Q3).	• A second meeting was scheduled and held between the Tongan Health Society clinical manager and a senior ADHB paediatrician to understand further any systemic issues that could also be addressed. A stock take of the issues and a proposal of future models has been drafted. • At Mt Wellington IFHC a range of services are being developed which include specialist clinics, facilities for minor surgery, walk in nurse services and allied health care support services such as radiology. A range of community outreach services is also being offered.	• Another meeting with AH+ and key stakeholder of the Onehunga IFHC will be scheduled in the near future to discuss and agree what models to implement. • It was agreed that a review of Mt Wellington IFHC will be undertaken to assess the health outcomes of patients resulting from these new models of care being offered.
		• Review current integrated care models being delivered in rural settings (Rodney) by December 2012 for potential networking between Integrated Family Health Centres in 2013/14.	• Initial meetings with Auckland Council to align IFHC with Council future development.	• IFHC locations for North have not yet been agreed.

7. Primary Care Operational Issues

Issue	Comment	Actions	Risks & future management
Unstable PHO practice affiliation	• The PHO Performance Programme (PPP) generates targets for January-June and July-December periods. PPP suggested targets based on previous PHO performance. The DHB and PHO have opportunity to negotiate targets. PPP target setting due 20th January 2013.	• Paper prepared for BSMC Funder Group (BFG) to endorse that the six monthly PPP targets generated by the Programme are confirmed as the PHOs' targets. Also requesting advice on whether the National Health Targets, where applicable, should be the PPP target. The GMs have approved the paper and advised that the National Health Target should be the PPP target where applicable.	• PHO with currently low PPP percentage may have difficulties reaching health target. PPP require incremental increases and potentially is a risk of not reaching the health targets.
SIA and HP plans	• Rural contracting direction from the Ministry has rolled over for another 6 months due to the inability of reaching a new model of funding.	• Contracts for providers developed to provide certainty of funding for another 6 months only.	• Uncertainty of future funding for rural providers.
Unspent funds	• PHOs are required to submit their audited annual accounts to 30 June 2012 and where they have a large cash balance, a forecast expenditure plan is required.	• This information has been requested from the PHOs in order to meet the MoH reporting due date. Audited accounts have been received from all PHOs for the financial year ending 30 June 2012.	• Forecast expenditure plans will not have been agreed to by the DHBs before they need to be submitted to the MoH. Further discussions and agreement will need to occur with the PHOs after the accounts have been submitted to the MoH. • Discussions will commence in February with final plans drafted by end of March 2013.

8. Statement of forecast service performance measures



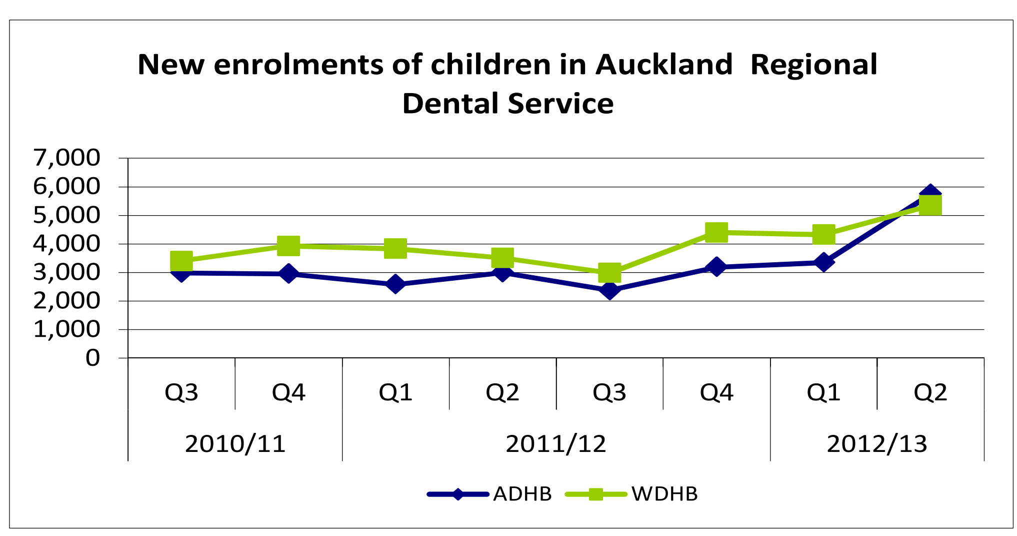
Commentary

The above graph shows the arrears rates for Maori at both DHBs. On 1 December 2012, the overall arrears percentage was 14%. Since June 2012, there has been a steady decrease in arrears which has been pleasing. It is expected that the target of 10% will be achieved by June 2013.

Auckland Regional Dental Service has implemented the following strategies to address the rise in arrears that has been evident during this period of change in service delivery and infrastructure:

1. All team leaders are fully aware of the importance of reducing arrears and are working towards achieving the target of 10%.
2. The number of Dental Assistants has been increased over the period. Receptionists (patient care assistants) have also been recruited and working at some hub clinics.
3. Teams with high arrears are identified, monitored and the necessary support and assistance is provided to achieve the target of 10%.

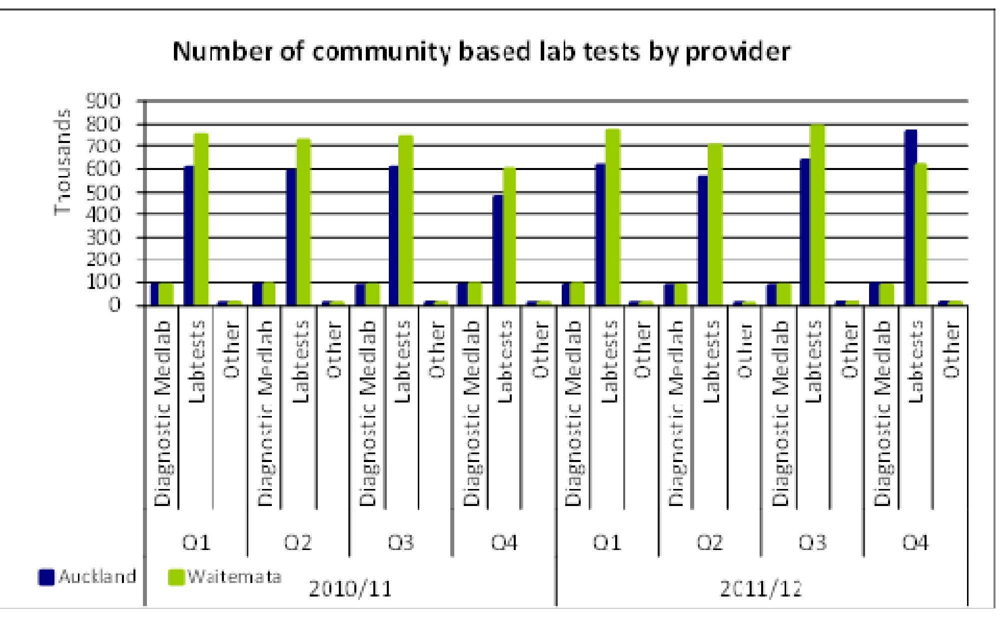
Currently, arrears are being monitored weekly at the General Manager level. Arrears can be monitored as frequently as daily to monitor both the number of arrears and the tail of children overdue. The reduction of arrears is a service priority.

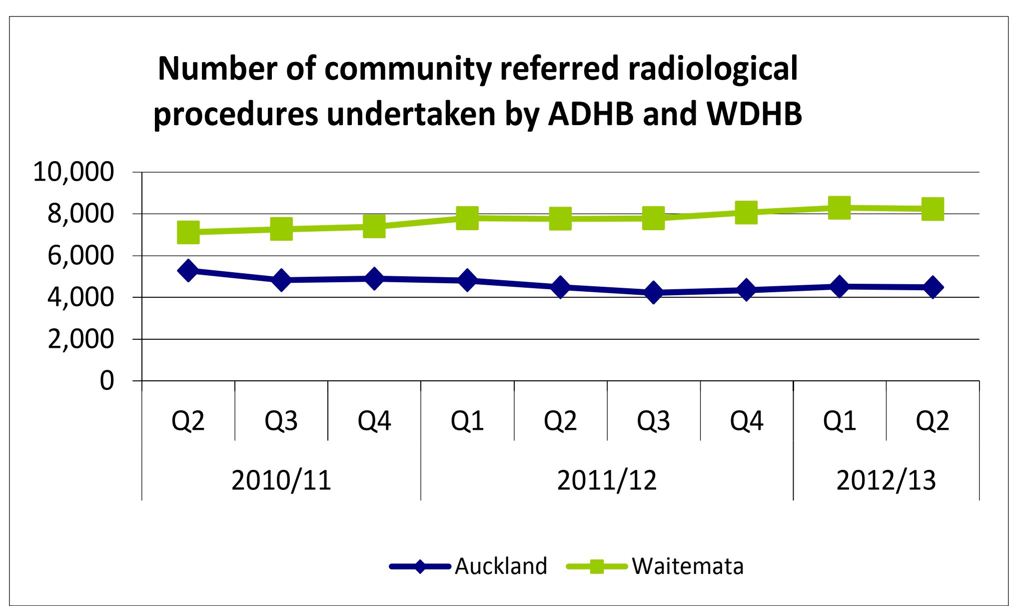


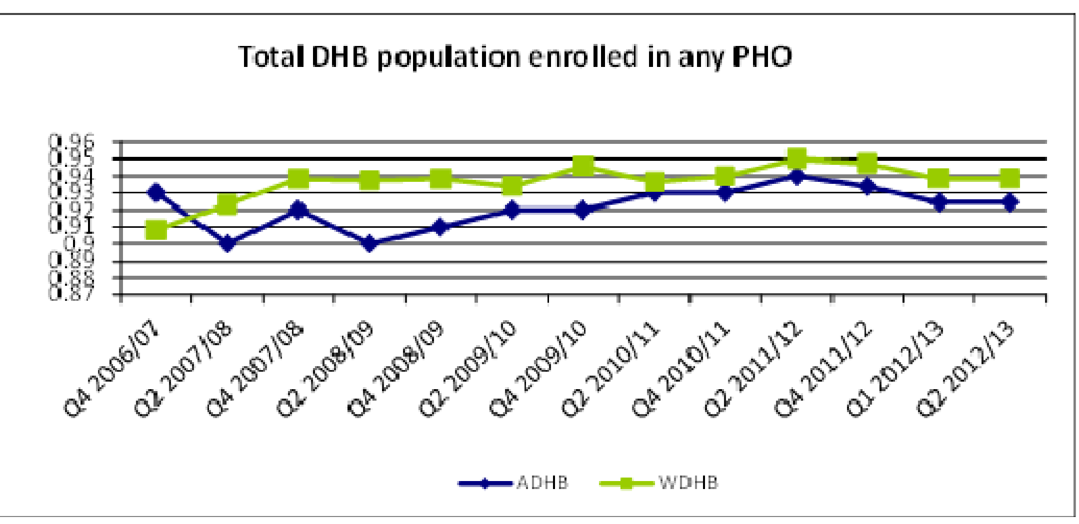
Commentary
Pre-school enrolments are behind target. This could be attributed to a period of vacancy of a preschool coordinator role in the previous reporting quarter the service over achieved in this age group. This vacancy has now been filled and orientation is in progress. Pre-school coordinators visit Waitemata DHB post natal wards twice weekly to raise awareness of the service and collect early enrolments.

Primary School enrolments - over achieved.

Adolescent enrolments - ARDS is encouraging transfer to CDA contracted dentists and therefore under achievement is not unexpected. ARDS has implemented criteria for continuing care of adolescent patients in order to support CDA contractors - this does however mean ARDS are not actively promoting an adolescent service.







Total DHB population enrolled in any PHO
0.96
0.95
0.94
0.93
0.92
0.91
0.9
0.89
0.88
0.87
Q4 2006/07
Q2 2007/08
Q4 2007/08
Q2 2008/09
Q4 2008/09
Q2 2009/10
Q4 2009/10
Q2 2010/11
Q4 2010/11
Q2 2011/12
Q4 2011/12
Q1 2012/13
Q2 2012/13
ADHB
WDHB

GAIHN

Business Case Deliverables	On track	Issues/Remedial Plans/Additional Informatior
OVERALL		
Proposals for consideration in DHB/PHO 2013-14 planning round submitted to ALT		
WORK STREAM 1		
Predictive Risk Algorithm (PRM) tool for patients at high risk of admission to hospital - Phase 2: Integration of primary care data		Initial version of algorithm prepared and reviewed by Clinical lead and University and additional data requirements determined to further refine algorithm. Additional data collection from practices underway has commenced for Phase 2.
Reports of High Risk Individuals (HRIs) delivered monthly to PHOs Weekly distribution		Monthly reports being prepared and disseminated by DHB Decision Support Services (DSS) teams to Primary Care by 5th of following month. Auckland PHO and Total Healthcare PHO now also receiving reports. Progressing automation of reports with each DHB DSS team. Increasing the frequency of reports will follow.
Develop the intervention model for HRIs		An initial intervention model has been included in the Work Stream proposal to ALT for 2013/14. Alliance Leadership Team (ALT) has endorsed the establishment of pilots in ADHB & CMDHB in Q3-4 2012/13. Project group reformed to provide stakeholder and technical guidance on the proposal, including intervention model.
WORK STREAM 2		
Aged Residential Care (ARC) sector Report – current service map		Two workshops with key sector stakeholders identified a range of issues and potential solutions: - Access to medical care, specialist nursing or medical advice, urgent diagnostics and interventions - Patient and family perceptions about the most appropriate care Leads have been identified to progress the identified solutions. ALT agreed pilot IV service to commence with Auckland DHB, Q3-4 2013/14, to be reviewed for expansion in 2013/14.
St John Transport project report – analysis of current		Collection of data to be completed.
St John Transport project - continue expansion into primary care		Approval from ALT to: Extend St John Transport project to the medical home agreed by ALT to start in July 2013. Extension to medical home to start Q4 2013/14.
Urgent care activity - current activity map and patient flows		Initial meetings held with ADHB as they are completing a similar process Patient journey map finalised. Limited responses from partners re urgent care activites so far, further work to take place to understand activity. Patient flow analysis to take place by end February.
Urgent Care network - establish and convene		After Hours Alliance agreed in principle for expansion of After Hours Network to create an Urgent Care network that includes in hours care. Workshop scheduled for January with ARAHN (Auckland Regional After Hours Nework) to progress. Terms of Reference (ToR) to be drafted for Urgent Care Network, for initial ALT approval.
Urgent care and palliative care access to after hours urgent care - Report with recommendations		Delayed – plan to hold a workshop in February 2013.
Model of acute responses in primary care		Initial scoping of project to begin January for completion July 2013.
WORK STREAM 3		
CLINICAL PATHWAYS		
Adult depression pathway development completed		Pathway finalised by the Regional clinical development group in November and presented to the Alliance Clinical Network (ACN) in December for clinical sign off and feedback. ACN requested type/dose of medication to be included for sign-off. Pathway to be amended and resubmitted for sign-off.

Adult Cellulitis pathway development completed		Updated pathway presented to ACN for clinical sign off following previous ACN recommendations. To be resubmitted to ACN for final review and sign off.
Chronic Kidney Disease (CKD) pathway development completed		Further amendments made to pathway, following request for substantive changes. To be submitted to ACN for final review and sign off.
Clinical Pathways Implementation Group (CPIG) - establish and convene		CPIG held its first meeting in October, and will meet again in January 2013 Membership includes a representative from each of the ALT partners with a range of skills in relation to the implementation of pathways. Final ToR have been drafted, with sign-off to be sought from the Executive team and CPIG at the next meeting. One-to-one meetings with CPIG members planned to promote shared, consistent understanding of the group's role and expectations of its members and drafting. An initial proposal has been submitted to ALT for the establishment of a pathways implementation system. This will be reconsidered by ALT in 2013.
Development of the guidelines (NRHP) for children for lower respiratory tract infections and skin infections including gap analysis		Consultation on skin infection pathways has commenced. First draft of lower respiratory tract infections (LRTI) pathway completed. Consultation planned for early 2013. Final review phase of skin infection pathways due for completion February 2013. Continued development of decision support tools, health literacy resources, referral pathways. Expert group scheduled to complete final review of skin infection pathways.
Support implementation of the guidelines for children for lower respiratory tract infections, skin infections and sore throat in General Practice		Consultation on implementation with some locality groups. Commenced implementation planning with PHOs and locality networks for skin infection pathway.
Paediatric eczema, gastroenteritis and asthma guidelines development		Development will begin in early-mid 2013.
ELECTRONIC DECISION SUPPORT (EDS) TOOL		
healthAlliance to conclude RFI/RFP process and select a vendor for a regional electronic solution		Overall six responses received in October for the RFP. Some responses were joint vendor responses Evaluation of the responses was completed in October. Three shortlisted vendors presented their solution to the evaluation team. Two remaining vendors presented further detailed information, but a final decision could not be reached. A further evaluation meeting is planned in January to determine the preferred vendor.
CHILD HEALTH and PREVENTION		
Contribute to regional and local coordination of child health planning and support development of West Auckland Locality Child Health plan		Continue to participate in Northern Regional Health Plan (NRHP), DHB, and locality child health planning meetings. e.g. Second West Auckland Locality child health planning meeting completed in November Planning to continue into early 2013 and draft child health plan for the West Auckland locality based on identified priorities due in February 2013.
Report to CMDHB 20,000 Days Campaign - prevention of skin infections - Report to CMDHB		Final report submitted in December. The findings and recommendations will be presented to the expert group meeting in February 2013.

National Hauora Coalition

PHO Reporting	Date Sent	Date Approved	Issues/Remedial Plans/Additional Information
FFP Plan (SIA,HP)	Approved by ALT	17/10/2012	The FFP Plan was approved by the ALT at the meeting of 17/10/12. The implementation plan to provide specific locality implementation advice is scheduled for the ALT on 20 February 2013.
Maori Health Plan		Approved with Business Case	The NHC is a Maori led organisation implementing a Whanau Ora service delivery model. The implementation of the Business Case remains the Maori Health Plan for the NHC.
PHO Reporting	**Targets**	**On track**	**Issues/Remedial Plans/Additional Information**
Overdue PMR Contract repor	All PMRs are up to date		The NHC Corporate Services Arm is also conducting an 'agreement reporting' reconciliation exercise (to be conducted during the month of January 2013) which includes confirmation from Sector Services. The purpose of this exercise is to to ensure that all required agreement reporting is completed and recorded accordingly - progress on this exercise will be reported in the Monthly report for February 2012.
PPP Indicator target. **Below Target only***	*Breast Cancer Screening Coverage 50-69 - High Need*		*See NHC PPP Health Targets Action Plan. Has improved from 58.14% to 58.99% in the July to September Quarter - On Target*
	CVD Risk Assessment - Total Population		*See NHC PPP Health Targets Action Plan. Has improved from 55.92% to 57.58% in the July - September Quarter - On Target*
	CVD Risk Assessment - High Need		*See NHC PPP Health Targets Action Plan. Has improved from 57.38% to 58.47% in the July to September Quarter - On Target*
	Cervical Cancer Screening Coverage - Total Population		*See NHC PPP Health Targets Action Plan. PPP Action Plan in Place*
	Cervical Cancer Screening Coverage - High Need		*See NHC PPP Health Targets Action Plan. PPP Action Plan in Place*
	Diabetes Follow Up After Detection - Total Population		*See NHC PPP Health Targets Action Plan. Impact of change over from DGC to DCIP and the roll out and implementation of NHC's DCIP programme.*
	Diabetes Follow Up After Detection - High Need		*See NHC PPP Health Targets Action Plan. Impact of change over from DGC to DCIP and the roll out and implementation of NHC's DCIP programme.*
	Age Appropriate Vaccinations - 2yr Olds - Total Population		*See NHC PPP Health Targets Action Plan. PPP Action Plan in Place*
	Age Appropriate Vaccinations - 2yr Olds - High Need		*See NHC PPP Health Targets Action Plan. PPP Action Plan in Place*
	Flu Vaccine Coverage - Total Population		*See NHC PPP Health Targets Action Plan. Has improved from 56.32% to 63.15% in the July to September Quarter.- On Target*
	Flu Vaccine Coverage - High Need		*See NHC PPP Health Targets Action Plan. PPP Action Plan in Place*
People registered to a PHO who state their ethnicity at enrolment	95%	99.66%	*As per Karo submitted data for Jan 2013 quarter*

* Indicators above target can go under acheivements for the month

PHO Cash balances	$	Definition
Working capital requirements	-41,351.00	Current assests less current liabilities
Total cash balance at end of financial year	582,564.00	Total cash assets shown in current assets section of the Statement of Financial Position including any term investments
Total income at end of financial year	70,663,919.00	
Forecast expenditure plan		The PHO's current liabilities exceed the current assets

Key PHO Activities /Acheivement for the month
Two new practices submitted their enrolment registers to start with NHC 1st Jan 2013. Further negotiations are progressing with other practises. The PPP comments remain the same as 30 November report as no new data is available until February 2012.The PPP Action Plan is underway and full achievement is planned prior to year end. It has been agreed with DHBs. Activity includes collaboration with practises and DHBs to target improved performance. FFP Transition Plan and associated workstreams in place, with locality change management plans in development for approval by ALT in February 2013. Agreed workstreams include: aligning locality information, developing IT software functionality and integrated IT development, defining reporting and data requirements, defining programme criteria and specifications, defining financial rules and costings, preparing communications and locality specific transition plans, establishing transition team to implement the FFP transition implementation plan, and risk management. The FFP Transition Plan with full transition team will be implemented during March to June 2013. Go live date for FFP delivery is 1 July 2013. The NHC has participated in a series of meetings and teleconferences with DHBs on preparation for 2013/14 DAPs. Early engagement is critical and valued by the NHC.

Priorities for the following month
DAP planning for the 2013-14 year is underway with a clearer relationship between the DAP, Whanau Ora System implementation and clinical integration.

Business Case	On track	Issues/Remedial Plans/Additional Information
NHC measurable contribution at aggregate practice level to acute demand management activities across appropriate DHBs		Reported quarterly - data not yet available. NHC Clinical Leadership is involved in acute demand projects with partner DHBs including 20,000 Bed days campaign, localities clinical network activity in CMDHB, ADHB/WDHB. After hours activity is mature in Auckland and emerging in Whanganui and Tairawhiti.

DHB Annual Plan	Target	On track	Issues/Remedial Plans/Additional Information
Auckland DHB	Whanau Ora case in DAP but not funded		NHC has beeing invited to participate in DAP Planning and Auckland DHB Maori Health Planning for 2013/14. This does not include a discussion regarding the funding of the Business Case.

Alliance Health +

PHO Reporting	Date Sent	Date Approved	Issues/Remedial Plans/Additional Information
FFP Plan (SIA,HP)	27-Jul-12		
Maori Health Plan	Nov-12		

PHO Reporting	Contract details	Issues/Remedial Plans/Additional Information
Overdue PMR Contract reports		
	1. CERVICAL SCREENING (ADHB 335700-02/336132-02)	Delay due to late ADHB contracting. Reports will be completed by 20 Jan 2013.
PPP Indicator target **Please record those indicators below target only***	*As at Sept 2012 (Dec report will be available soon)*	
	1. Cervical Screening Coverage (Tot. pop.)	Narrowly missed PHO target (57.72%/58). Programme Plans underway to support practices.
	2. Breast Cancer screening	Narrowly missed (< 2%). Programme Plans underway to support practices.
People registered to a PHO who state their ethnicity at enrolment	AH+ = 99.9%	AH+ actively supports Practices to maintain a clean register.

* Indicators above target can go under acheivements for the month

PHO Cash balances	$	Definition
Working capital requirements	486,000	Current assests less current liabilities (see attached .doc for more detail)
Total cash balance at end of financial year	882,000	Total cash assets shown in current assets section of the Statement of Financial Position including any term investments
Total income at end of financial year	19,310,000	
Forecast expenditure plan	N/A	Of the cash balance, $130,000 has been subsequently paid out to practices by 30 September 2012 and $320,000 relates to cash which was received at balance date but which was held in income in advance at 30 June 2012

Key PHO Activities /Acheivement for the quarter

* Proactive focus on meeting national health targets. Three Programme Plans that provide practices with step by step guide to improve their performance were implemented across all practices and are being used to drive performance: Immunisation, Smoking Status, Brief Advice and CVD Risk Assessment. AH+ staff worked closely with practices to provide training and guidance as well as weekly update on each practice's performance and weekly meetings at PHO. Graphs of PHO performance against these three targets are provided weekly to CMDHB and ADHB.
* Developed an integration model for community, health, social services and Whanau Ora to deliver synergistic improvements. Transformational change programme is also progressing well.
* Provided leadership in the establishment of a Pacific Technical Advisory group for Whanau Ora. Diagnostic Process completed for the Strengthening of 6 Pacific Primary Care Providers where AH+ is the lead contactor.
* Devolution of contracts from ADHB and CMDHB were underway during this quarter.
* Developed and submitted the Operational Host Plan for Mangere. An implementation plan for the Operational Host role was also developed.
* Financial Audit completed for 2011/2012 with clean report
* More discussions with ADHB on possible specialised services to be delivered at the two IFHCs - Tongan Health Society and Mt Wellington IFHC.
* AH+ hosted Ailsa Claire, the new CE of ADHB who also spent a day with the AH+ Clinical Director during his normal GP work at South Seas Healthcare.
* Three practices to join AH+ in 2013

Priorities for the following quarter
1. Devolution of contracts from ADHB and CMDHB
2. Improving PHO performance to hit the three national targets by 30 June 2013
3. Embedding Operational Host role and responsibilities for the Mangere Locality and to enhance active development in the Mangere locality
4. Strengthening 6 Pacific Primary Care Providers - Development Plan underway

Business Case Deliverables	On track	Issues/Remedial Plans/Additional Information
Consolidation & Infrastructure	On track	* Ongoing enhancement of systems and processes - particularly contract management, reporting, practice payments, programme plans to support practices with health targets. * Major improvement with reporting quality and deadlines - only one outstanding report to date (due to late contracting).
IFHC Development	Underway	A united paper with concrete requests on behalf of AH+ , Langimalie and Mt Wellington IFHC were presented to ADHB for additional services to support these IFHCs.
Enhanced Service Delivery	On track	Practices have been supported to improve efficiency and service quality through HR processes, workforce and step by step programme plans. Increase use of Text to remind service has enhanced uptake and attendance at appointments too. This is also reflected in positive improvements toward health targets.
Nurse Led Services	On track	* A model for Nurse-led clinics is being developed to define and demonstrate the financial arguments and advantages of Nurse-led clinics. * A Nurse-led process and guidance paper has been developed to assist the Clinics to improve efficiencies and maximise the capacity of their nurses. *Some providers are refining a new model of care where there is better collaboration between GPs and Nurses - nurses do phone triage then direct patients appropriately. This surely assists the flow of patients which reduces waiting time but also educates patients to see appropriate staff and not necessarily the GP at all times.
Performance & Accountability	On track	* The new AH+ Clinical Framework has been fully implemented which supports the work of AH+ in delivering improved outcomes. * Programme Plans for three health targets were implemented across all practices to help improve their performance and a further three targets will be implemented in the next quarter. * Implementation of "Focus on Targets" programme to drive the performance of AH+in achieving improved performance data.
Reduction of Acute Demand	On track	AH+ actively participated in the regional After Hours Alliance which has successfully delivered reduction in growth of demand on Emergency Dept.

DHB Annual Plan deliverable	On track	Issues/Remedial Plans/Additional Information
Implementation of new models of care in collaboratively agreed priority areas within AH+ and IFHC	On track	This is still being discussed with the network with some practices leading the way in 'holistic' model of care with a strong emphasis on nursing and allied staff. We have found that there is a limit to the amount of change that can be introduced and that our first priority is to get the Clinical Framework embedded and improved clinical performance. However, we are planning to do further work on looking at process improvement and value stream mapping within practices and applying 'lean' methodology to improve efficiencies and patient flow within practices. In addition to broader model of care changes.
ADHB, in partnership with CMDHB, provide Nursing Leadership to support AH+ to develop Nurse Led Clinics	On track	Nurse Leader is developing a paper to support Nurse Clinic activities. We are aiming to pilot the LECG model for investing in Nursing workforce with several practices to see if this is a useful tool to rollout to other practices. This helps determine whether to 'employ' another doctor or add more nursing staff. There has been discussion between WDHB Director of Primary Care Nursing and our Nurse Leader to see what support is needed in order to progress change.

Waitemata PHO

PHO Reporting	Date Sent	Date Approved	Issues/Remedial Plans/Additional Information
FFP Plan (SIA,HP)	22/08/2012	Awaiting	
Maori Health Plan	29/08/2012	Awaiting	
PHO Reporting	**Targets**	**On track**	**Issues/Remedial Plans/Additional Information**
Overdue PMR Contract reports	Refugee in Primary Care		Did not receive contract until 6.12.2012
	Nurse enter to practice		Did not receive contract until 18.12.2012
PPP Indicator target **Please record those indicators below target only***	CVD Risk Assessement - Total Population - 67%	55.74%	Current data shows that WPHO is on track to attain year end target.
	CVD Risk Assessement - High Need - 67%	49.34%	Current data shows that WPHO is on track to attain year end target.
	Diabetes Follow Up After Detection - Total	66.40%	New Diabetes Improvement Package (DIP) will address issues of follow-up
	Diabetes Follow Up After Detection - High Need - 71%	67.91%	New Diabetes Improvement Package (DIP) will address issues of follow-up
	Smoking Status Ever Recorded - 73%	70.39%	
	Cervical Cancer Screening - Total Population - 75%	74.39%	
	Cervical Cancer Screening - High Need - 70%	65.42%	Continue to identify new strategies of engagement
	Breast Cancer Screening Coverage 50-69 - High Need - 69%	62.96%	
	Age Appropriate Vaccinations - 2 Year Olds - Total Population - 95%	90.26%	Outreach activity dictated by NIR referral rate. Practice enegagement continues to be high with enrolled population.
	Age Appropriate Vaccinations - 2 Year Olds - High Need - 95%	89.90%	Outreach activity dicated by NIR referral rate. Practice engagement continues to be high with enrolled population.
	Flu Vaccine Coverage - Total Population - 65%	60.69%	2013 planning underway to promote vaccination pre flu season
	Flu Vaccine Coverage - High Need - 63%	59.44%	2013 planning underway to promote vaccination pre flu season
People registered to a PHO who state their ethnicity at enrolment	95%		

* Indicators above target can go under acheivements for the month

PHO Cash balances	$	Definition
Working capital requirements	$ 76,417.00	Current assests less current liabilities
Total cash balance at end of financial year (June 2012)	$ 762,439.00	Total cash assets shown in current assets section of the Statement of Financial Position including any term investments
Total income at end of financial year (June 2012)	$ 37,108,383.00	
Forecast expenditure plan	N/A	Cash balance has been paid out to practices by 30 September 2012

Key PHO Activities /Acheivement for the month		
	Target	Performance
Ischaemic CVD Detection - Total Population	90.0%	96.9%
Ischaemic CVD Detection - High Need	90.0%	112.3%
Diabetes Detection - Total Population	90.0%	112.4%
Diabetes Detection - High Need	90.0%	113.9%
Smoking status ever recorded - Other	76.0%	77.2%

Priorities for the following month

Long Term Conditions - Quarterly report due 20.1.2013
Northland Outreach - Six monthly report due 20.1.2013
Rural retention - Quarterly report due 20.1.2013
Radiology - Quarterly report due 20.1.2013
Smokefree PHO - Quarterly report due 20.1.2013
Rural after hours - Quarterly report due 20.1.2013
Asian Smokefree - Quarterly report due 20.1.2013
B4 School Check - Quarterly report due 20.1.2013
Whanau Smokefree - Quarterly report due 20.1.2013
Cervical Smear - Quarterly report due 20.1.2013

Auckland PHO

PHO Reporting	Date Sent	Date Approved	Issues/Remedial Plans/Additional Information
FFP Plan (SIA,HP)	Aug-12		Plan provided by PHO is comprehensive and clearly details the activities the funding will be utilised for
Maori Health Plan	Sep-12		The Maori Health Plan has been received by ADHB. The DHB has provided feedback to the PHO on the plan which the PHO has incorporated.
PHO Reporting	**Targets**	**On track**	**Issues/Remedial Plans/Additional Information**
Overdue PMR Contract reports	1		Contract reporting on track
PPP Indicator target **Please record those indicators below target only***	2 yr imms		Currently coverage is 81% due to very high numbers of decliners. We are working very closely with these practices to ensure every child is accounted for.
People registered to a PHO who state their ethnicity at enrolment	95%		96%

* Indicators above target can go under acheivements for the month

PHO Cash balances	$	Definition
Working capital requirements	698,875	Current assets less current liabilities
Total cash balance at end of financial year	933,025	Total cash assets shown in current assets section of the Statement of Financial Position including any term investments
Total income at end of financial year	10,647,201	includes capitation
Forecast expenditure plan	900,000	Auckland PHO plans on a break even budget for this financial year so will be reducing their cash balance by $900,000. This level of funding however is dependent on when the practices are paid out, i.e. when the PHO pays the practices for their care plus or capitation funding

Key PHO Activities /Acheivement for the month
According to PPP November reports Auckland PHO has achieved all PPP and health targets with the exception of 2 year childhood immunisations.

Priorities for the following month
During the next 2 months we are planning and implementing an influenza vaccination strategy that builds on increasing coverage, particulary for Maori.

ProCare

PHO Reporting	Date Sent	Date Approved	Issues/Remedial Plans/Additional Information
FFP Plan (SIA,HP)	30/08/2012		
Maori Health Plan	01/11/2012		Still in discussion with DHBs Maori Team. Current plan will be modified to align with DHB plans and priorities.

PHO Reporting	Targets	On track	Issues/Remedial Plans/Additional Information
Overdue PMR Contract reports			
PPP Indicator target **Please record those indicators below target only***	1 PPP Overall		The results of the Jul to Dec 2012 PPP performance period (and the Oct to Dec 2012 quarter) are not yet known as they will only be submitted on 20th Jan 2013.
	2 Diabetes Annual Review		Performance against this indicator has continued to drop off since the uncertainty about the future of Diabetes Get Checked last year. With the introduction of the new DCIP contracts we expect to see this improve and we are working on new initiatives to achieve this target, but they will not have a noticeable effect until the Jan to Jun 2013 PPP period.
	3 CVD Risk Assessment		In general we expect to see this indicator improve, though final results will not be known until Feb after the submission of the PPP data. We have provided an action plan to both ADHB and CMDHB with a set of initiatives intended to support the achievement of the National Health Target by 30th June 2013.
	4 Smoking Cessation Advice		As with CVD we are working towards the National Health Target and initiatives designed to achieve this are outlined in the plan provided to CMDHB and ADHB.
People registered to a PHO who state their ethnicity at enrolment	95%		Actual for ADHB and WDHB is 99.65% ethnicity stated at enrolment.

* Indicators above target can go under acheivements for the month

PHO Cash balances	$	Definition
Working capital requirements	approx $8.5m	Current assets less current liabilities.
Total cash balance at end of financial year	11,385,562	Total cash assets shown in current assets section of the Statement of Financial Position including any term investments (as at 30 June 2012)
Total income at end of financial year	166,314,722	Year ended 30 June 2012 per audited accounts including First Level Services funding
Forecast expenditure plan for both cash balances and income in advance, including quarterly targets for reductions in cash balances to the agreed level	Reduction in cash balances and income in advance of $1.5m forecast by 30 June 2013 in line with prior year reduction.	Additional reduction in cash and income in advance of $2m forecast for 2013/14. The DHB will work with the PHO to agree a forecast expenditure plan.

Key PHO Activities /Acheivement for the month

Priorities for the following month

5.2 Planning and Funding Update

Recommendation:

That the report be received.

Prepared by: Denis Jury (Chief Planning and Funding Officer ADHB), Debbie Holdsworth (Chief Planning and Funding Officer WDHB), Julie Helean (Manager Planning and Service Development ADHB), Janine Pratt (Group Planning Manager WDHB), Tim Wood (Group Funding Manager WDHB) and Cliff La Grange (Group Finance Manager WDHB)

Glossary

CPSA - Community Pharmacy Services Agreement
CRC - Community Residential Care
DHB - District Health Board
LTC - Long Term Conditions
PHO - Primary Health Organisation

1. Summary

This report updates the Committees on Auckland and Waitemata DHBs' Planning and Funding activity for the month of January 2013.

2. Summary of activities in common

2.1 Planning

The Annual Plan (incorporating the Statement of Intent) for 2013-14 is under development. One document is being constructed across Waitemata and Auckland DHBs to ensure that the style and format are identical, and content where appropriate. A Regional Service Plan and updated Maori Health Plans are also required this planning round.

Planning instructions were given to staff in December. Instructions cover the process for developing Annual Plans and for achieving sign off by the first submission date of 22 March 2013.

Waitemata DHB held a half-day planning workshop on 23 January for key stakeholders including primary care, mental health, community, other agencies and our own staff to assist with alignment and integration of the plan across the organisation and with stakeholder organisations. Those responsible for preparing content for the annual plan are also including stakeholders in priority area specific meetings and communications as part of their planning process.

Additional information to help with planning is expected to be released by the National Health Board on 8 February. Still to come: DHB Performance Measures; and policy information including primary care and integration, Children's Actions Plans, Mental Health and suicide prevention. The National Health Board acknowledges that this supplementary information is coming to DHBs late in the planning process. The National Health Board will hold a seminar on this information on 14 February.

The first draft of Annual Plans for Auckland DHB and Waitemata DHB will be presented for discussion at the 20 March meeting of the CPHACs. Prior to that each Board will have a chance to comment on a working draft of the Plan (20 February for Auckland, and 27 February for Waitemata). Material presented to the Boards for review in February will be incomplete. As in previous years, each Board will be asked to delegate sign-off to the 20 March meeting of the CPHACs.

Maori Health Plans are underway, with the sign off process for these linked to the Annual Plan process. Manawa Ora and our MoU partners will also be closely involved with the construction and approval of the Maori Health Plans. While there are two Maori Health Plans required, they will be largely identical across Auckland and Waitemata, except where are differences to specifically note.

DHB planners are also linked into Regional Service Planning. Drafting and approvals of the Northern Region Health Plan will be managed via the NDSA.

The Statement of Intent is tabled as a separate document even though most parts of it are also covered in the Annual Plan. These will come to the respective Boards for approval in June.

Timeline for planning documents

Date	Activity
20 February	Auckland DHB Board meeting Review Annual Plan draft 1 and delegate approval First Budget Presentation to Board Members
27 February	Waitemata DHB Board meeting Review Annual Plan draft 1 and delegate approval Approve: AMP draft 1, Production Plan and Capital Plan
1 March	Financial templates provided to NHB
8 March	Regional Service Plans (RSP) submitted to NHB
15 March	Maori Health Plans (MHP) submitted to NHB
20 March	Audit and Finance and CPHACs meet: update on Annual Plan progress Request approval to submit as a draft for NHB review
22 March	Annual Plan with Statement of Intent submitted to the National Health Board for review
April	Feedback received from NHB. Boards notified of feedback. Amendments made to the plan and Statement of Intent as required
19 April	Maori Health Plan feedback provided to DHBs by Maori Health Business Unit
3 May	NHB feedback on Annual Plans/Statement of Intent and Regional Service Plans to DHBs
9 May	Final Board-approved Maori Health Plans submitted to NHB
15 May	Auckland DHB Board meeting. Annual Plan for Board approval
17 May	Final board-approved Annual Plan (including the Statement of Intent) and Regional Service Plan due with the National Health Board
22 May	Waitemata DHB Board meeting. Annual Plan for Board approval
June 2013	Final Statements of Intent to Boards for respective DHB approval
1 June	Maori Health Business Unit provide feedback on final draft Maori Health Plan to DHBs

2.2 Community Pharmacy Agreement

In July 2012, a new Community Pharmacy Services Agreement (CPSA) came into effect which involved significant changes to community pharmacy’s funding and service model.

The new contract promotes a more patient-centred approach to pharmacy services delivery. It is a transitional contract being implemented over the next three years.

DHBs and Pharmacy sector agents (e.g. Pharmacy Guild) have agreed on a service and funding package for the second phase of the CPSA - this requires a contract variation to be implemented on 1 March 2013. This variation continues the path of promoting clinical partnerships and integrated healthcare.

The service change components of the variation are:

- Commencement/setting of the Long-term Conditions (LTC) Service fees to reimburse pharmacists for the provision of medication adherence support to eligible patients
- A new Pharmacy High-needs and Adherence Management (PHAM) Service, which caters for very high-needs LTC patients (e.g. daily dispensing to at-risk mental health clients); it is anticipated that there will be 1,000 eligible patients nationally; strict criteria will need to be met for entry into the service
- Registration of LTC Service patients under an exceptional circumstances process; this is for patients who do not satisfy the usual LTC Service criteria, but for whom additional support may be necessary; it is anticipated that there will be 6,000 eligible patients nationally
- Community Residential Care (CRC) Services, which will provide additional support to service users that require medication management support who live in supported residential care.

The service changes relating to the LTC Service are required to mitigate risk. The changes will meet the needs of patients who do not currently fulfil LTC Service entry criteria (e.g. people in CRC facilities) or for whom the level of care may be inadequate (e.g. patients with very high needs).

The funding and contractual components of the variation are:

- Core Service fees will not be paid at this stage (initially scheduled for February 2013); instead an Interim Funding Adjuster will apply to ensure that pharmacies are not disadvantaged with the introduction of LTC Services fees (and corresponding reduction in the Transition Payment Pool)
- The removal of clauses in the CPSA that prohibit co-payment discounting. This follows receipt of advice from the Commerce Commission who holds the view that such clauses are anti-competitive. Pharmacists are now able to choose whether or not they provide "inducements" that were prohibited under clause M1.3; and/or charge the full co-payment amount (or some lesser amount) under clause H4.4 (a).

Planning is underway for a series of meetings (25th – 28th February) with community pharmacy to discuss the changes to the contract.

3. Waitemata DHB Update

3.1 Funding

More Heart and Diabetes Checks

The Health target is that 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. DHBs are required to achieve at least 75 percent by 1 July 2013 and 90% percent by 1 July 2014.

For the current year we developed a single integrated contract that pulled all primary care delivered services together. Within this agreement specific funding was applied to support the achievement of this target. Both PHOs, ProCare and Waitemata PHO, are actively

working with their practices to support the achievement of the target. Discussion with the PHOs have identified a number of additional opportunities to support practices complete the necessary risk assessments and provide appropriate care for those patients assessed as high risk. We are finalising how we can use these opportunities to refine the service model to improve performance against the target. Some of these opportunities such as provision of additional nursing staff to complete the risk assessments will be implemented quickly. However, we are also looking at opportunities that will have a longer term focus on reaching the 90% level and maintaining the performance on an ongoing basis. One key issue appears to be patients not getting the required blood tests done. We are exploring mechanisms to overcome this barrier.

The DHB provider arm has implemented the inpatient risk assessment service. With support of the PHOs a system has been put in place to identify eligible patients without a risk assessment who are inpatients in the DHB services. Nurses undertake the assessments that are then reported back to the patient's general practitioner. The patient is also advised of the outcome of risk assessment and given advice on the need to follow up with their GP. In December 109 assessments were undertaken.

Work is not underway to look at offering risk assessments to our staff that are eligible. Consideration of risk assessments in the out patient setting has been given. However, risk assessments in the out patient setting are not feasible at this time.

Palliative Care

The funding team has completed an engagement process with our three hospices, the PHOs and the DHB palliative care team on the initiation of a work programme to develop a district wide consistent service delivery model for palliative care. It has been agreed the work programme will have the following objectives:

- Establish a district wide palliative care clinical governance framework
- Develop a district wide palliative care service delivery model
- Develop an outcomes measurement framework to monitor and evaluate the palliative care services
- Identify the palliative care workforce requirements for the district
- Identify the requirements for the implementation of the model.

It is planned that this work will be undertaken over the next six months.

The key drivers for this programme are:

- Projected increase in demand for palliative care service of 37.9% between 2006 and 2026.
- Inconsistent palliative care models across the district.
- Support move to meet requirements of the draft Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand. The framework has been developed to provide guidance for the planning for, and purchasing of, accessible and equitable palliative care services.

Counties Manukau DHB has already initiated a programme of work in their area. We are working closely with them to share learnings and maximise commonality of approach.

3.2 Funder Finance

The December 2012 consolidated core result for the Waitemata Funder was $522k favourable to budget for the month and $3.3M favourable to budget for the year to date.

Funder NGOs

The December 2012 core result for Funder NGO was $504k favourable to budget for the month and $2.0M favourable to budget for the year to date.

The year to date favourable position includes an upside of $1.1M relative to PHO First Contact Capitation Services (payments based on number of PHO enrolees). This position takes into consideration any offsetting variances in IDF caused by changes in General Practice memberships between ProCare PHO and Waitemata PHO. As previously reported, eight Practices changed from ProCare PHO to Waitemata PHO during the first quarter of this year.

Another significant driver of the year to date favourable position is an upside of $1.0M relative to Health of Older Persons demand services (Age Related Residential Care and Home Based Support Services). This is mostly representative of lower than expected Rest Home expenditure growth than was budgeted and the historical tendency for Private Hospital monthly expenditure to be lower than average in the first half of the financial year. Current year on year growth in Rest Home bed day volumes is a negative 4%. However Private Hospital and Dementia bed day volumes continue to experience strong growth of 8% and 20% respectively. The current growth across all Home Based Support Services is 8%. The current forecast year end spend in Health of Older Persons Services is covered in the Funder budgets.

The year to date favourable position also includes various other lesser value upside variances within Mental Health Services and General Practice demand services (General Medical Subsidies, Practice Nurse Subsidies and Immunisation).

Community Pharmacy currently has a negative impact on the Funder NGO year to date core result. This is expected to improve. As previously reported there are a number of significant national strategy changes that are occurring concurrently within the Community Pharmacy budget spend. These include the devolution of the Vaccines budget, the new national Combined Pharmacy Service Agreement and the national PHARMAC drug budget reduction. From January 2012, this will also include an increase in the user co-payment charge from $3.00 to $5.00 and from March a substantive revision to the Pharmacy Service Agreement. The exact financial implications of these changes are not as yet fully transparent or definitive.

Funder IDFs
The December 2012 core result for Funder IDF was $18k favourable to budget for the month and $1.3M favourable to budget for the year to date. The main factor contributing to the favourable result is a positive year to date inpatient wash-up position receivable in part through the MOH default wash-up process. This is mostly reflective of lower acute utilisation of Waitemata domiciled patients at Auckland DHB and other DHB facilities.

4. Auckland DHB Update

4.1 Funding of Sexual Assault Services – Auckland Sexual Abuse HELP Foundation (ASAH)

Work to resolve the funding issue of HELP which in turn will inform a national funding model is being lead by MSD at a national level. Other agencies involved at this point include ACC, NZ Police, the Ministries of Justice and Health, Women's Affairs and ADHB.

Existing funding for provision of a telephone service and crisis counselling ceased at the end of December 2012 and officials had been unable to agree a new funding package at a level that would enable the service to continue at the current level. Just before Christmas the Minister of Social Development Paula Bennett visited HELP and on behalf of herself and the Ministers of Health and ACC, committed immediate funding for 4 months that would enable to enable the service to continue to be provided at the current level. A further commitment was made that a new 3 year contract for provision of these services would be in place by 1

May 2013. MSD is also funding a business consultant to work with HELP to review their business model and recommend any changes that would provide efficiencies.

Although ADHB is not a contributor to the multi-agency funding package, the Planning & Funding Manager has an established relationship with HELP and has agreed to take a central role in negotiations and ongoing relationship management on behalf of the Wellington-based multi-agency working group.

ADHB (on behalf of Auckland, Waitemata and Northland DHBs) also contracts with HELP to provide 24 hour, 7 days per week specialist support for victims of rape or sexual assault undergoing forensic medical examination and Police interviewing. The value of this contract is currently under review with the possibility of increasing it to ensure that the service is appropriately funded.

4.2 Oral Health

The final dental clinic to be constructed under the 'Oral Health Business Case' was completed on 5 February and a dawn blessing scheduled for 15 February. Patients will be treated in this clinic by the first week in March.

4.3 B4 School Check Programme

National data supplied by the Ministry of Health on DHB B4SC programme performance as at 6 January 2013 showed that ADHB's performance has largely maintained the improvement noted in the previous report despite a change in 'outreach' provider and an expected activity downturn during December. The year to date target for all children was met and that for quintile 5 children was close to being met.

4.4 Online Support: "Big White Wall"

The service is now fully operational. Further tailoring for a New Zealand market is underway and in liaison with MH P&F. The CEO visits NZ in March for an international conference and discussions with potential partners for future expansion are planned; such developments are likely to benefit ADHB consumers and could include online therapy, monitor wide range of long term conditions, and a youth option.

4.5 Reconfiguration of Mental Health Residential Rehabilitation

This project continues to progress well. The stepped approach to conversion is generally operating smoothly although it has identified the need for the expansion of supported accommodation with 24 hour onsite support staff rather than visiting mobile staff for a significant group. Most of these are older consumers with long histories of mental health and they require more careful oversight than irregular support visits. Discussions with potential providers are underway and this service will be funded through a new contractual model that utilises WINZ for meeting accommodation costs and targets mental health funding towards appropriate support.

4.6 Mental Health Child and Youth Work Stream

Work continues to progress well. Of note is that this project has grown larger than anticipated but this development is worthwhile as it ensures integration and engagement with other agencies particularly CYF, WINZ, and Education. A stocktake of existing services across agencies has been completed and mapped. Next steps include identifying a possible structure for layered interventions both sequential and in parallel. Following that, discussions with specialist CAMH service will take place to look at options for change to meet priorities.

4.7 Funder Finance

For the month of December 2012 the funding accounts show a surplus of $5.8m compared to a budget surplus of $5.5m, a favourable variance of $0.3m. YTD the actual surplus is $10.2m compared to a budgeted surplus of $1.0m, a favourable variance of $9.2m. The YTD variance is split between a favourable variance for the “funder” of $9.5m combined with “provider” unfavourable variance of $0.3m.

The main features of the YTD result are a favourable budget variance in Personal Health and Med/Surg of $8.5m, Mental Health favourable to budget by $0.2k, Health of Older Peoples favourable to budget by $0.8k and an unfavourable variance of $0.3m in Provider services.

In Personal Health there were practice changes for the October to December quarter. On the 1st October 7 practices, 60,000 enrolled persons, moved from either Waitemata PHO (WDHB) or National Maori PHO (CMDHB) to ProCare PHO, and therefore became hosted by ADHB. The effect of this is $2.5m greater total capitation payments per quarter. This moves close to offsets the movement on 1st July of 8 practices (70,000 enrolled persons) who transferred out of ProCare (ADHB) to Waitemata PHO. Accordingly ADHB’s PHO expenditure is close to budget for the month and favourable YTD which is offset by lower IDF revenue from Waitemata DHB and the MOH SCI funding for the Under 6 and Care Plus funding. IDF outflows were lower in December following the MOH’s calculation of 2012-Q4 wash-up following the practices in WDHB & CMDHB being hosted by ADHB as commented on earlier.

Health of Older People is favourable for the month by $210k and a YTD favourable variance of $862k. The changes in the month are predominantly driven by Long Term Services for Chronic Health Conditions. The additional revenue is substantially MOH funding for the Long Term Conditions for Chronic Health Conditions (LTS-CHC) contracts that that the MOH has devolved to the DHBs. This additional revenue is offset by the higher costs for these services. Initial information is that the MOH funding is insufficient to fully cover the costs of these contracts.