



Community and Public Health Advisory Committee Meeting

Wednesday 18 May 2011

2:00pm

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

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



Community and Public Health Advisory Committee

For discussion with Board

CPHAC Meeting Date:	
Feedback By:	
DAP	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
KPIs	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
RISKS	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
3.	

KARAKIA

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD AND COMMITTEE (CPHAC) INTERESTS REGISTER

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	<ol style="list-style-type: none"> 1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board 	<p>Self-employed</p> <p>Professional Conduct Committee member</p> <p>Professional Conduct Committee member</p>	<p>Fees</p> <p>Hourly fee</p> <p>Hourly fee</p>	<p>Writer, editor and public relations services</p> <p>Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes</p> <p>Lay member of PCC to assess complaints and determine outcomes</p>	7 August 2009
Dr Chris CHAMBERS	<ol style="list-style-type: none"> 1. Employee, Auckland District Health Board 2. Wife employed by Starship Trauma Service 3. Clinical Senior Lecturer in Anaesthesia Auckland Clinical School 4. Associate, Epsom Anaesthetic Group 5. Member, ASMS 6. Shareholder, Ormiston Surgical 				20 April 2011

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

	7. NZ Council of Midwives	Council member	Fee	Statutory Authority	
Robyn NORTHEY	1. Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB	16 December 2010
	2. Hope Foundation	Board member	Nil	Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	
	3. Northern Region Ethics Committee	Member	Fee		
Gwen TEPANIA-PALMER	1. Waitemata District Health Board	Board member	Fee		2 February 2011
	2. Manaia PHO	Board member	Fee paid to NHHT		
	3. Ngati Hine Health Trust	Chair	Fee		
	4. Awanmarangi Waonangi	Committee member			
	5. Te TAitokerau Whanau Ora	Committee member			
Ian WARD	1. Principal/Director C -4 Consulting Limited				4 May 2011
Rev Alfred NGARO	1. 4pm Group Ltd	Consultant	Salary	Community Development	11 May 2009
	2. Pacific Advisory Committee, PHAC	Chair	Fee	Pacific Advisory for ADHB	
	3. National Task Force for Family Violence MSD	Member	Fee	PHAC representative	
	4. Family and Community Services national advisory group	Task Force member	Fee	Representative from Family and Community Services national advisory group	
	5. Auckland Safer Communities	Advisory Member		Development and implementation of a comprehensive social intervention logic for supporting families nationally	
	6. Tamaki Achievement Pathways Schooling improvement	Executive member	Voluntary	Development of Auckland Safer City plans	
		Chair	Voluntary	Chair management committee for cluster of 13 schools in management improvement initiative	

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

CONFIRMATION OF MINUTES
- WEDNESDAY 20 APRIL 2011

Community and Public Health Advisory Committee Minutes

MEETING DETAILS											
Time and Date	2:00pm, Wednesday, 20 April 2011										
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom										
1	KARAKIA										
	The Chair declared the meeting open at 2:00 pm. Naida Glavish led the meeting with the karakia.										
2	ATTENDANCE AND APOLOGIES										
	<p>Committee Members</p> <table> <tr> <td>Dr Lee Mathias (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Susan Buckland</td> </tr> <tr> <td>Dr Chris Chambers</td> <td>Dr Lester Levy</td> </tr> <tr> <td>Robyn Northey</td> <td>Gwen Tepania-Palmer</td> </tr> <tr> <td>Ian Ward</td> <td></td> </tr> </table> <p>In Attendance</p> <p>Warren Flaunty – Waitemata District Health Board</p> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Hilda Fa'asalele – General Manager Pacific Health Naida Glavish – Chief Advisor Tikanga, General Manager Maori Health Keri Hiini – Planning and Funding Manager Janice Mueller – Director Allied Health Ian Bell – Board Administrator</p> <p>Apologies</p> <p>Rob Cooper was on leave of absence and apologies had been received from Judith Bassett and Taima Campbell.</p>	Dr Lee Mathias (Chair)	Jo Agnew	Peter Aitken	Susan Buckland	Dr Chris Chambers	Dr Lester Levy	Robyn Northey	Gwen Tepania-Palmer	Ian Ward	
Dr Lee Mathias (Chair)	Jo Agnew										
Peter Aitken	Susan Buckland										
Dr Chris Chambers	Dr Lester Levy										
Robyn Northey	Gwen Tepania-Palmer										
Ian Ward											
3	CONFLICTS OF INTEREST										
	There were no declarations of conflicts of interest with any item on the agenda. Chris Chambers advised that he was no longer a surveyor for Quality Healthcare New Zealand.										
4	CONFIRMATION OF MINUTES 16 MARCH 2011										
	<p><u>Moved Gwen Tepania-Palmer; seconded Jo Agnew</u></p> <p><i>That the minutes of the Community and Public Health Advisory Committee meeting held on 16 March 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

5	ACTION POINTS 16 MARCH 2010
	<p>Strategies for Children</p> <p>This would now be on the May agenda.</p> <p>Pacific Smoking Cessation</p> <p>There had been some communication with the Ministry of Health with a good chance that there would be funding. It has been supported by funding from the previous year and a reduced overhead charge from Public Health. The change in the overhead application by Public Health was as a result of a review of their allocation methodology.</p> <p>Contracting</p> <p>There would be a paper going to the Finance Committee.</p> <p>Weight Management</p> <p>This was a issue better addressed nationally however it was suggested that there should be tools at the practice level, such as building it into the diabetes coordinators package. The evidence was not strong for sustained weight reduction just due to diet and exercise. The weight management guidelines were very practical and were aimed for use by GPs with a strategy to distribute these through PHOs and then wider.</p> <p>The Long Term Conditions Management approach was about self management and was not disease focused for which the guidelines were appropriate and had been established. The contents of vending machines had been limited to a calorific value and Subway had reduced some products on taking the lease at the hospital, although there is still debate with Muffin Break. It was noted that the new Director General was focused on population health, smoking, alcohol, public health and food policy.</p>
6.1	Planning and Funding Summary Report
	<p>The Annual Plan had been submitted but nothing had yet been heard back from the MoH. Work was continuing to make the document more usable in the organisation with this 70% - 80% completed as well as checking its consistency with the Northern Region's Health Plan. There had been favourable feedback on the Northern Region's Health Plan. There was also further work on the primary care side with the primary care structure being very complex and confused.</p> <p>The PHO Retreat looked at ways to work better together with agreement to focus on things tangible and specific i.e. to manage and reduce acute demand.</p> <p>Maori Service Development</p> <p>Bernard Te Paa, General Manager Maori Health, Counties Manukau was in attendance advising that the project had two key deliverables being the devolvement of certain contracts held with Waitemata and Counties Manukau and development of a framework for discussion to devolve other services. Youth, Drug and Alcohol Services had been devolved and while Well Child from Waitemata was being devolved the MoH may take that back to the centre. Counties Manukau smoke free programme had been devolved to a Maori provider and while it had been intended to devolve suicide prevention this was due to end in 2012 so was not being devolved.</p> <p>The development of the framework had not progressed well with a limit on resources, both at project manager level and Bernard Te Paa's own resources. The project manager engaged had been involved with two devolution projects as well as Midland Mental Health Services devolution to Maori providers and would initially do a literature review. While the literary review would be on target the framework development needed more resources and a plan of action would be developed with the project manager discussing this with each DHB which would take a 2 - 3 months process.</p> <p>Well Child was funded by the MoH but there was difficulty in unbundling that particular funding. It was a service provided direct through the main provider, Plunket.</p> <p>If the framework was not developed the possibilities were for individual DHBs to do their own framework, not have devolution through this process or go back to the business cases to have the</p>

	<p>regional collaborative undertake, although this would be the most difficult.</p> <p>It was noted that this was one of the priorities in the business cases and that Counties Manukau appeared to be reprioritising by taking away resources. The CEO and Chief Planning and Funding Officer were to discuss this regionally to get the resources and a plan, to be signed off by the regional DHB CEOs.</p>
6.2	Planning and Funding Indicators Exception Report
	<p>Diabetes Annual Check had Maori and Pacific close to target with Others below however for management by Get Checked patients Maori and Pacific were below target. There was a focus on self management programmes. Diabetic Retinal Screening was below target with an interim service and getting the optometrist network set up was taking longer. Cardiovascular screening was on target. Percentage of two year olds Immunised was having the data reviewed and tidy up and there was confidence in getting to target. It was noted that courtesy letters had been sent to NIR parents noted as having declined immunisation with approximately 50% of those that responded being a genuine decline and the others were being followed up to be immunised. There was a suggestion of linking records i.e. to the maternity record and using social networks.</p> <p>For children enrolled with PHOs there was audits being done at practice level on ethnicity recording and declaration which showed discrepancies.</p>
6.3	National Targets
	The National Health Targets reports were noted.
7.1	DAP Projects Report
	While Skin Lesions was shown as an exception there was confidence that the target would be met.
8	Maori Health Advisory Committee
	There had been discussion on the context in which the Committee operated with a view to get more “how” rather than “what” and improve performance indicators. The terms of reference of the Committee were work in progress.
9.1	Social Sector Engagement
	Tony O’Connor Engagement and Planning Manager, ADHB was in attendance. The Social Sector Group was 13 agencies mostly set up for sharing information but now moving to doing something and for Health this was immunisation and the homeless. There were links to Ministry of Social Development Link offices and to the Auckland City on their planning. Local Boards fitted with the localities approach i.e., the Tamaki/Panmure link to the Tamaki Transformation Project. The Spatial Plan was also being developed which would be important for health localities. The Committee supported strengthening of the regional approach and encouraging Local Board members to be involved as health links to their Board.

9.2	<p>Consumer and Community Engagement Framework</p>
	<p>The proposal had three elements being the establishment of a Consumer Council, an on-line community and trained consumer representatives. An RFP had been issued for the on-line portal with Buzz Channel selected. It was proposed to enrol people on discharge as well as promote it in the community. Costs would be \$4,000 per month to administer with a set up fee of \$20,000. The value to the organisation of the Consumer Council was queried although taking the three fold framework was to make it as wide as possible. It was thought that a Consumer Council would not have a level of independence and Waitemata had used "Health Links".</p> <p><u>Moved Lee Mathias; seconded Lester Levy</u></p> <p><i>That the Committee supports the development of the on-line community and the investigation of "Health Links".</i></p> <p><u>Carried</u></p> <p>The Committee did not support the Consumer Council establishment.</p>
10.2	<p>Tender for Assisted Reproduction Services</p>
	<p>Ruth Bijl was in attendance.</p> <p>Waitemata as the lead DHB for the contract with a new provider in the market. It was suggested that there should be a set price and that a specification be done, including training, and the contract let to the market.</p> <p><u>Moved Lee Mathias; seconded Robyn Northey</u></p> <p><i>That the Committee recommends that there be consideration of a value based contract, which would include all available certified providers working with transparency, to be let to the market and that unintended consequences be explored.</i></p> <p><u>Carried</u></p>
10.1	<p>MoH Devolution of Interim Funding Pool</p>
	<p>The report was received noting that any issues with risk sharing would be escalated to the regional level.</p>
11.1	<p>Action Points for next CPHAC Meeting</p>
	<p>Action points for the next CPHAC meeting were the Child paper, contracting to the Finance Committee, the on-line strategy and the a report back on the Assisted Reproduction RFP process.</p>
12	<p>GENERAL BUSINESS</p>
	<p>Committee Structure</p> <p>The Board Chair outlined the proposal for a collaborative CPHAC Committee of ADHB and WDHB. Ministerial permission has been given for joint CPHACs, DSACs and Maori Health Committees noting three joint appointments to the two Boards. The membership would consist of a Chair (ADHB), Deputy Chair (WDHB), Ex Officio the Board Chairman and representing both Boards a joint Board member with the other membership to be for elected members from ADHB and four elected members from WDHB. There could be external appointments up to three on the recommendation of the Chair and Deputy Chair. It was also proposed to move to a six-weekly meeting cycle.</p> <p>ED Targets</p> <p>The Committee was advised that the AED would meet the six hour target.</p>

	NEXT MEETING
	The meeting closed at 4:50 pm The next scheduled meeting is for 2:00pm, Wednesday, 18 May 2011 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Epsom
CONFIRMED CHAIR: DATE:	

ACTION POINTS

- **WEDNESDAY 20 APRIL 2011**

**Community and Public Health Advisory Committee
Action Points from the meeting on Wednesday 20 April 2011**

Item	Detail	Designated	Action
Carried forward	A paper on strategies for children to be provided	Denis Jury	May
Carried forward	The Committee is to be kept informed on smoking cessation funding	Denis Jury	

PLANNING AND FUNDING PERFORMANCE

6.1 Planning and Funding Summary Report

**6.2 Planning and Funding Indicators List and Exception
Report**

6.3 National Targets

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Planning and Funding Functional Group

Summary Report

1. Lifting the Health of people in Auckland City

Planning

The Annual Plan for 2011-12 was submitted to the National Health Board for their review in March. Formal NHB feedback was received on 29 April. The Board will be reconstituted following the CPAC meeting on 18 May to consider the responses to NHB feedback and to approve submission of the plan to the NHB on 20 May.

Child, Youth and Women's Health

Immunisation

Provisional data as at 3 May shows 89% coverage of 2 year olds fully immunised for all ethnicities (Maori 83%, Pacific 89%, NZE 88%, Asian 93% and Other 86%). This reflects an increase in Maori coverage of 8% since February.

B4 School Check programme

This programme was transitioned to a primary care service delivery model from 1 January 2011 managed through a Service Alliance Agreement. Although it had been expected that performance would drop in the initial period following the transition, performance data for the last quarter indicate a much poorer performance than expected. As at 6 April the Alliance had achieved 40% against target for high needs children and 47% against target for all eligible children. The expected level of achievement was 75%.

There are a number of reasons for this poor performance including; training of practice nurses (over 200) was not completed until the end of February; unfamiliarity with the B4SC data system; more than expected practices not having a secure IS link resulting in data having to be manually entered; the need for further training of key operational staff. Overall this was a new programme for primary care who not only had to become familiar with it and train staff but also had to establish systems to support the programme. This has all taken longer than expected.

Performance data for April showed little improvement and as a consequence the Service Alliance Leadership Team (SALT) has agreed a plan of action to address identified performance issues. This includes increased training and coaching for key staff, closer monitoring by the SALT and a focus on large practices with significant numbers of enrolled children.

Primary Care

Consultation on the merger of ADHB and WDHB primary care teams was undertaken in April. Six formal responses were received as well as a number of informal conversations informing the final decision. The feedback was mainly supportive and constructive and has been summarised in a document that has been circulated to both teams. There are no changes to the proposed structure and it was implemented on May 2. Further work will occur over the next 6 months to work through the operational detail required and weekly progress reports will continue to ADHB & WDHB.

Implementation of Governments BSMC Primary Care Strategy:

Regional Progress to Date:

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

Business Cases

Active involvement continues to support the three Business Cases. Alliance Health + and the National Hauora Coalition have both raised the issues of resources and DHB support which is being worked through by the BFG. Issues around the GAIHN governance to a five of DAP projects still needs to be clarified and worked through to be appropriately reflected in new contracts and governance models.

Progress with PHO Consolidation

When BSMC was released during October 2009 there were 19 PHOs across Metro Auckland. By the close of quarter three there were 13 PHOs, a reduction of six PHOs (32%). Total Healthcare Otara submitted a single patient register with Te Hononga for the final quarter of 2010/11 with a view to become part of the National Hauora Coalition, a national PHO as at 1 July 2011. By 1 July 2011 the Metro Auckland region will have reduced its PHOs by over two thirds to six PHOs.

PHO	Merge Date	Previous PHO	Host DHB	Partner DHB
Te Hononga	01.10.10	<ul style="list-style-type: none"> •Te Kupenga o Hoturoa •Tamaki PHO 	ADHB	CMDHB
Alliance Health+ (AH+)	01.01.11	<ul style="list-style-type: none"> •Ta Pasefika •AuckPac •Tongan Health Society 	CMDHB	ADHB
ProCare Networks	01.01.11	<ul style="list-style-type: none"> •ProCare Network Manukau •ProCare Network Auckland •ProCare Network North 	ADHB	CMDHB WDHB
Waitemata PHO	01.07.11	<ul style="list-style-type: none"> •Coast to Coast •Harbour Health •Waioira Healthcare 	WDHB	N/a
Unknown at this stage	01.07.11	<ul style="list-style-type: none"> • Mangere Community Health Trust 	n/a	n/a
Te Hononga	01.04.11	<ul style="list-style-type: none"> •Total Healthcare Otara 	ADHB	CMDHB
National Hauora Coalition	01.07.11	<ul style="list-style-type: none"> •Te Hononga •North Waikato •Total Healthcare Otara 	CMDHB	ADHB WDHB

ADHB Specific Progress to Date

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

Progress with the ADHB PHO Alliance

The third of the 'fast five' workshops occurred in April with the 4 ADHB PHOs facilitated by an 'Alliance' expert to support the development of a District Alliance to operationalise for the ADHB population the BSMC Strategy as described by the

ADHB Primary Care Plan 2008 – 2020. This work was positively featured in NZ Doctor magazine article on 23 March. With the merger of ADHB and WDHB primary care teams now confirmed the newly formed Waitemata PHO will join the group from 1 July 2011.

This workshop focused on Primary Mental Health and whether there was potential for alliancing a review of the existing contract. Issues with the current contract for all parties as well as service gaps and opportunities were discussed. It was agreed that a further piece of work would be explored around the severe to moderate mental health care delivery in primary care as part of a research/pilot project.

Progress with the Locality Planning

Model development is continues and discussions are taking place with Waitamata DHB regarding the adoption of a joint approach to Localities Management. It is planned to bring a positions paper to the first combined ADHB and WDHB CPHAC.

Health Needs Assessment for Maungakiekie Tamaki is underway. Guided interviews with health and other professionals working in the locality are being undertaken. Negotiations with Ka Mau Te Wero for DHB questions to be included in the planned Random Household Survey are underway.

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

Access to Diagnostics-Radiology

By 20 March, 113 general practices across ADHB and 3 in CMDHB (who are trialling the ADHB version) have the ProExtra Radiology tool installed.

The continued focus across ADHB to encourage GPs to use ProExtra Radiology; of those not using it the rate of inappropriate referrals to ADHB Radiology is around 35% of total GP referrals, which is creating waste in the system and causing patients to experience unnecessary waiting times. Two of the ADHB GP Liaisons are manually triaging all GP referrals on 'old forms' and sending a rejection letter to the respective referring GPs. This peer review process is resulting in GPs increased use of ProExtra Radiology.

After six months use, the review of the clinical triage criteria is almost complete and forwarded to the regional radiology forum for endorsement.

CMDHB has elected to rollout ProExtra across 100 of its practices and the customisation of ProExtra to achieve this is near completed.

Minor Surgery - Skin Lesions

Contracts are in place with 16 GPs in 20 sites across metro Auckland. This project is now proceeding to plan and while previously the sponsors were reporting that the target would be met, it is now thought the current gap of 370 will not be achieved in 3 months. The programme is supported with;

- Actively advertising to GPs
- Increase DHB assessments and referrals to contracted providers
- Supporting contracted providers to deliver increased volumes

Regional Clinical Pathways

The Dyspepsia and Iron Deficiency Anaemia (IDA) pathways have been signed off and are now being utilised. The pathways are accessible to primary and secondary care via Health Point. Progress continues on the other clinical pathways and the

Annual Plan target of having five pathways fully developed and implementable by the end of June is on track to be achieved.

As previously reported, it is unlikely to meet 30% reduction in FSA for dyspepsia, but should achieve 20% across all five pathways.

Acute Demand / POAC

This project is tracking to plan and the target will be met.

After Hours

Sector feedback from the RFP Consultation phase asked for an extension of deadline. A one week extension was granted, and subsequently detailed response was received. This questions the need for an RFP process and a number of points about the proposed service. This is currently being considered by the DHBs.

Pharmaceuticals CMDHB & ADHB Project

During April GP cell groups focussed on medication for pain management relating to osteoarthritis, neuropathic pain, migraine and the use of prophylaxis regimes. Work continues looking at cardiovascular prescribing and antidepressant medicines and overall the initiative is progressing well. It is apparent that prescribing is being optimised, but the financial impact is still to be agreed.

Maori Service Development

As previously reported these projects have progressed more slowly than planned. However, the devolution of the smoke free contract (CMDHB) and CAYAD contract (WDHB) have been completed. The Well Child contract at WDHB is on hold waiting MoH decision.

Draft devolution framework due to CMDHB by mid-May.

Health Targets

The regional immunisation and diabetes detection targets will be met, but it is unlikely that diabetes management and immunisation targets will be met. ADHB has focussed immunisation initiatives at practice level and is confident that its 90% target will be met.

Initiative		Regional Volumes		Target to end June 2011
		April	YTD	
Acute Demand / POAC		1,318	13,152	15,000 cases Tracking to plan, (risks noted above)
Access to Diagnostics	DAP Target 1 <i>Measures elective plain x-ray and ultrasound referrals by GPs for diagnostic radiology to Non DHB Providers (N.B. GP's cannot refer CT Scans and MRI to Private Radiology Providers)</i>	77 (March data)	1206	4,500 With CMDHB rollout commencing from March 2011, and acceptance by Ministry of Health that WDHB manual triage of all GP radiology referrals can be included, has enabled regional volumes to be added to the previous ADHB only volumes

Initiative		Regional Volumes		Target to end June 2011
		April	YTD	
	DAP Target 2 <i>Measures elective referrals by GPs to DHB Radiology Services for diagnostic radiology</i>	3,106 (referred via Clinical Triage Criteria) (March data)	20,344 ** requires during Mar/Apr a significant data audit was undertaken to clean the data	16,000+ With CMDHB rollout commencing from March 2011, and acceptance by Ministry of Health that WDHB manual triage of all GP radiology referrals can be included, has enabled regional volumes to be added to the previous ADHB only volumes
	Skin Lesions	55 (March data)	531 to Mar 11	1,200 community based skin lesion procedures over 2010/11. Now a risk that target will not be achieved. Volumes of procedures to date are up to 30 March for WDHB & CMDHB. As the volumes are only processed through invoice generation there is a delay on the reporting of volumes.
	Regional Clinical Pathways	On track with the noted variance in the target for FSA reduction in Dyspepsia.		
	After Hours	Not tracking to plan (risks as noted previously)		
	Pharmaceuticals CMDHB & ADHB Project	Tracking to plan (risks as noted previously)		
	Maori Service Development	Not tracking to plan. The original 31.12.10 targets are unlikely to be met due to the complexity and volume of work involved. Three regional leads are managing the process collectively. (risks noted separately)		
	Health Targets.	Data for the month of February 2011 <ul style="list-style-type: none"> •88% Immunisation – target 90% •76% Diabetes Detection (Get Checked) – target 55% •65% Diabetes Management – target 70% •80% CVD Risk Assessment – target 80% 		

Overview of Primary Care Business Cases

National Hauora Coalition

The six DHBs involved in the National Hauora Coalition (NHC) continue to meet (teleconference) on a weekly basis to ensure that a PHO agreement will be available

for signing in May – as requested by the NHC. Much activity has revolved around the most appropriate register submission model to adopt to ensure that each DHB pays their fair share of capitation based funding in the most practical and efficient manner.

NHC have been clear that they do not have the infrastructure required to sustain a 'virtual PHO' or 'network' model with separate DHB enrolment registers which is the current Midland Network model. The intent is that the NHC will save on management fees by economies of scale and redirect funding to service delivery.

A decision has been made to pursue the single PHO enrolment model in the interim at least, with some details to still be worked through by the DHBs. This will however impact on DHB resources, particularly CMDHB as Host DHB.

CMDHB is also working closely with NHC in developing a package of template documents and agreements required by PHO members to successfully merge, including template back to back agreements, exit letter and unspent funds, SLA and Alliance charters etc.

NHC has also proposed a framework whereby devolution of Maori funding and contracts would be ceded to NHC as the agent for DHBs to subcontract as appropriate. This paper is under consideration by BFG (Auckland Metro Better Sooner More Convenient Funding Group) and will need considerable modification to fit within the legal framework for DHBs.

Alliance Health +

Consolidation of three Pacific PHOs into one Regional Pacific led and governed PHO has already occurred.

Alliance Health+ plans the development of three IFHCs located at Mt Wellington, Mangere and Onehunga.

Mt Wellington IFHC is on track to be completed by June 2011.

Onehunga IFHC has recently received confirmation from Auckland Council of its resource consent, and currently is commencing design and determining service priorities. Completion is expected by December 2011.

The Bader Drive /Mangere family Doctors IFHC network is expected to have completed their stock-take of services between the two organisations and initiated the development of a strategic and operational framework by year end.

To enhance Primary Health Care Services, AH+ is working up the development of Navigator roles and systems commencing from May 2011. AH+ are also using the whanau ora developments i.e. vertical integration processes to enhance primary health care service delivery.

GAIHN

ALT has taken the decision to refocus GAIHN on a single goal for 2011/12. The focus is "Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions".

A paper identifying a programme of initiatives aimed at achieving this goal has been considered and approved in principle by ALT. This is to be finally agreed at the May 24 ALT meeting. The DHB Annual Plans are currently being updated to reflect this.

Key Activity for Planned for May

- Signing of new documentation including ALT workshop agreement and formal alliancing agreements. This will allow for the creation of the Flexible Funding Pool (FFP) amongst other things

- Establishment of project leadership for the 2011/12 initiatives where none currently exists.
- Reconfiguration of the Clinical Activity Teams (CAT's) into project teams that will focus on delivery of initiatives for 11/12.

2. Performance Improvement

Suspension of pharmacist

A pharmacist that has premises in ADHB and CMDHB and operates in WDHB through rest homes is undergoing a second threat of suspension. Investigations have been ongoing since November by Medicines Control and have been closely monitored by ADHB and shared regionally. Despite repeated opportunities to remedy the issues raised, the pharmacy has not satisfactorily done so. ADHB have decided to cancel the pharmacists monitored therapies contract for fears of patient safety and a number of other contracts which are not being executed according to protocol. Work has been underway with the Ministry and team leader for community mental health to identify affected patients so they can be transferred to an alternate provider before the license is terminated so as not to disrupt their supply.

Oral Health - Otahuhu (3 Chair Clinic)

The clinic has started seeing patients. The opening of the clinic was held on Wednesday 13 April. Margie Apa, Deputy Director General, attended to officially open the clinic. There was a good turnout from the school, Construction Company, MoH representatives, ARDS staff and ADHB.

Interim Funding Pool (IFP)

Work has continued with the risk share arrangement and this will be considered at RFF in early May. ADHB's position is that the financial risk must be shared across the region and if not agreed will elevate to CEOs to resolve as a regional issue. Planning for service devolution is well advanced.

Mental Health - Secure Rehabilitation

A full options analysis paper has been presented. This includes a reasonably detailed financial analysis for capital development. Options for operational funding are being considered. Initial indications are that a new ten bed unit will cost around \$4m to build.

Mental Health of Older People

We have completed the review of all independent placements for older people so that we better understand the feasibility of publishing an RFP and establishing an older people's rehabilitation and longer term stay mental health service.

3. Live Within Our Means

Month's Funding Issues

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

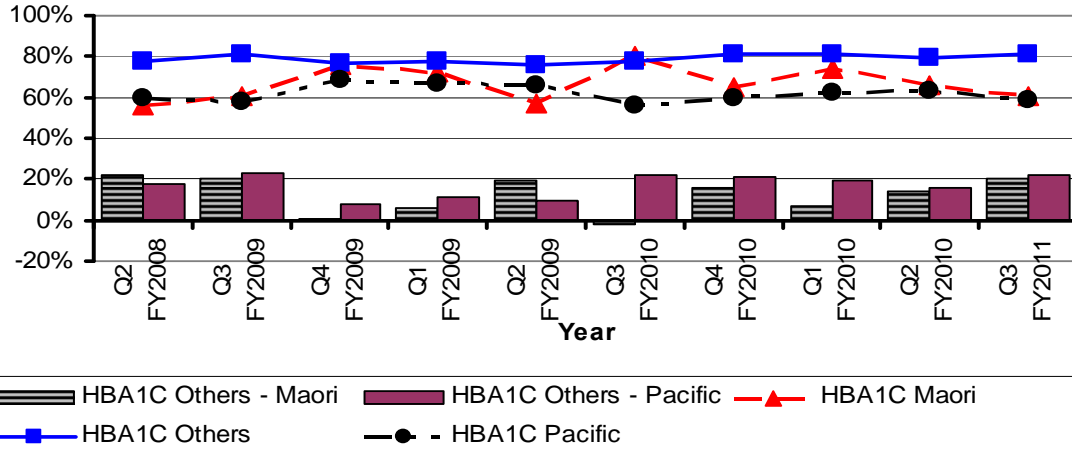
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April 2011

Exceptions this month

L20 - A downward movement has been observed. This movement is being monitored. However, April 11 data suggests a marked improvement for Maori. A report on Diabetes Management has been requested by the board and will be presented there in an upcoming meeting.

L20. (MOH-06) Get Checked Patients with an HbA1c<8



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Project: Diabetes

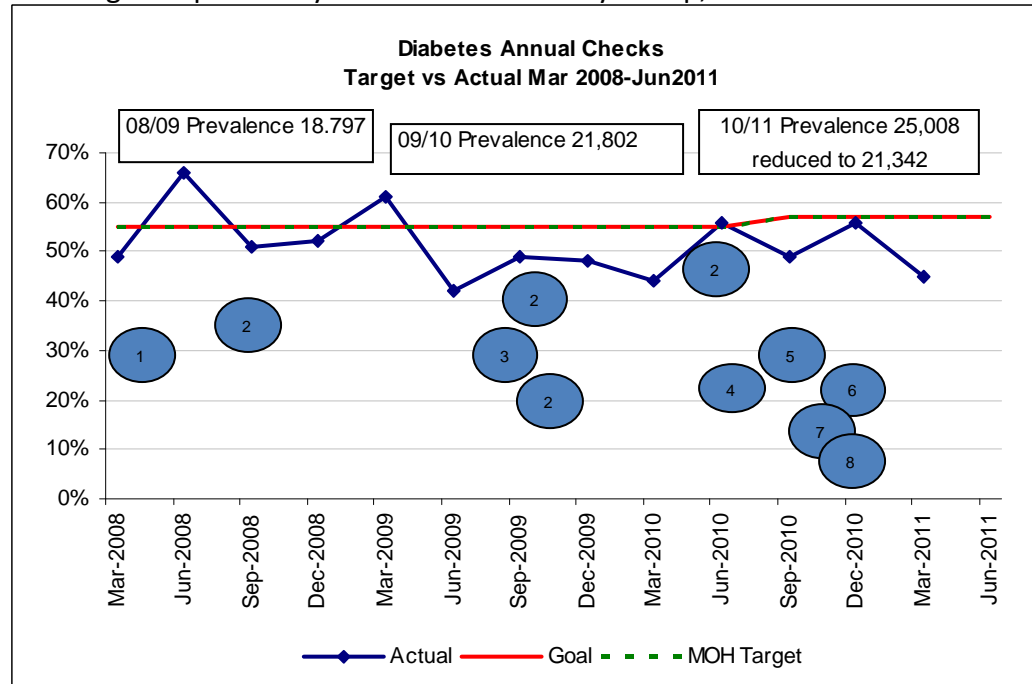
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

Date of Delivery: 55% June 2011

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

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

**Recent and Current activities:**

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

Project Risks / Comments:

Q3 activity shows we have dipped significantly below target to 45% for the quarter, which was due to the low number of diabetes annual reviews during the holiday period (January). The number of reviews for Pacific and Indian populations continues to perform above target but activity for "Other" is significantly underperforming this quarter (35%). In order to improve performance, the DHB is working with primary care to implement a comprehensive range of activities to improve DGC numbers and initiate an overall quality improvement framework. The contract for the long term condition quality improvement coordinators is underway with the coordinators starting work with priority practices to improve Diabetes Annual Check numbers. Performance against this target is also being raised with the PHO CEO's and Primary Care Clinical Advisory Group this month, and we are working with our largest PHO (where most of the underperformance lies) to devise and implement strategies, in addition to those we have put in place, to improve performance for the remaining quarter of this year.

[Note: Q2 data has been updated to reflect actual activity from Tongan Health Society – this was estimated in last quarter's report, changing Q2 performance from 57% to 56%]

Project: Diabetes

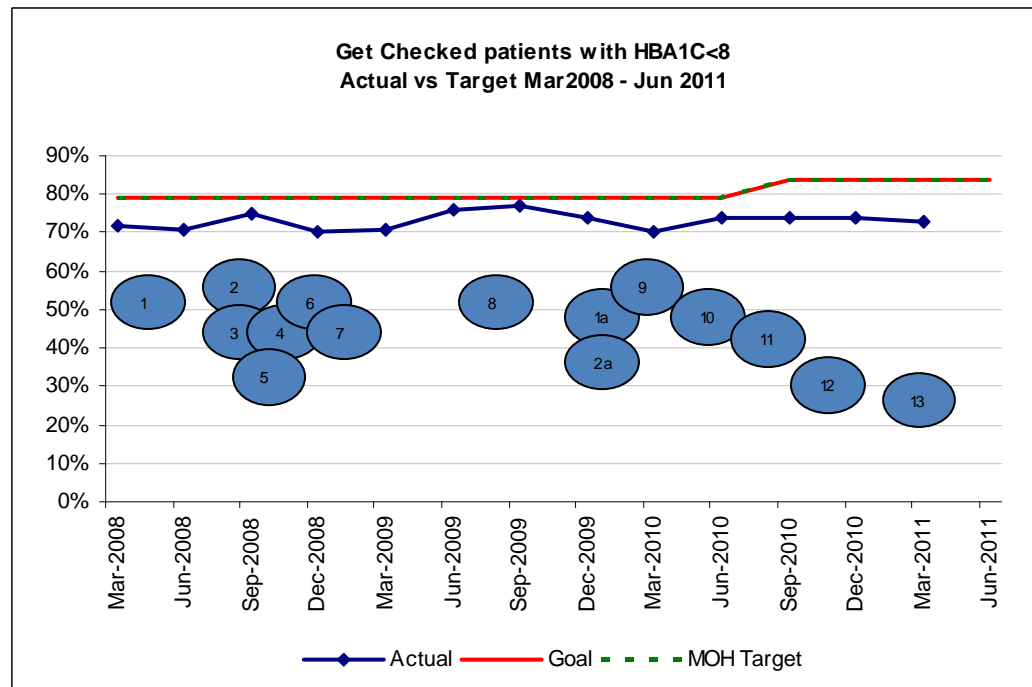
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

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

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

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



Recent and Current activities:

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

Project Risks / Comments:

Q3 performance continues in the same trend as in the previous two quarters, achieving 73% against a target of 84% of people having an HbA1C $<$ 8. The target for Other has been achieved (83%) however the target for both Maori and Pacific has not been met (61% and 59% respectively). The long term condition quality improvement coordinators will be working with practices to improve this target as part of their overall approach. The contract for Diabetes Self Management Education services has started, with four courses (of 4 sessions each) being run in February and March. This contract delivers to all of ADHB and aims to ensure accessibility (in terms of access and cultural competency) to our high needs populations. Additionally a generic self management course for long term conditions (based on the Stanford model) is being implemented for our Pacific populations through the HVAZ framework, with the first courses due to start this month.

[Note: Q2 data has been updated to reflect actual activity from Tongan Health Society – this was estimated in last quarter's report, changing Q2 performance from 73% to 74%]

Project: Cardiovascular Risk Assessment

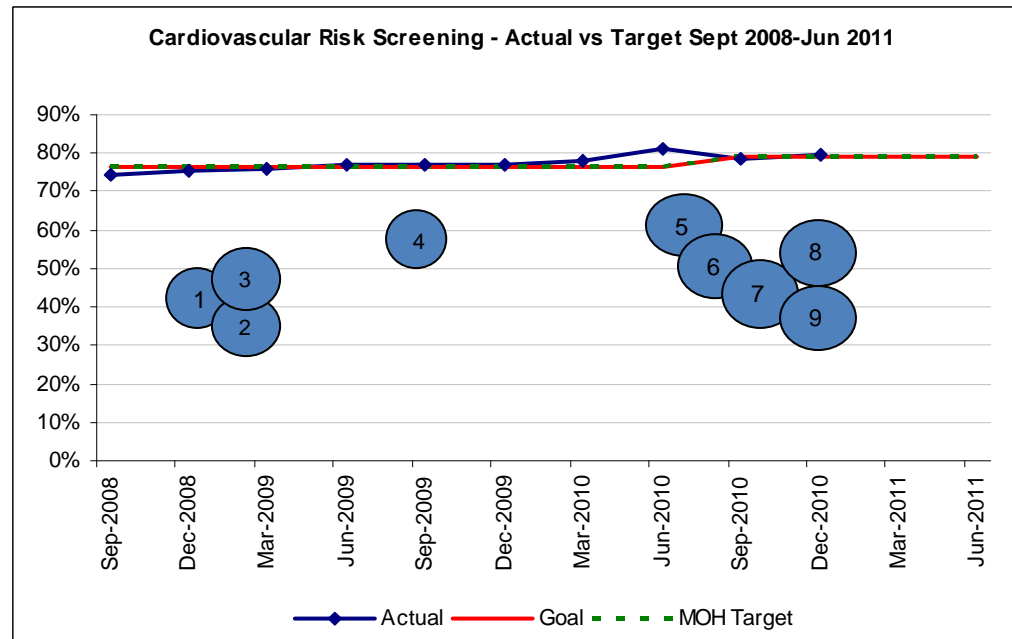
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

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

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team



Recent and Current activities:

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

Project Risks / Comments:

The Q3 CVD data from the MOH shows a small but steady improvement on this target with an increase of 0.5% from the last quarter, giving us a 79.9% performance against a target of 79%. Individual targets for each ethnicity have also been met.

We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract, which we will be reviewing in the coming months to ensure that incentives are properly aligned.

Project: Increased Immunisation

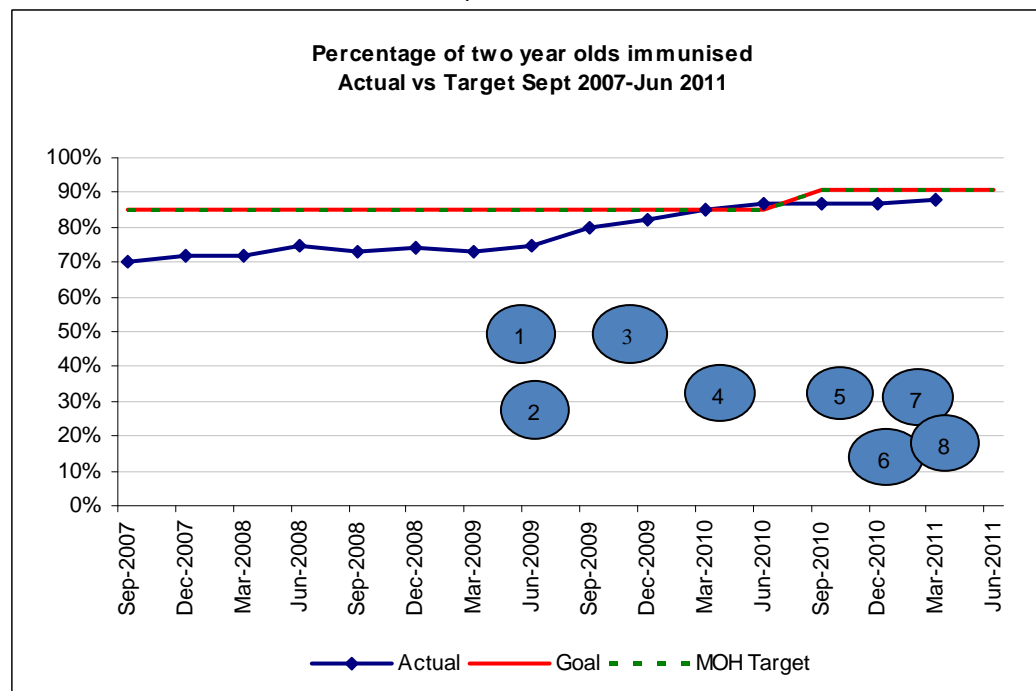
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

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

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

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

**Current activities**

1. Practice level reporting available
2. Primary care Immunisation Co-ordinators funded - ongoing
3. ADHB Immunisation Strategy approved
4. Funding application made to Starship Foundation to fund social marketing programme
5. Data cleansing project in primary care approved and funded
6. Scoping project for multi-agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices begins with final results expected by June 2011.
8. Letters sent to all parents who are noted on the NIR as having declined immunisation for their child to check that this is correct.

Project Risks / Comments:

Coverage for Quarter 3, 2010/11 (2 years olds full immunised all ethnicities) is 88% (regional target 90%, ADHB target 91%). Maori coverage at 18 months increased by 4% in February. The data quality and practice nurse education project targeting systems issues is well underway with so far 2426 missing doses entered manually on the NIR including 214 children who will turn 2 in the next 3 months. In addition, all children turning 2 in the next 3 months who are currently overdue for a scheduled immunisation are being automatically referred to the Outreach Service for follow up and as of 1 April 63 children had been referred. 'Courtesy' letters to check 'decline' status on the NIR have been sent 554 parents to check that they had intended to decline immunisation. Of 95 responses received so far 31% did not intend to decline immunisation and these children will be followed up. Together, it is expected that these initiatives will result in at least a 2-3% increase in coverage by 30 June 2011.

IMPROVEMENT ACTIVITIES

7.1 DAP Projects Report

Group Pack Report

Group/Committee: Community and Public Health Advisory Committees



Goal Level Summary

DAP Projects - total projects: 26

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	19	19	4	3	2	7	2	0	15	2	1	18	0	0	18	0	0	1	1	0	0
2 Performance improvement	7	7	0	1	0	6	0	0	5	2	0	7	0	0	4	3	0	0	0	0	0
3 Live within our means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	26	26	4	4	2	13	2	0	20	4	1	25	0	0	22	3	0	1	1	0	0
Total %	100%	100%	15%	15%	8%	50%	8%	0%	77%	15%	4%	96%	0%	0%	85%	12%	0%	4%	4%	0%	0%

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

High Level Summary - total projects: 19




High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Define	Plan Measure	Analyse	Do/Check Improve	Act Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
1.1 Reduce inequalities in health status	7	7	3	1	0	3	0	0	6	1	0	7	0	0	7	0	0	0	0	0	0
1.2a Improve outcomes for children and young people	2	2	0	1	0	0	1	0	2	0	0	2	0	0	2	0	0	0	0	0	0
1.2b Improve outcomes for older people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2c Improve outcomes for mental health and addictions	3	3	0	0	0	2	0	0	2	0	0	2	0	0	2	0	0	1	1	0	0
1.2d Improve outcomes for long term conditions	5	5	1	1	1	2	0	0	3	1	1	5	0	0	5	0	0	0	0	0	0
1.2e Improve outcomes for Palliative care	2	2	0	0	1	0	1	0	2	0	0	2	0	0	2	0	0	0	0	0	0
Total #	19	19	4	3	2	7	2	0	15	2	1	18	0	0	18	0	0	1	1	0	0
Total %	100%	100%	21%	16%	11%	37%	11%	0%	79%	11%	5%	95%	0%	0%	95%	0%	0%	5%	5%	0%	0%







Objectives

Objective	Objective Owner	Comment
1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	Aroha Haggie (ADHB)	Projects under this objective are progressing as expected. Significant support is being provided to these activities especially in the BSMC space to support the implementation of whanau ora and activities focused on reducing inequalities. Whanau Ora Outcomes Framework - We are experiencing some delays in the development of outcomes for the framework however we are seeking to align DHB:MAPO outcomes with those recently development in the primary care and BSMC business case space.
1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	Hilda Faasalele (ADHB)	HVAZ work and evaluation with Pacific churches/communities continues. PHO Parish Community Nurses and health workers have agreed on Action Plan and who holds primary responsibility for each objective. Activities/objectives related to Health targets. Pacific Nurse SME Co-ordinator has started within HVAZ and is engaging with key churches to begin programme with samoan speaking churches. Strong interest following successful implementation at CMDHB. Community Leaders meeting held with good support and interest for ongoing health initiatives. Pacific Best Practice education session delivered to CYFS/ADHB Liaison programme for senior staff across ADHB. Awaiting evaluation and reports from combined workshops held with Le Va. ADHB Pasefika Week commences March 7th - ADHB services, external agencies and Pacific providers/NGO's to profile their services.
1.1.3 Increase access to services for culturally and linguistically diverse populations	Denis Jury (ADHB)	Increased utilisation of online cultural competency training modules and interpreters by both primary and secondary care has continued over the last month.
1.1.4 Support disabled people and improve their	Denis Jury (ADHB)	Disability Responsiveness Audit recommendations currently being reviewed and prioritised and paper to SLT planned for June / July. Regional work underway to manage devolment of the IFP by July 2011, and issues of regional processes and risk sharing to be considered by RFF in May.

access to health care and support services		
1.2a.1 Achieve immunisation targets	Denis Jury (ADHB)	Immunisation rates are now 88% and focus continues on the data improvement project and the follow up training for practice nurses. The rate for Maori is now 81%, an increase of 6% over the last two months.
1.2a.2 Improve the oral health of children	Denis Jury (ADHB)	Construction of clinics and service development continues according to plan -the Otahuhu clinic was opened in mid-April.
1.2b.1 Home-based support services and restorative homecare initiatives	Denis Jury (ADHB)	Casemix work, and particularly that related to high and complex needs client on tract to meet deadline of 31 May.
1.2b.2 Quality improvement in residential care	Denis Jury (ADHB)	Development of the process for introduction of the EDEN programme continues with support of the relevant providers. Number of complaints decreased compared to last financial year.
1.2c.1 Increase effectiveness across primary, secondary, tertiary services for mental health and addictions	Denis Jury (ADHB)	Satisfactory progress with all projects.
1.2d.1 Strengthen community participation and action for long term conditions	Denis Jury (ADHB)	280 clients now enrolled with the community breast feeding service over the last quarter. Coordinator employed and Plunket and Ngati Whatua working in partnership.
1.2d.2 Integration of services across primary and secondary care for long term conditions	Andrew Coe (ADHB)	BSMC DAP targets for for clinical pathways are progressing satisfactorily. Regional work continues on the establishment of an Auckland Region diabetes network.
1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	Andrew Coe (ADHB)	The interim retinal screening community provider continues to work throuh patients on the wait list, and all new referrals are now seen within the screening guideline requirements.
1.2d.4 Support whanau and self resilience for long term conditions	Aroha Haggie (ADHB)	The Diabetes Self Management Education service is establish. Te Hononga O Tamaki Me Hoturoa was awarded the contract at competitive tender. Two training courses are underway with more planned over the six months. The wider communication and raising awareness about the service has commenced. The diabetes self management project progressing as expected.
1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	Andrew Coe (ADHB)	All projects progressing well, with clients in the primary care programme now at the planned levels and implementation of Liverpool pathway ahead of schedule.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Develop Care Pathways for people with Long Term	National	Define				The original pathways have been incorporated into the BSMC plan and the Diabetes pathway is included in the regional health plan. The 5 pathways under development will meet the DAP target.

Conditions						
Increase access and capacity to community diabetic eye screening	National	Analyse				Loads of activity happening. Good progress on volumes etc. ,Need to keep aware of the timelines and the implications of them being delayed. It is good to see that MCHT are working through the assigned volumes and that this has relieved some of the pressure in the GCC retinal service.
Māori Service Development	Regional	Define				Merger activity to date has been complex and time consuming. Progress has been made although slow. A project framework is under consideration. Additional activity is planned to ensure the project gets back on track.

Legend: Red - , Orange - , Green - 

57

Goal: 2 Performance improvement

High Level Summary - total projects: 7

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

Objectives

Objective	Objective Owner	Comment
2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	Andrew Coe (ADHB)	ADHB continues participation at national, regional and local level regarding primary care planning and implementation. The PHOs in GAIHN responded to the consultation process regarding the proposed RFP for after hours services questioned various aspects of the proposal and particularly the need for an RFP. Alternative approaches to deliver this project to the timeline are currently being considered.
2.1b.1 Improve access and efficiency of service delivery for primary–secondary system	Andrew Coe (ADHB)	Overall projects are progressing well and while there have been time delays most of the targets will be met; this does require constant attention though to ensure delivery. As noted previously there are issues regarding the RFP for after hours and calculation of the savings from the pharmaceutical utilisation project.
2.1b.2 Reduce acute demand	Andrew Coe (ADHB)	Development of the extended POAC services continue, but the RFP approach will be designed following completion of the after hours project.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Pharmaceuticals	Regional	Measure				Original benefits identified may not be delivered although work is underway to forecast benefits likely for the end of the financial



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

PAPERS

- 9.1 Child and Youth Health in ADHB**
- 9.2 Tender for Assisted Reproduction Services –
Fertility Services**

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Community and Public Health Advisory Committee Paper

Date	18 May 2011
To	Community and Public Health Advisory Committee (CPHAC)
From	<p>Dr Denis Jury Chief Planning and Funding Officer Greenlane Clinical Centre, Building 13, Level 8 Phone: (09) 630 9943 ext 8071 DenisJ@adhb.govt.nz</p> <p>Dr Richard Aickin Director of Child Health Auckland City Hospital, Level 5 Admin Suite, Building 32 Phone: 021884636 RichardA@adhb.govt.nz</p>
Author	<p>Carol Stott, Strategy and Planning Manager, Child Youth and Women</p> <p>Ruth Bijl, Associate Strategy and Planning Manager, Child, Youth and Women</p> <p>Dr Alison Leversha, Community Paediatrician</p>
Functional Group	Planning and Funding Functional Group
Subject	Child and Youth Health in ADHB
1	<p>Purpose</p> <p>This paper provides the Committee with an opportunity to discuss child health issues, consider future strategies and have formative input to the shape of the Child Health Plan 2012 – 2017.</p>
2	<p>Recommendations</p> <p>It is recommended that CPHAC:</p> <ol style="list-style-type: none"> 1. Note the contextual and health status information for children and youth in ADHB. 2. Endorse and shape the proposed approach for development of a new Child Health Plan 2012 – 2017 for the Child (and Youth) Healthcare Service Group. 3. Endorse the proposed approach for implementation of the ADHB Youth Health Improvement Plan.
3	<p>Context – opportunities and challenges</p> <p>The new ADHB Child Health Plan (CHP) needs to align with Better, Sooner, More Convenient (BSMC) business case planning and with the Northern Region's Health Plan. The current planning environment creates opportunities to find whole of system solutions to lift the health of children and young people in Auckland. The Child (and Youth) Healthcare Service Group (HSG) is actively working towards more effective regional working and alignment with primary care, particularly through the BSMC business cases, but also through DHB/PHO Alliances. Opportunities to engage in joint regional initiatives, particularly with the metro Auckland DHBs, are being explored where significant common issues exist such as in immunisation.</p> <p>Work is underway to develop the ADHB Child Health Stakeholder Advisory Group (CHSAG),</p>

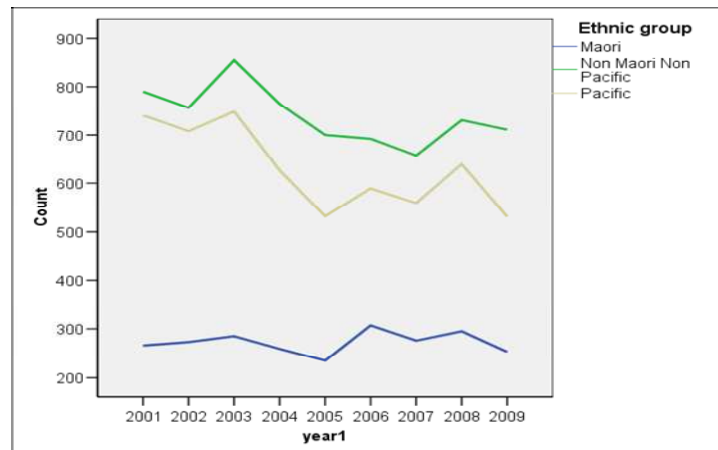
	<p>which engages stakeholders from health and other sectors, into an Auckland regional group. This will enhance the ability of the group to advocate on behalf of children, address Auckland-wide issues and promote inter-sectoral alignment and approaches to improve child health. Engagement with or through Whanau Ora initiatives are also being sought. Achieving child and youth health gain, increasing productivity and improving the patient's journey and whanau experience throughout the healthcare system is a priority for the Child HSG.</p> <p>Alongside these opportunities, the DHB faces challenges associated with its own facilities and as a result of increasing cost pressures. Specifically, Starship is positioned for excellence in delivery of tertiary child health services at national, regional and local levels. This is supported by the developing clinical networks, a culture of 'First Do No Harm' and Starship's history as New Zealand's largest secondary and tertiary children's hospital. However, the age of the physical Starship building and its facilities means that significant capital investment is required to maintain and develop this role. In addition, other cost drivers, such as new technologies, research and development and consumable and pharmaceutical costs are increasing cost pressures. The HSG has to have a clear vision to support innovative ways of working, streamline effort and determine priorities. This context is driving planning for the HSG. The HSG wants to engage the Board in this conversation from the outset. That is the purpose of this paper.</p>
4	<p>Overview</p> <p>The Child Healthcare Service Group (HSG) is forming under the clinical directorship of Dr Richard Aickin and will be fully operational by July 2011 when the new child health nurse director begins. The HSG is supported by Strategy and Planning and is well placed to take a strong leadership role in child and youth health in Auckland. This paper requests that the Board endorses the approach being taken to improve child and youth health including:</p> <ol style="list-style-type: none"> 1. development of a new Child Health Plan 2012 – 2017, and 2. design of specific activities to affect the Youth Health Improvement Plan 2010-2014. <p>While the focus of this paper is on the ADHB population, approximately 60 percent of Starship's services are delivered to children from outside the district.</p>
5	<p>Background</p> <p>Children</p> <p>There are 79,225 children aged 0 – 14 years living in Auckland District Health Board (ADHB), 17.2% of the total Auckland District Health Board population. While the absolute number of children is projected to increase, children will comprise a smaller proportion of the total population. The ethnic composition is diverse: 13.4 % Maori, 20% Pacific, 26.5% Asian and 40% Other. The proportion of Asian is projected to increase, Maori and Pacific are also increasing but at a slower rate, while Others will decline proportionately. Auckland is also home to many families from refugee backgrounds.</p> <p>Most children born or living in Auckland enjoy good health but some do not with the distribution of poor health marked by significant socio-economic and ethnic differences. Inequities can be clearly seen across a range of measures. Maori children and Pacific children experience poorer health than non-Maori, non-Pacific children. Children living in poorer neighbourhoods also have poorer health. This is evidenced in hospitalisation data for:</p> <ul style="list-style-type: none"> - Asthma - Pneumonia and bronchiectasis - Respiratory tract infections - Cellulitis - Rheumatic Fever - Dental disease, and - Injury.^{i, ii, iii}

Using the example of bronchiectasis (a chronic suppurative lung condition associated with frequent hospitalisations and reduced life expectancy), Pacific children are 10.6 times more likely and Maori children 4 times more likely than European children to be admitted to hospital with bronchiectasis.ⁱⁱⁱ Children living in the poorest decile are 15.6 times more likely to be admitted with this condition than a child from one of the wealthiest households. Rheumatic fever is similarly strongly associated with inequity. These rates of poor health reduce overall population health statistics and contribute to New Zealand having some of the poorest health outcomes by comparison with OECD countries.^{iv}

Over the last five years, while we have seen gains in some protective factors such as immunisation we have seen little movement in ambulatory sensitive hospital admissions (with the exception of gastroenteritis related conditions). Injury rates have been trending down although rates of intentional harm remain concerningly high. Overall, the likelihood of being hospitalised with a medical condition with a social gradient (associated with crowded housing and smoking) was 2.8 times higher for Pacific children and 1.78 times higher for Maori children than for European children (while Asian children were less likely to be admitted).ⁱⁱ

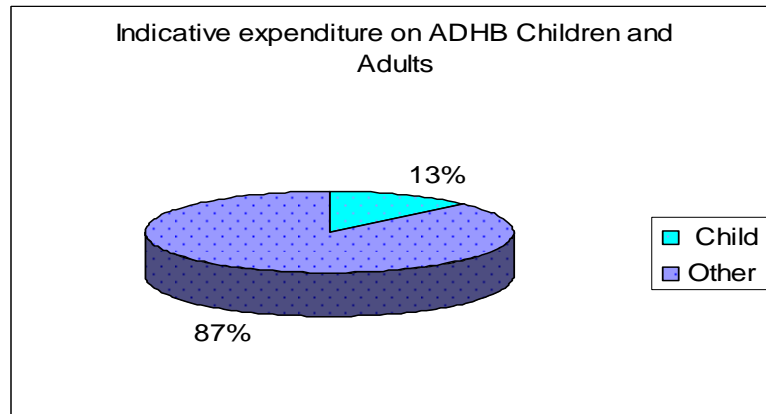
Inequity is demonstrated in the following graph showing avoidable hospitalisation by ethnicity.

Avoidable hospitalisation < 15 years by ethnic group (2009)



The effects of poor health are experienced in every aspect of a child's life and continue to be felt throughout the life course with missed opportunities to learn, increased long term health conditions in adults, and untimely deaths. The costs are borne by individuals, families and society as a whole. *The Best Start in Life* report notes, "The early years are important because they shape a person's ability to engage in work, family and community life. Substantial international evidence shows that adult unemployment, welfare dependence, violence and ill health are largely the results of negative factors in the early years [yet] New Zealand's investment in the early years is low by international standards."^{iv} This is also seen in health expenditure in ADHB with only c.13% of expenditure going into child health, proportionately less than the relative population size (17.2%).¹ This relative (under) investment in child health needs to be considered within the context of the DHB's overall strategic direction if real health gain and reduced inequity for the population are to be achieved over time.

¹ It is recognised that the population based funding formula takes into account a range of issues other than proportionate size of population groups.



The Child (and Youth) Healthcare Service Group considers that Auckland District Health Board (ADHB) has a responsibility to every child and to the community to maximise the health and well being of children and young people and to ensure that they access services that meet their health needs. However, funding for services is finite and demand growing so funding must be directed to where the greatest health gains can be made for the population as a whole. This can present challenges at an individual level.

ADHB has introduced successful innovations since the first Child Health Improvement Plan 2006 - 2011 including:

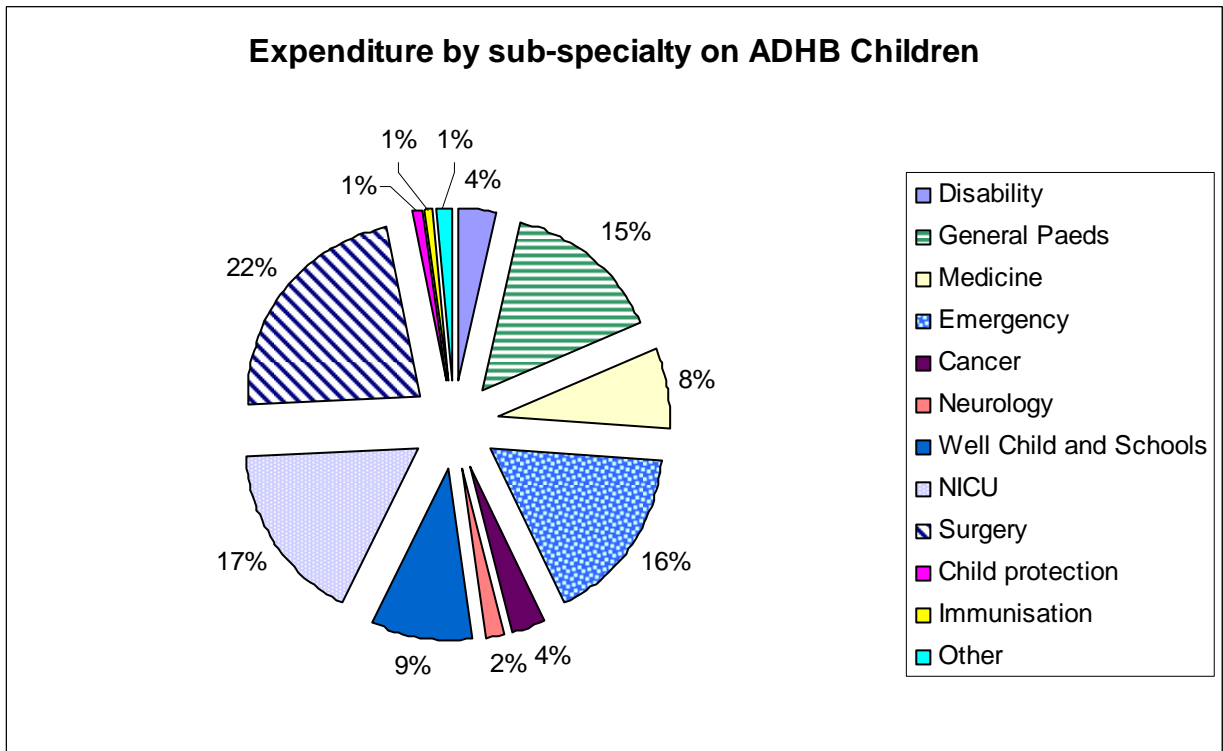
- Establishment of a multi-sectoral Child Health Stakeholder Advisory Group (CHSAG) (reflecting that many of the determinants of child health lie outside the health sector - in housing, education, social conditions and access to primary care).
- Participation in intersectoral initiatives such as the Strengthening Families Programme.
- Enhancement of the ADHB family violence prevention and intervention programme (which includes child abuse prevention).
- Implementation of a Health Assessment Programme for children in state care.
- Innovative approach to B4 School Check programme.
- Introduction of a Shaken Baby Prevention Programme.
- Immunisation initiatives including introduction of the national immunisation register, an Outreach Immunisation Service and establishment of Immunisation Coordinator positions in primary care (resulting in significantly increased immunisation rates) as well as introducing the HPV cervical cancer vaccine programme.
- Establishing a universal newborn hearing screening and early intervention programme.
- Significant redevelopment of dental services.
- Establishing a Child and Youth Mortality Review Group.
- Contributing to the SNUG homes project (insulation and heating in homes of low income families at risk of respiratory illness) to improve respiratory health.
- Breast feeding and other healthy eating, healthy action programmes and smoking cessation programmes.

In addition, ADHB has continued to deliver primary care services, mental health services and inpatient, outpatient and community child health services to the ADHB child population. Starship also provides tertiary paediatric care to a large number of children and young people from other DHBs.

Considering predominantly child health hospital expenditure for children resident in ADHB, expenditure is approximately \$62 million. However, a further c. \$103 million is expended by ADHB provider arm delivering services to children from outside the district. These figures are indicative and do not include mental health, primary care, maternity related services, laboratory or pharmaceutical expenditure.² Hospital services for adolescents are generally delivered under adult services and are also not included. (Generally Starship patients are aged up to 15 years.)

² Proportionately, expenditure in these categories is expected to significantly favour adult and older persons' health.

The majority of expenditure supports delivery of services provided by Starship as shown by sub-specialty in the following diagram. (Some community services are also delivered through this funding.)



Income for services comes from the Ministry of Health (calculated using the population based funding formula), Ministry of Health for specific programmes (eg. B4 School Checks), other districts and from philanthropic giving (with the Starship Foundation providing Starship with over \$7 million annually).

Currently, there is only one national child specific health target; immunisation coverage at 24 months. The immunisation health target can be viewed as a proxy measure for engagement in primary health care. A range of other child health measures are reported to the Ministry and to the Board. Immunisation rates in ADHB have increased significantly over the last 2 years, and while improvement can be seen in Maori immunisation rates these are still lagging. A range of initiatives are being delivered to address this inequity.

Youth

As with children, most young people (up to 25 years) are well but some experience particular health issues associated with youth development including mental health, sexual health, injury, and alcohol and other drug related health problems. This is manifest in internationally high rates of youth pregnancy and suicide. Services for youth include mainstream services in primary care, Starship and Auckland City Hospital. In addition, ADHB funds a range of youth specific services. These include:

- School based health services (for decile 1-3 high schools, some decile 4 schools and Waiheke High School (decile 6)) in 9 schools, as well as services for students in Alternative Education and the Teen Parent Unit.
- Health Assessments for young people in state care.
- Counselling services (through Youthline).
- Mental health services, particularly related to alcohol and other drug services.

There are no youth specific national health targets.

6

Current approach and proposed future direction

Children

The current Child Health Improvement Plan (CHIP) has come to the end of its defined term. The context has also altered. ADHB is poised to function under the clinical direction of the HSG structure, more regional working is occurring, stronger clinical networks are developing and tertiary specialist excellence continues to be built. As such it is timely to develop a new Child Health Plan (CHP) that responds to this new environment, sets an aspirational, clear vision and focuses the actions of the Child HSG. Better, Sooner, More Convenient (BSMC) health care principles and engagement with the three local business cases and Whanau Ora are keys to success in a whole of system approach.

The framework for the new CHP includes establishing prioritisation principles and agreeing priorities within a matrix covering prevention; early identification and intervention; intensive treatment; (re)habilitation and support against four broadly developmental stages: mother and baby; pre-school; primary school, and; junior high school.

The proposed process for developing this Plan under the leadership of the Director of Child Health includes engagement with primary, secondary and tertiary clinicians, ADHB staff, Maori and Pacific, other stakeholders (including other sectors), metro Auckland DHBs and the community to identify health needs, develop a shared vision to aspire to, set clear goals and prioritise activity. This process has just begun and is expected to include:

- Clinical leadership from the HSG and Community Paediatrician
- A project structure
- A steering group reporting back to the CHSAG to ensure clinical, primary care, regional DHBs, wider social sector and Ministry of Health engagement
- Community engagement through an on-line panel, in addition to more traditional engagement approaches
- Maori and Pacific analysis and engagement
- Development and consultation on a draft Plan including targets
- A request to the Board to consider, comment on and endorse the proposed Plan
- Finalisation of a new Child Health Plan 2012 – 2017 by the end of 2011
- Implementation of the new CHP from 2012.

In addition, a number of opportunities and challenges need to be harnessed and responded to. These include:

- A planning environment in flux at national, regional and local levels including restructuring at the Ministry of Health, regionality, BSMC and primary care business cases, as well as the internal establishment of HSGs and development of a localities approach.
- A national health board, potentially more centralised funding and concomitant loss of local influence on outcomes as well as ongoing tensions between national and local priorities (including inequity).
- An evolving demographic profile with a decreasing proportion of children and young people alongside absolute growth, on a base of historic under investment in children's health.
- Capacity and viability issues associated with Starship.
- Continual technological advances.
- Changing national priorities and health targets to which we need to remain responsive.

Youth

In 2010, ADHB launched a Youth Health Improvement Plan (YHIP). Responsibility for actioning the Plan sits with the Director of Child Health and HSG. The HSG is being guided by a steering group which has representation from Maori Health, Pacific Health, mental health, sexual health,

	<p>adolescent cancer services, NGO sector, teen parent, school based health services, primary care and community paediatrics. The group is developing a set of activities which will best deliver the Plan's goals. These will be prioritised in terms of health gain and achievability. This process is being managed within the context of budgetary constraint but may result in business cases being developed to support funding bids to the HSG. Targets and indicators will be developed and refined alongside this process.</p>
7	<p>Issues and Risks for Chosen Option</p> <p>The development of a new CHP and of activities associated with the YHIP, with associated stakeholder engagement, may raise expectations for increased delivery of children's and youth health services. This is being managed by being clear with stakeholders that funding is limited and that new activities may need to be provided in the context of divestment and/or reconfiguration of other services.</p> <p>Harnessing opportunities in the BSMC, regional, and national planning environments is essential if we are to improve child health outcomes. This includes contributing to national discussion on the development of new child and youth health targets. However, much of this activity is beyond our direct control making outcomes uncertain. As a consequence we need to remain flexible whilst being clear about our own vision and what changes we can control, influence or participate in to ensure the health of children improves and inequality decreases. To support this we will be further developing indicators to monitor and report progress against the Plan.</p>
8	<p>Budget Implications</p> <p>The costs associated with planning processes are being managed within existing budgets.</p> <p>Future changes are expected to be fiscally neutral over the next two to three years, however some service (re)development may be considered cost effective but require a shift of expenditure within, or to, Child Health. Any such initiatives would be subject to further development of BSMC, Starship or HSG business cases and may include proposals for re-investment from other areas.</p>
9	<p>Regional / National Implications</p> <p>ADHB child and youth health services have to be responsive to national requirements. This necessitates continuous review of priorities within the planning framework. National and regional planning processes inform and guide development of initiatives in ADHB. This has been evidenced in immunisation as well as other areas and is part of the context in which the HSG functions.</p> <p>ADHB is developing closer working relationships with regional child and youth health counterparts. This is especially so in immunisation and increasingly in youth health. Waitemata and Auckland DHBs have agreed to share information about youth health service development and share a number of regional contracts led by one or other of the DHBs. Any changes to existing contracts or opportunities for further regional collaboration will be explored with metro Auckland DHBs and Northland where appropriate.</p>
10	<p>Appendix attached: The Health Status of Maori Children in Auckland District (May 2011)</p> <p>Other appendices available on request</p> <p>Child Health Appendix: Child Health Indicators</p> <p>Youth Health Appendices: Youth Health Plan.</p>

References

- i Asher I. 2010. The Porritt Lecture: *Improving the Poor Health Outcomes for Children in New Zealand - What Can Be Done?* Department of Paediatrics: Child & Youth Health, The University of Auckland.
- ii Craig E. McDonald G. Reddington A. Wicken A. 2009. The Determinants of Health for Children and Young People in Auckland DHB. New Zealand Child and Youth Epidemiology Service.
- iii Craig. E. Jackson C. Yeo Han D. 2007. The Health of Children and Young People in the Auckland DHB. New Zealand Child and Youth Epidemiology Service.
- iv Public Health Advisory Committee. 2010. *The Best Start in Life: Achieving effective action on child health and wellbeing*. Wellington: Ministry of Health.

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Community and Public Health Advisory Committee Paper

Date	18 May 2011
To	Community and Public Health Advisory Committee (CPHAC)
From	Dr Denis Jury Chief Planning and Funding Officer Greenlane Clinical Centre, Building 13, Level 8 Phone: (09) 630 9943 ext 8071 DenisJ@adhb.govt.nz
Author	Ruth Bijl, Associate Strategy and Planning Manager, Child, Youth and Women
Functional Group	Planning and Funding Functional Group
Subject	Tender for Assisted Reproduction Services – Fertility Services
1	<p>Purpose This paper informs the Board of progress in relation to the tender process for Assisted Reproduction Services.</p>
2	<p>Recommendations It is recommended that CPHAC:</p> <ol style="list-style-type: none"> Note that Waitemata DHB as lead DHB for the regional contract process has put the tender for Fertility Services process on hold, is clarifying expectations from ADHB and is revising the proposed process for contracting with fertility service providers.
3	<p>Description of Solution (Option) Waitemata is the lead DHB for the contract currently held by Fertility Associates to provide Fertility Services to the northern DHB regions' populations. This contract was due to expire and, following an NDSA led process in 2010, a decision to request proposals for fertility services from the market had been taken. A separate fertility service is delivered to the same population and managed by ADHB. Following a paper to the April 2011 meeting of CPHAC, the ADHB service is now to be included in any future tender and/or procurement process. The procurement documentation will clearly state that:</p> <ul style="list-style-type: none"> - more than one service provider will be engaged - the service being purchased includes training - a joint process for managing referrals and demand needs to be continued - value for money is one outcome being sought.
4	<p>Update since April CHPAC meeting The RFP process was put on hold. The four regional DHBs and representatives on the Evaluation Panel have been informed. Providers have yet to be notified while details regarding the revised process are clarified.</p> <p>As the total contract value has increased to c. \$5.6m pa individual DHBs needed to re-assess their individual financial commitment and levels of delegated authority. NDHB does not require Board approval but CMDHB is still determining whether Board approval is now required.</p> <p>Clarification has been sought by the Procurement Chair (WDHB) from ADHB regarding the Board's expectations. It is understood that ADHB provided fertility services will now be included in the revised process; documentation will clearly state that more than one provider will be engaged in service delivery; the service being procured includes training of specialist medical and allied workforces; and, a joint process for managing referrals and demand needs to be continued. Obtaining value for money will be an explicit outcome from the process.</p>

	Legal advice will be sought on managing the procurement process.
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	Once clarification of these issues has been obtained and a revised process developed, updated information will be brought back to each of the four DHB Boards.
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10

FOR INFORMATION

10.1 Phobic Trust: Update on Discussions

Community and Public Health Advisory Committee Paper

Date	Wednesday 18 th May 2011
To	Community and Public Health Advisory Committee (CPHAC)
From	<p>Dr. Denis Jury, Chief Planning and Funding Officer Greenlane Clinical Centre, Building 13, Level 8 Phone: (09) 630 9943 extension 8071 Email: DenisJ@adhb.govt.nz</p> <p>Dr Clive Bensemann, Director of Mental Health Services Level 5 Admin Suite, Building 32, Auckland City Hospital Ph: (09) 375 7105 Email: clive.benseman@adhb.govt.nz</p>
Author	Robert Ford, Strategy & Planning Manager, Mental Health & Addictions robertford@adhb.govt.nz
Functional Group	Planning & Funding Functional Group
Subject	Phobic Trust – Update on Discussions
1	<p>Purpose</p> <p>The CEO of Phobic Trust, Marcia Read, approached the Board requesting an opportunity to present information about both their current financial difficulties as well as their plans for future expansion and development. Phobic Trust sought ADHB and regional funding assistance to extend their services.</p> <p>Phobic Trust were invited to present this information to a senior management group that included, regional representation, as well as Denis Jury, Clive Bensemann, and strategy and planning managers.</p>
2	<p>Recommendations</p> <p>It is recommended that CPHAC</p> <ul style="list-style-type: none"> • Note the report on the presentation from the Phobic Trust on the needs of people experiencing anxiety or phobias. <p>Background</p> <p>The Phobic Trust currently holds a regional contract (metro DHBs) to deliver a telephone advice and support service for people experiencing anxiety and phobias. This contract has been running for many years and the service provided is general beneficial.</p> <p>The recent presentation from Phobic Trust highlighted the specific needs of this group of consumers, some with severe and debilitating conditions that restrict their enjoyment of life.</p> <p>During the presentation we acknowledged that these conditions are representative of our responsibilities across a continuum of care including from health promotion, to primary care, secondary care, and through to the very high acuity and severe issues.</p> <p>We noted that these consumers have components of physical health presentation and effect, and so effective treatment modalities must also work with services more widely than primary care and mental health.</p> <p>In the meeting and afterwards we explained that we need to consider the whole continuum and</p>

where services for this population are best placed. We noted that further work was needed to best understand the balance of needs between a primary care led intervention and responsiveness to the more severe and enduring conditions and whether gaps exist within the currently provided services in primary and specialist services.

We concluded that a response by the sector might appropriately include a comprehensive approach to treatment of anxiety and phobias and that this was worth further investigation, possibly even at a national level with the development of an appropriate policy on treatment options and service delivery; this is being discussed at the next National Clinical Directors and General Managers meeting for mental health. We said that were senior clinicians to agree that this is warranted, these clinicians would also engage in discussion as to the best evidence base from which to develop models for service provision.

Finally at the meeting and in a comprehensive follow up letter to Phobic Trust we said that District Health Boards provide significant funding for primary mental health and specialist mental health services. We noted that the new allocations of funding into mental health and addictions services have tended to be provided in a targeted manner from government. We cited funding for eating disorders services as a recent example.

We explained the funding process, such that if health boards were to agree funding for this group from within existing resources then this would have to come from service reconfiguration and changes elsewhere in the system and be agreed as part of a prioritisation decision within the annual planning process.

We also noted our requirement for probity with public money and that any decision to develop a new service would be subject to a commercial tender process, and there would likely be significant interest from the wider sector.

No decision was taken at the meeting or later to provide funding to Phobic Trust over and above their current contract.

11

CONFIRM

11.1 Action Points for next CPHAC Meeting

11.2 CPHAC Feedback to Board

Use Forms at beginning of Meeting Pack

12

GENERAL BUSINESS

13

BOARD

13.1 ADHB 2011-12 Annual Plan
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Board Paper

Date	Wednesday 18 May 2011
To	Special meeting of the Board
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denis.jury@adhb.govt.nz
Author	Tony O'Connor Ext 26765 tony.oconnor@adhb.govt.nz Julie Helean Ext 4390 julie.helean@adhb.govt.nz Aroha Haggie Ext 4262 aroha.haggie@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	2011-2012 Annual Plan (incorporating the Statement of Intent), Maori Health Plan and the Northern Region Health Plan: all due with NHB on 20 May 2011
1	<p>Purpose</p> <p>Consider adopting the updated Auckland DHB Annual Plan (incorporating the Statement of Intent) as the Board's final Plan for submission to the National Health Board.</p> <p>Consider adopting the Northern Region Health Plan as final and approve Auckland DHB's share of its implementation budget.</p> <p>Consider adopting the updated Maori Health Plan as the Board's final Plan for submission to the National Health Board.</p>
2	<p>Recommendations</p> <p>It is recommended that the Board:</p> <ol style="list-style-type: none"> 1. Review the National Health Board's feedback on the draft Annual Plan and Statement of Intent. 2. Consider the updates in the Annual Plan, marked in blue font. 3. Approve the Annual Plan for submission to the National Health Board as final on 20 May. 4. Note that modules 1, 2, 4, 5 and 8 will be pulled from the final Annual Plan and will be submitted under a separate title page as The Statement of Intent 5. Agree the signatures to the Annual Plan and the Statement of Intent, including sign off from our Treaty partners 6. Approve the Maori Health Plan for submission to the National Health Board as final draft on 20 May. 7. Agree the signatures to the Maori Health Plan, including sign off from our Treaty partners 8. Approve the Northern Region Health Plan 17 May version as final with budget indications as available at this time 9. Note the regional budget and approve ADHB's share of the \$1.2 million implementation budget.
3	Northern Region Health Plan

	<p>On 6 April the Auckland DHB Board endorsed the progress being made on the Northern Region's Health Plan. The development of the plan is being managed by the NDSA. Feedback from across the region was supportive and positive.</p> <p>We will highlight to the Board for discussion any differences between the new draft (expected by 17 May) and the version sent under separate cover to the 18 May Board meeting. We recommend that the Board approve as final the version to be completed by the NDSA on 17 May which we expect to have no substantive change.</p>										
4	<p>National Health Board Feedback on the Auckland DHB Annual Plan</p> <p>The National Health Board's review of our draft Annual Plan was the only review round prior to their requirement that a final Annual Plan be submitted on 20 May.</p> <p>NHB feedback was colour-coded as follows: Most of the feedback was "green", which indicated no further action is required but improvements could be made. Overall, ADHB's draft Plan was considered to be well written and well developed in many areas. The NHB issues coded "orange" that they considered to be easily resolved. Items coded "red" were considered by the NHB to be substantial issues on which they would work closely with us to resolve. See section 6 below for discussion about the orange and red feedback, particularly those items where there remains some risk or where further work is required before the plan can be approved.</p>										
5	<p>Auckland DHB's Maori Health Plan</p> <p>The NHB has provided feedback on Auckland DHB's Maori Health Plan. The Plan has been amended to address that feedback in time to seek the Board's approval for it to be submitted as final on 20 May. The Plan will be circulated to Board members under separate cover prior to the meeting.</p>										
6	<p>Living within our means</p> <p>The financial component of the Annual Plan was coded orange. The National Health Board has communicated directly with the CFO requesting further information and a response has already been forwarded by the finance team. Adjustments made to the finances have resulted in a new operating statement and changes to the balance sheet re assets and a loan.</p> <p>The region's CEOs have agreed \$1.2 million for year 1 of the NRHP's implementation. Further detail about this budget will be available at the Board meeting.</p>										
7	<p>Issues and Risks</p> <p>Summary of NHB feedback on the Annual Plan (incorporating the SOI)</p> <p>Red (Must be resolved: High importance)</p> <table border="1"> <thead> <tr> <th>Area of concern</th> <th>Issue</th> <th>ADHB Response</th> </tr> </thead> <tbody> <tr> <td>Strategic outcomes</td> <td>Annual Plan needs to detail regional work programmes and the plans ADHB will lead</td> <td>More detail has been added although the exact work programme will not be available until July 2011. This is being developed (by the NDSA) at the moment as part of a more detailed implementation plan</td> </tr> <tr> <td>Elective services</td> <td>Your proposed target is 613 surgical discharges below expectations and needs to be reconsidered An approved Electives Funding Schedule is required Confirmation required that ADHB will treat</td> <td>Resolution process underway and figures will be amended. However we have yet to agree the final volumes with NHB</td> </tr> </tbody> </table>		Area of concern	Issue	ADHB Response	Strategic outcomes	Annual Plan needs to detail regional work programmes and the plans ADHB will lead	More detail has been added although the exact work programme will not be available until July 2011. This is being developed (by the NDSA) at the moment as part of a more detailed implementation plan	Elective services	Your proposed target is 613 surgical discharges below expectations and needs to be reconsidered An approved Electives Funding Schedule is required Confirmation required that ADHB will treat	Resolution process underway and figures will be amended. However we have yet to agree the final volumes with NHB
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	patients within six months	
Aged Care	Detailed mitigation strategies needed to manage demand and access Respite targets needed for 2011/12 and a baseline figure for 2010/11 Financial forecasts for respite services, day services and carer support are not consistent with expectations	Resolved
Primary Care	Lack of tangible specifics about alignment with GAIHN business case and the role primary care will play in developing a sustainable health system NHB concern about the extremely small volumes of shifted services	This work has been amended

Orange (must be resolved: moderate importance)

Area of concern	Issue	ADHB Response
Impacts and measures of performance	ADHB's objectives and expected outcomes should be reinforced by specific measures that relate to your strategic direction	Clearer link between ADHB activity and strategic direction (module 2)
Cancer treatment	The Plan needs to include the correct health target wording Detail of key actions from the radiation oncology regional strategic plan need to be included	Resolved
Immunisation	More detailed actions needed to show how the DHB will meet the 95% target	Resolved. More activity added to module 3, section 4
Smoking	The primary care target of 90% needs to be added as a performance measure	This has now been amended (module 3, section 5.0)
Diabetes and CV services	Some of your targets for CVD risk assessment need to be reconsidered to show you are committed to improving performance	These have been amended (module 9, appendix 1)
Regional Collaboration	Show specific areas of ADHB participation, sponsorship or leadership For regional priorities, vulnerable clinical service priorities implementation plans there is a need for a greater degree of specificity required	The exact work programme will not be available until July 2011. This is being developed (by the NDSA) as part of a more detailed implementation plan
Clinical Leadership	More commitment to regional training hubs should be evident	Resolved (module 3, section 14.6.3)
Output Class description, measures and financials	Where possible, quantify output measures as targets for reporting against and include baseline as a reference point	Issues resolved. Further work is being done with Audit NZ to further improve module 4
Organisational Health	Include comment on how you apply the DHB's Equal Employer policy to your DHB's operation	Resolved
Production	Concerns with the quality of the data provided	The financial tables in the

	Planning	and the automated template did not work. We will send you an alternative table Electives: substantive issues with the template Mental Health: level of mental health underspend needs to be agreed with NHB. Clarify reductions in the Child and Family Unit and the planned price reduction to NGO-provided services. IDF outflows to the Mental Health Production Plan need to agree with your financial templates. Update all PU codes	annual plan have yet to be updated
	Financial Performance	Some areas need further information and a response Follow-up discussion is required and a revised template to support the final Plan	The financial tables in the annual plan have yet to be updated
	Appendix 1	Targets must be addressed. Make sure all Performance Measures included elsewhere align	Resolved (module 9, appendix 1)
8	Annual Plan, Maori Health Plan and the Northern Region Health Plan Documents All documents will be circulated to members under separate cover prior to the meeting.		
9	Timeline and process		
	Date	ADHB Meeting	Required
	20 May		Annual Plan (SOI), Maori Health Plan and the Northern Region Health Plan due at National Health Board
	May/June		Resolve any outstanding issues raised by NHB Annual Plan along with NHB recommendations/review comments sent to Minister for his consideration
	15 June	Board/CPHAC	Update the Board on any further NHB issues with our 20 May, Final Annual Plan (incorporating SOI) Statement of Intent considered for approval as final
	30 June		Statement of Intent sent to House of Representatives (45 hard copies) with 2 hard copies sent to the Minister's Office
	1 July		Statement of Intent is made available to the media and public via the ADHB internet site
10	Appendix Nil.		

APPENDICES

14.1 The Health Status of Maori Children

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The health status of Maori children and young people living in Auckland District Health Board

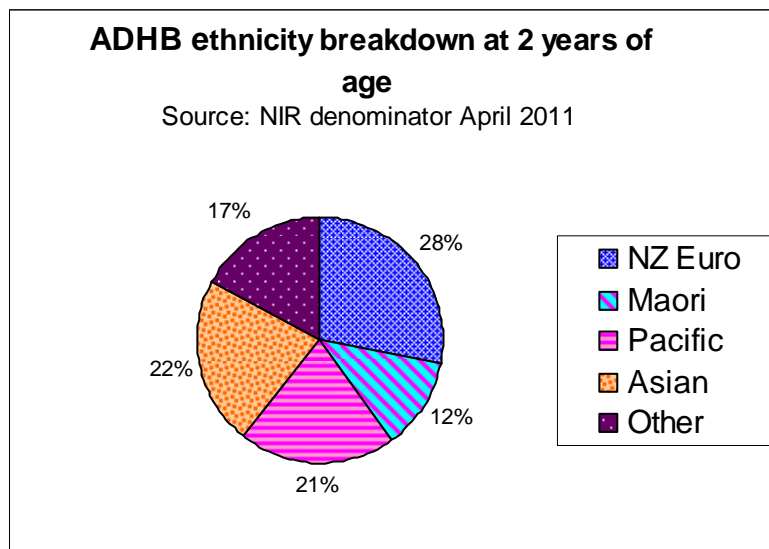
Overview

Information specifically about Maori children and young people in Auckland is provided as a supplement to the Child and Youth Health in ADHB paper. Information and data is primarily sourced from New Zealand Child and Youth Epidemiology Service reports commissioned by ADHB to support planning and funding.

Population profile

The proportion of Maori children and young people living in Auckland is considerably lower than the national average (2006 census data) with:

- 11.5% ADHB vs 23% NZ of children aged 0 – 14 years identifying as Maori, and
- 8.5% ADHB vs 17.7% NZ of young people aged 15 – 24 years identifying as Maori.
- The population structure for Maori is younger than for other ethnic groups, except Pacific.
- NIR denominator data as at April 2011 suggests the proportion of Maori at 2 years of age was 12% compared with 28% NZ European, 22% Asian, 21% Pacific and 17% Other. (NIR)



Engagement with primary care – PHOs and Well Child/Tamariki Ora Services

- Nationally, rates of enrolment in PHOs is lower for Maori children than other ethnicities, at around 90% (aged 0 – 24 years). (2009)
- ADHB data shows that Maori enrolment rates with PHOs for the Total population (all ages) is under reported by c.13% (Pacific is over-reported by c.46%). After adjusting for this around 80% of Maori are enrolled in a PHO.
- National Well Child data shows only 66% of Maori babies are enrolled with Plunket vs 94.8% of non-Maori, non-Pacific. Over 90% of all babies are enrolled with Plunket

- and, of these; there is lower participation rate in core visits by Maori whanau. (2007, p105). There is geographic variation in how services are provided however.
- In ADHB, four additional providers are contracted, two Pacific, one Maori, one high needs. Ngati Whatua o Orakei is contracted to provide a Tamariki Ora service and has approximately 151 total children were enrolled in these services.
- ADHB provider arm (Community Child and Disability Service) delivers an enhanced multidisciplinary WC/TO service for the highest need families. Nearly 1000 children were enrolled at the end of 2010. Of these, 25% identified as Maori. (ADHB monitoring report).
- Data from Plunket specifically for ADHB shows 6,406 children newly enrolled in the year, 10% (663) of whom identified as Maori, accessing 11% of all face-to-face contacts (Year ended 30 June 2010).

Risk and Protective Factors

Breast feeding

- Breast feeding is protective against a range of childhood and adult health problems including obesity and is associated with improved attachment (a component of positive mental health).
- Auckland breast feeding rates are lower than national rates but there is a general trend upwards in rates. Plunket data suggests breast feeding rates are:
 - o 62% Maori vs 72% non-Maori, non-Pacific at 6 weeks
 - o 53% Maori vs 63% non-Maori, non-Pacific at 3 months, and
 - o 22% Maori vs 30% non-Maori, non-Pacific at 6 months.
- Improvement over time is seen with rates at 3 months for Maori of 45% in 2008, 47% in 2009 and rising to 53% in 2010. (Plunket)

Immunisation

- The Maori fully vaccinated for age coverage rate is currently the lowest of the ethnic groups measured at 79% Maori vs 88% Total at the 24 month milestone age (the Health Target). (NIR data, April 2011)
- However, significant gains in coverage over the last two years have been achieved with inequity decreasing from 12 percentage points (March 2009) to 9% percentage points (April 2011), or coverage of 61% Maori vs 73% Total (March 2009) increasing 18 percentage points to 79% Maori vs 88% Total (April 2011). (NIR)
- Coverage continues to lag at 6 months which, while not a Health Target is an important measure of timeliness following scheduled immunisations at 6 weeks, 3 months and 5 months, when babies are most vulnerable.
- Inequity has been decreasing but coverage remains poor at 6 months with 58% Maori vs 72% Total fully immunised, a gap of 14 percentage points but improved from a gap of 18 percentage point in March 2009 (43% Maori vs 61% Total).

Smoking

- Smoking impacts the health of the smoker as well as the baby exposed in utero and others exposed to environmental tobacco smoke within the household. Associated effects include prematurity, low birth weight, sudden unexplained death in infancy (SUDI), increased hospitalisation, respiratory disease, heart disease, cancer and so on. There is also thought to be an association with neurobehavioral problems such as attention deficit disorders, hyperactivity [and] learning difficulties". (2009, p139)
- Maori smoking rates during pregnancy are high. Rates in Auckland are lower than national averages but smoking throughout pregnancy is present in around a third of

all Maori births with even higher rates seen in younger women (over 40% of teen pregnancies). (Smoking is also highly associated with deprivation.) (2009)

- In-home smoking is also higher in Maori families, with around half of children living with a smoker although rates of smoking inside the home have decreased over the last decade. (2009)
- "Given the significant association between passive smoking and outcomes such as SIDS, bronchiolitis, and pneumonia, it is likely that exposure to second hand cigarette smoke made a significant contribution to child health disparities in Auckland." (2009, p153).

Teen pregnancy

- Teen pregnancy is of concern due to the association with preterm birth, low birth weight and educational attainment of both mother and child.
- Rates of teen pregnancy (<20 years) are higher in Maori, as are abortion rates. (2007, p 365)

Family violence

- Rates of hospital admission for children due to injuries arising from assault, neglect or maltreatment is highest for Maori at a rate of 37.9/100,000 or 3.43 times higher than European. (2010)
- Rates are highest amongst the very young (<1 year) and increase in the early teens although mortality is highest in the very young. During 2000 – 2007, 5 Auckland DHB children were killed. (2010, p301).
- Over a third (35.3%) of victims of family violence are Maori. (2009, p202).

Crowded housing

- Crowded housing is associated with infectious diseases and with mental health issues including family violence.
- Household crowding is worse in Auckland than nationally and higher for Maori, although highest for Pacific families. A third of Maori live in crowded homes. (2009, p91)

Educational participation/attainment

- Educational participation/attainment is a key determinant of future economic and general well being status which influences the socioeconomic position of future families (ie. inter-generational effect).
- Rates of educational attainment are higher for Maori in ADHB than nationally and have improved (since the introduction of NCEA). However, a higher percentage of Maori students continue to leave school with no formal qualification and achieve the lowest university entrance (UE) standard in New Zealand. In Auckland fewer Pacific students obtain UE standard. Boys' attainment is poorer than girls.
- Suspension rates were higher for Maori students than for other ethnic groups, although lower than the NZ average. Truancy rates were also higher for Maori than other ethnic groups, although rates in Auckland were lower than national averages. (2009)

Indicators of health status

SUDI

- Nationally, Maori babies accounted for 61.6% of deaths from sudden unexplained death in infancy (SUDI) during 2003 – 2007 (202/326).

- SUDI is associated with the baby sleeping on her/his front, cigarette smoking, not being breastfed and bed sharing. (CYMRC, 2009)

Obesity

- Maori children are 1.23 time more likely to be overweight and 1.43 times more likely to be obese than children from total population (2010, p197). This pattern was also seen but more so in Pacific children.
- Intake of fizzy drinks and of takeaway/fast food was higher as was time spent viewing television. (2010)

Mental health

- The NZ teen suicide rate is high by international standards with Maori twice (2.03) as likely as NZ European to commit suicide. (2009, p 260)

Injury

- Injury is the leading cause of mortality at both 0 – 14 years and 15- 24 years. Motor vehicle deaths are the biggest contributor.

Conditions associated with a social gradient – infectious disease

- Rates for diseases associated with poverty and overcrowding including Rheumatic Fever, TB and meningococcal disease are high by international standards with marked ethnic disparity. Both Maori and Pacific children are over-represented.
- The most common bacterial infection related admission is due to skin infection (sepsis). Other conditions include: meningococcal disease, osteomyelitis, acute rheumatic fever, septic arthritis, tuberculosis, bacterial meningitis, rheumatic heart disease and mastoiditis. Across all of these diseases, Maori children and young people were over twice (2.08) as likely as NZ European to be admitted with a serious bacterial infection (Pacific were 3.15 times as likely). (2007, 251). In contrast, Maori children and young people were less likely to be admitted with gastroenteritis than both Pacific and NZ European children.

Conditions associated with a social gradient – respiratory disease

- Collectively considering bronchiolitis, asthma, pneumonia, acute unspecified LRTI, Bronchiectasis, pertussis and lung abscess, Maori children are 2.85 times as likely to be admitted to hospital with a respiratory illness. Pacific children are 5.17 times more likely to be admitted to hospital with a respiratory illness. (2007, p281)

Oral health

- Oral health indicators are poorer for Maori children in ADHB, but better than for New Zealand overall. (2009)

Current and proposed initiatives to achieve Maori child health gain

The following points highlight significant initiatives currently underway or due to begin and designed to improve the health of Maori children in ADHB.

Immunisation

- A major ADHB project is underway which, in part, aims to ensure that families receive timely pre- and recalls but when a child is overdue for immunisation (based on NIR data) they are referred promptly to the outreach immunisation service (OIS) which provides a home visiting vaccination service. The OIS provides a culturally

appropriate service including through a Maori community health worker and a Maori nurse vaccinator. Response rates indicate that the service is acceptable to whanau.

- An audit of under-immunised Maori children analysing data held by the NIR and by the OIS service is exploring patterns for under immunisation within ADHB. (This audit is focusing specifically on Maori children turning 2 years of age in Q4). Initial results indicate that:
 - o They were highly mobile (10/25 changed their address 2 times or more, up to 4 times)
 - o They did not have a secure primary care home (12/25 changed their nominated provider at least once and up to 3 times)
 - o They often turned down the outreach offer (7/25 declined OIS)
 - o The NIR recorded their birth promptly (all bar one was registered with the NIR 2 - 15 days after birth).
- An awareness raising poster campaign promoting immunisation messages with Maori specific images is due to be rolled out in range of venues including Community Links (TBC), GP practices, Plunket rooms and other Well Child provider venues, Starship Children's Health and National Women's.

Well Child/Tamariki Ora

- A new nationally led revised Well Child/ Tamariki Ora framework including more screening for family violence, post natal depression screening, and care planning, is due for implementation from 1 July 2011.
- The Before School Check (B4SC) programme transitioned to primary care at the beginning of 2011 with a dedicated outreach service provided by a Maori health nurse/community health worker team based at Te Hononga PHO.
- An improvement programme to ensure data regarding Maori PHO enrolment rates is accurate is currently being considered.

Breast-feeding

- A national social marketing campaign is underway.
- An ADHB community breast-feeding service (Plunket) is in place which is focusing on Maori (Pacific and Asian) and being delivered by Maori breast-feeding support workers (home visitors).
- A baby friendly community initiative which includes Ngati Whatua is working towards accreditation as a baby friendly organisation.
- A peer counselling service has begun and includes Ngati Whatua as a provider.

Children in care

- The children in care programme targets children who have been taken into state care and provides them with a full health assessment in order to identify unmet health needs and ensure appropriate services are delivered. This group of children has high levels of unmet health need.
- Maori children over-represented in care with 72% (50/69) of ADHB children and young people referred for a health assessment over a 12 month period indentified as Maori. (Leversha 2010)
- ADHB initiated children in care programme which was then piloted in 4 other DHBs
- The Ministry of Health are currently exploring options for a national roll out to all children taken into state care.

Better sooner more convenient (BSMC) business cases

- There are three groups which include Auckland in their coverage.
 - o The National Hauora Coalition (NHC) includes Mama, Pepe and Tamariki as a priority.
 - o GAIHN is developing a child health focus which seeks to identify unmet health need.
 - o Alliance Health + includes children and youth in their priority groups.

Family Violence

- ADHB currently provide a family violence intervention programme, this programme is delivered in partnership with Shine*. There are two components of the programme these are nurse training for the screening of families/whanau and monitoring of the screening programme and programme utilisation. The programme is there to support any families/whanau who identify family violence and or safety as an issue and appropriate follow-up as required.
- Maori whanau and children are disproportionately represented in family violence statistics.
- Prevalence of partners abuse in New Zealand
 - o Lifetime incidence: Between 33 and 39% of women have been hit or forced to have sex by a partner at least once during their lifetime (Fanslow and Robinson 2004). Eighteen percent of men have been hit by a partner at least once during their lifetime (Morris and Reilly 2003).
 - o Last year incidence: Five percent of women reported being physically or sexually abused by a partner or ex partner in the previous year (Fanslow and Robinson 2004). No preceding twelve months figures are available for men.
 - o Leibrich et al conducted a random telephone survey of 2000 men (Leibrich et al 1996). This survey asked men to report if they had been a perpetrator of family violence, including physical, sexual and psychological abuse. Twenty-one percent of the men surveyed reported a low level incident of physical or sexual abuse against their partner on at least one occasion in the preceding 12 months, with the lifetime prevalence of physical or sexual abuse being 35%. Fifty- three percent of men reported psychologically abusing their partner on at least one occasion in the preceding 12 months, with the lifetime prevalence of psychological abuse being 62%.
 - o Emergency department studies on the prevalence of partner abuse for women showed 21% of women experiencing current abuse, with a lifetime prevalence of 44% (Koziol-McLain et al 2004).
- Prevalence of Child Abuse in New Zealand
 - o About 4–8% of New Zealand children experience physical abuse. Of this group:
 - 8% regularly experience physical punishment
 - 4% have experienced severe or harsh and abusive treatment
 - punches around the head and body (65%)
 - beatings with a cane, strap or other object (57%)
 - kicks (52%)
 - 80% suffer injury as a result of physical abuse
 - 37% are also sexually abused (Ferguson et al 1997).
 - Twenty two percent of girls and 11% of boys experience sexual abuse, excluding non-contact sexual abuse (e.g. being forced to watch pornographic material) (Ferguson et al 1997).

- Childhood abuse is associated with increased risk of victimisation later in life (Ferguson, 1997).
- In 2005, Child, Youth and Family Service (CYFS) report they received 53,097 notifications of child abuse, of which 43,460 required further action by Social Worker (CYFS, 2005).
- Violence affects a victim's health. Because health professionals come into contact with the majority of the population, they are well placed to identify abuse, assess risk and refer victims to appropriate services.

Whanau Ora

- While agreement on what Whanau Ora will look like in ADHB is still work in progress, the key aims of Whanau Ora in a health context are Maori families supported to achieve their maximum potential, where the whanau themselves are the navigators of health services. For ADHB, whanau ora is considered a service delivery model and would have the following characteristics;
 - o A whanau ora whole of system approach
 - o Development of more whanau focused healthcare delivery
 - o equitable Maori health outcomes
 - o Maori participation at all levels of decision making
 - o Sharing common Whanau Ora information
 - o Improved Maori health gain
 - o Reduction in Maori health inequities
- Complementary to the whanau ora development in health is the development of the whole of system Te Puni Kokiri whanau ora providers of which six have been confirmed in the Auckland metro area (many of the providers developing programmes of action currently provide health services such as Ngati Whatua Orakei).
 - o The programmes of action will develop a plan to provide whānau centred services. Providers will have Whānau Ora practitioners who will act as navigators or champions for whānau, helping them to develop a whānau plan and to access health and social services.
 - o Each POA will address infrastructure needs; workforce training and development needs; a process for integrated contracts; the development of outcomes framework and an agreed action research, evaluation and monitoring plan.
 - o Research, evaluation and monitoring will measure results and gauge the success of the design, implementation and impact of Whānau Ora. It will help providers refine the systems, processes and programmes delivered to support whānau to achieve their goals and aspirations.

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