



Waitemata
District Health Board
Te Wai Awhina

Community and Public Health Advisory Committees Meeting

Wednesday, 1st February 2012

2.00pm

Venue

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 14 December 2011

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards Community and Public Health Advisory Committees Meeting held on 14 December 2011 be approved.

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community & Public Health Advisory Committees

Wednesday 14 December 2011

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna
commencing at 2.02p.m

PART I – Items considered in public meeting.

COMMITTEE MEMBERS PRESENT:

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

ALSO PRESENT: Dale Bramley (WDHB, Chief Executive)
Garry Smith (ADHB, Chief Executive)
Debbie Holdsworth (WDHB, Acting Chief Planning and Funding Officer)
Denis Jury (ADHB, Chief Planning and Funding Officer)
Paul Garbett (WDHB, Board Secretary)
Andrew Old (ADHB and WDHB, Medical Advisor – Service Integration)
Janine Pratt (WDHB, Group Planning Manager)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Tim Wood (WDHB, Funding Manager)

(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Tracy McIntyre, Waitemata Health Link
Margaret Willoughby, Rodney Health Link
Lynda Williams, Auckland Women's Health Council
Lorelle George, Waitemata PHO
Ngairé Harris, Waipareira Trust and Waitemata PHO (West Manager)

LEAVE OF ABSENCE: Peter Aitken

APOLOGIES: Apologies were received and accepted from Rob Cooper, Janice Mueller, Taima Campbell, Hilda Fa'asalele and Deborah Dalliessi (North Shore Community Voice).

KARAKIA

Eru Lyndon led the meeting in a karakia

WELCOME

The Committee Chair, Lee Mathias, welcomed those present to the final CPHAC Meeting for 2011. She advised that Alfred Ngaro's resignation from the Committee had been accepted, following his election as a Member of Parliament. An approach would be made to the Health Pacifica community for a replacement in the New Year.

DISCLOSURE OF INTERESTS

Robyn Northey advised that she had been appointed as a member of the University of Auckland Human Participants Ethics Committee.

There were no declarations of interests that might give rise to a conflict of interest with a matter on the open agenda.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 9 November 2011 (agenda pages 1-10)

Resolution (Moved Warren Flaunty/Seconded Chris Chambers)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 9 November 2011 be approved.

Carried

Matters Arising:

With regard to the paper on Whanau Ora by Eru Lyndon, it was noted that Ministerial approval would be needed to release it to Committee members. It was considered that it would be very helpful to have access to the report as there are various perspectives on what Whanau Ora involves and the report could be useful in reaching a common understanding, particularly as the Boards would need to accelerate their involvement in this area over the next 24 months. The Committee Chair offered to contact the Minister responsible for Whanau Ora for permission for CPHAC to have access to the report in the New Year.

3. DECISION ITEMS

There were no decision items.

4 INFORMATION ITEMS

4.1 Auckland and Waitemata DHBs' Annual Planning Process for the 2012-13 Financial Year (agenda pages 11-14)

Janine Pratt (Group Planning Manager, Waitemata DHB) introduced the report. Matters covered in discussion and in answer to questions included:

- In the final Planning Package and Guidelines from the National Health Board, a number of mandatory expectations had been re-sized, but overall the level of prescription remained greater than in previous years.
- The approach taken locally last year had been to customise the requirements and that appeared to have been accepted, although there were some general messages from the Ministry of Health (not specific to Auckland DHB and Waitemata DHB) that they had not received enough detail in 2011/12.
- The Board Chair suggested that the Annual Plan should be seen primarily as an accountability document rather than a business plan. He suggested focussing on producing a good accountability document and then extracting from it to develop a planning document.
- Performance measure requirements for the Annual Plan – not too much significance should be placed on what had been removed, as recording and reporting on many of these measures to the Ministry and the Boards will continue whether or not they are reported in the Annual Plan. It was agreed that it would be worthwhile when referring to those measures that are no longer included in the Annual Plan to note that “while these matters are not part of Annual Plan reporting, they are still being focussed on.”
In further discussion about performance measures the importance of being selective and identifying those that make a difference was emphasised.
- At CPHAC's next meeting on 1 February 2012, there will be reporting on Maori, Pacific and Asian Action Plans, which will give a broader picture on what is being reported on in those areas.
- Auckland DHB Board members are having a strategic workshop on 31 January and Waitemata DHB on 8 February, which will assist in identification of Board priorities. If necessary a joint workshop could be arranged after those meetings had taken place.

The Committee Chair thanked Janine Pratt.

The report was received.

5. STANDARD MONTHLY REPORTS

5.1 Primary Care Update (agenda pages 15-23)

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

The Board Chair updated the meeting on developments relating to GAIHN. He advised that following the Audit and Finance Committee meetings of both Boards, he had met with the Chairman of GAIHN and advised him that both Boards are committed to GAIHN but wanted a more focused involvement. This response had led to further consideration of the way GAIHN might operate.

Denis Jury further updated the meeting following a GAIHN Alliance Leaders Team meeting held earlier on 14 December. He advised that there were mixed views about changing the nature of GAIHN, but there had been agreement to fund GAIHN until the end of February 2012, while that is being resolved. There was an expectation that GAIHN could combine some joint projects which all the DHBs would be involved in with a mix of other projects where individual DHB participation would be voluntary.

The Board Chair emphasised the importance of ensuring that agreement on GAIHN proposals for 2012/13 occurs in time to be built into the Annual Plan process, avoiding the problems that had occurred this year.

With regard to the dissolution of the Alliance Health + Board, Denis Jury explained the background, which related to an antecedent organisation, and that the Ministry of Health had funded Health Partners to work with Alliance Health + on a new governance structure and to provide advice on management structure and processes. He advised that he was satisfied with the process and where it was heading, and that it provided an opportunity to create a good organisation. The remaining members of the Alliance Health + Board had been very honest and clear about what was occurring.

Other matters covered in discussion and in response to questions included:

- The Government's new policy of free after hours visits for under-6s (page 18 of the agenda) – Andrew Coe will come back to CPHAC with information from the Ministry on what the funding will be (when that information is available) and on how the policy will be implemented and any funding implications in terms of the regional after hours network (currently seven of the eleven A&M clinics are free for under 6's).
- With regard to the National Hauora Coalition and the setting of PHO Performance Programme targets (page 16), the importance of getting sound PHO data was emphasised.
- Regional Afterhours Service (pages 17-18) – Andrew Coe advised that good, helpful communications coverage had been received, including television and radio, with more recently a focus on specific audiences, for example advertising on Pacific radio. Dale Bramley also noted that when the Afterhours proposal was agreed to, part of that agreement was for an evaluation report around March 2012 on the impact of the new structure. Andrew Coe advised that Auckland and Waitemata DHBs would be driving that evaluation process.
- Andrew Coe will obtain and provide additional information on the College of Urgent Care (page 18) which has responsibility for accrediting new after hours providers, and on the accreditation process.
- Localities (page 21) – with regard to Auckland DHB considering the health links concept as part of its locality approach, this was still being considered and assessed.
- Whanau Ora – Eru Lyndon outlined two components. The first is focused on building systems and capacity, but doesn't provide for how that capacity will be used. The second, navigator, component looks to navigate people through health and social services, for example to educate people about health opportunities.
- Networks (page 21) – the “benefit framework and value proposition” referred to involves such matters as meeting health targets, quality and reporting flow. Objectives for integrated health networks included improving health outcomes, value for money and improving systems performance.
- Unspent PHO Funds (pages 22-23) – there is an issue in that the legislation makes it difficult to retrieve unspent funds without the agreement of the PHOs. The Primary Care Team is pushing for more information from the PHOs and hopefully would have that by the end of the calendar year. At some point a decision would be needed from the Boards. Andrew Coe will check that funds from Te Hononga had been transferred to the National Hauora Coalition and that there were no funds that should be recorded as unspent funds. Strong concerns were expressed at the non return of unspent funds and the Committee Chair talked of the need for a disciplined approach in matters like this.
- Primary Care – the Board Chair commented that over the last year there had probably not been the kind of progress that was needed in primary care. There are too many structures in this area. There is a need to move more assertively to bring patients' needs to the forefront with providers. Unspent PHO funds are neither acceptable nor ethical. There will be a need to push hard to make progress on Whanau Ora. With family health networks, real progress needed to be made and more bureaucracies needed to be avoided. In dealing with primary care providers, there needed to be clarity, consistency and

consequences. Overall he would like to see the pace of change with primary care twenty times quicker than this year's. Integration did not always mean shifting services out; the key is to get patients flowing through the health system and dealt with at the right time.

The report was received.

5.2 Planning and Funding Update (agenda pages 25-28)

Denis Jury (Chief Planning and Funding Officer, Auckland DHB) and Debbie Holdsworth (Acting Chief Planning and Funding Officer, Waitemata DHB) presented the report.

The Committee Chair noted that it had been identified that cervical screening rates in the region are not good and that there need to be more strategies to deal with that. In addition to the duty of care, cervical cancer is a very expensive cancer to treat and every effort should be made to improve levels of screening.

In answer to a question, Denis Jury advised that the failure with WONS was in its ability to achieve screening of high needs women, but this had provided an opportunity to rethink the approach. There had been some good results at Auckland DHB when free smears had been experimented with. There were mixed views concerning the Ministry of Health funding a regional co-ordination service (as it did for all other regions in New Zealand except Auckland), however, the view at the moment was that this option should probably be taken up. In early 2012 they would come back with a clear recommendation on the approach that should be taken to this issue.

Further discussion on cervical screening included:

- Committee members suggested innovative approaches might be looked at, for example clinics in workplaces or making cervical screening available through the mobile breast screening service.
- Data on screening did not come directly to DHBs from the general practices, but is accessed via the Ministry of Health.
- Some time in 2012, the national responsibility for screening will be transferred to the Health Promotion Agency.
- One of the problems in effectively approaching this issue is that some of the funding sits with the National Screening Unit and some with the District Health Boards. There needed to be good consultation to achieve an effective approach.
- Debbie Holdsworth noted that at Waitemata DHB this had been a significant issue of concern and discussion at the Hospital Advisory Committee. The plan was to come back to CPHAC concerning the issues raised. It was also hoped that there would be relevant experience gained from the bowel screening pilot, which involved a new model of working with primary care.

In answer to a question concerning the Commerce Commission investigation into Rest Home Providers alleged "double dipping" (page 26), Denis Jury explained the issue and offered to distribute some information on the "Ryman Model" which looked to provide the clearest solution.

North Shore Hospice (page 26) – the closing of four of the nine beds is critical. Tim Wood advised that he had serious discussions with the CEO and Chair of the Hospice who had been made very aware of the Board's concerns and this had been followed up with a letter to the Hospice re-iterating those concerns. A distributional mechanism for the palliative care workforce across Waitemata is being looked at. He also advised that while the West Auckland Hospice is pursuing its proposal for future expansion, interim measures are being looked at to provide additional beds in the West. The Hibiscus Coast Hospice had six beds which are close to maximum occupancy, and is pursuing plans to provide another ten beds in the future. The Committee was also advised that hospices receive a substantial amount of Government funding but are required to raise a proportion of their operational costs.

Resolution (Moved Lee Mathias/Seconded Max Abbott)

That the report be received.

Carried

6. GENERAL BUSINESS

There was no general business.

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved Warren Flaunty/Seconded Robyn Northey)

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

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

General subject of item to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting with public excluded held on 9 November 2011	<p>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</p> <p>[NZPH&D Act 2000 Schedule 3, S.32 (a)]</p>	<p>Confirmation of Minutes As per the resolution from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.</p>
2. Child Health	<p>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</p> <p>[NZPH&D Act 2000 Schedule 3, S.32 (a)]</p>	<p>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</p> <p>[Official Information Act 1982 S.9 (2) (i)]</p> <p>Negotiations The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations.</p> <p>[Official Information Act 1982 S.9 (2) (j)]</p>

Carried

The Committee Chair thanked members for their participation and wished all a Happy Christmas.

The meeting concluded at 3.48p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA
DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY
COMMITTEES HELD ON 14 DECEMBER 2011

_____ CHAIR

Actions Arising and Carried Forward from Meetings of the Community & Public Health Advisory Committees as at 25 January 2012

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 10/8/11	3.1	<u>CPHAC Terms of Reference</u> – suggested improvements from Chris Chambers to be considered.	Denis Jury, Debbie Holdsworth		Will be included in review of CPHAC in early 2012.
CPHAC 12/10/11	3.1	<u>Paper on Whanau Ora by Eru Lyndon</u> – to be circulated to Committee members.	Lee Mathias		Paper yet to be publicly released – Committee Chair to seek access to it for CPHAC from the Minister responsible for Whanau Ora.
CPHAC 12/10/11	3.1	<u>Local Approach to Health Service Planning</u> - progress report requested for February or March 2012.	Andrew Old	CPHAC 14/03/12	
CPHAC 12/10/11	3.3	<u>Oral Health</u> - issue of schools declining mobile oral health services to be discussed with the Ministries of Health and Education and reported back to CPHAC -more detailed information to be obtained on number and type of mobile services visiting schools (primary and secondary).	Vicki Scott, Rachel Mattison Vicki Scott, Rachel Mattison	CPHAC 14/03/12 CPHAC 14/03/12	
CPHAC 9/11/11	3.1	<u>2012/13 Planning Process</u> – options to keep the Boards involved in the work in process (for example a sub Committee, additional meetings or use of “drop box” technology) to be worked on, with suggestions/further information to be available at the Strategic Planning Days in early 2012.	Janine Pratt, Julie Helean		
CPHAC 9/11/11	5.1	<u>Business Case Reporting</u> – Information requested on expenditure on the different regional business cases over time and results achieved for that expenditure.	Andrew Coe	CPHAC 14/03/12	Formal request from all three DHBs made and will be considered at the next BSMC meeting in early March.
CPHAC 14/12/11	5.2	<u>Planning and Funding Update –Rest Homes</u> – information on the Ryman Model for separating different types of cost to be distributed to CPHAC members.	Denis Jury		Will be provided in February.

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 14/12/11	5.1	<p><u>Primary Care Update</u> – Information to be provided on:</p> <ul style="list-style-type: none"> - Funding of Government’s new policy of free after hours visits for under 6’s, how policy will be implemented and funding implications for the regional after hours network. - - College of Urgent Care and accreditation process for new providers for the regional after hours network. - - What occurred with any unspent funds from Te Hononga PHO. 	Andrew Coe		<ul style="list-style-type: none"> - In contact with Ministry; they are not able to provide further details yet. - Requested and awaiting further information on College of Urgent Care; accreditation process for new providers on After Hours Work Plan but not yet addressed. - Refer Feb CPHAC Primary Care Update (Information not yet available but being progressed)

4.1 Maori Health Report

Recommendation

That the Committee receives this update on the implementation of the Waitemata and Auckland DHBs' joint Maori Health Action Plan.

Prepared by: Aroha Haggie (Maori Health Gain Manager, Auckland DHB) and Edith McNeill (Maori Manager Planning and Funding Waitemata DHB)

Glossary

ALT	- Alliance Leadership Team
BP	- Blood Pressure
BSARG	- Breast Screening Auckland Regional Group
COPD	- Chronic Obstructive Pulmonary Disease
CVD	- Cardiovascular Disease
DAP	- District Annual Plan
DAP Metro	- Auckland Metro District Annual Plan
DSME	- Diabetes Self Management Education
HSG	- Health Service Groups
LTC	- Long term conditions
Manawhenua	- Iwi belonging to an area e.g. Ngati Whatua
MHGAC	- Maori Health Gains Advisory Committee
MHAP	- Maori Health Action Plan
MoH	- Ministry of Health
MoU	- Memorandum of Understanding
NIR	- National Immunisation Register
PHOs	- Primary Health Organisations
Runanga	- Te Runanga O Ngati Whatua (Manawhenua governance body)
Te Ha	- Te Ha O Te Oranga O Ngati Whatua (Maori Provider)
TPK	- Te Puni Kokiri
Waipareira	- Te Whanau O Waipareira Trust
WONS	- Nursing, Education and Health Promotion Services

1. Introduction

This report is a combined report from Waitemata and Auckland DHBs. It highlights current work towards implementation of the Auckland DHB and Waitemata DHB joint annual Maori Health Plan. National Health Targets and other targets common to both DHBs are reported jointly, with activities specific to each DHB reported separately. In relation to the targets in common, this report covers both 2010/11 Q4 and 2011/12 Quarter 1 results.

It is noted at the time of the preparation of this paper that the combined Maori Health Gain Advisory Committee is to next meet on 25 January and therefore has not yet had the opportunity to consider these results. A verbal update where appropriate will be given at the meeting.

The report is laid out in three parts:

1. Commentary updates on key priority areas. These include:
 - Whanau Ora
 - Bilateral ADHB/WDHB Collaboration

- Iwi relationships
 - National Hauora Coalition
 - Health target and priority area progress.
2. Progress against National and other targets for both ADHB and WDHB Maori (Appendix 1)
 3. Summary scorecard for each DHB of progress against the joint plan (Appendix 2)

2. Background

The requirement for all DHBs to have an annual Maori health plan, closely linked to gains in health status, was introduced in 2011. Since the development of separate plans, Auckland and Waitemata District Health Boards have developed a joint plan. This joint plan represents an initial step towards closer alignment of strategic intentions within Maori health while maintaining an emphasis on addressing the distinctive needs of local populations within each DHB region.

The purpose of the joint plan is to document the Auckland and Waitemata DHBs' direction for improving health outcomes and reducing health inequalities for Maori. The plan confirms the DHBs' Maori health vision, and identifies the shared principles that underpin the plan and have provided practical direction for the identification of Maori health priority areas and associated activities and indicators. Underlying conceptual frameworks are also described.

The plan states Auckland and Waitemata DHBs' Maori health priorities for 2011/12, what activities the DHBs will carry out over the course of the year to address those priority issues and why, and how progress will be measured. The plan is aligned to national level Maori health priorities identified by the Ministry of Health and regional priorities developed by the four Northern Region DHBs and their primary care partners and presented in the Northern Region Health Plan. Further, joint Waitemata and Auckland district priorities and local level priorities specific to either DHB that reflect the distinctive needs of local populations are identified.

This plan is consistent with, and draws directly from, both DHBs' key Maori health planning documents, including Maori health needs assessments (Loring and Ratima 2009, Auckland District Health Board 2008), the Annual Maori Health Plans (Auckland District Health Board 2011, Waitemata District Health Board 2011) and previous Maori Health Action Plans (Planning and Funding Team Waitemata DHB 2010, Auckland District Health Board 2006).

3. Key Priority area updates

3.1 Whanau Ora

Whanau Ora service provision within the framework of Better, Sooner, More Convenient Primary Health Care is a Maori health priority area for both WDHB and ADHB as outlined in the DHBs' respective Annual Maori Health Plans. However, there is currently no one explicit shared understanding between Waitemata DHB and Auckland DHB of the concept of whānau ora. Further, there is a lack of clarity with regard to: the range, reach and impact of local whanau ora provision (e.g. systems, programmes, services and tools); the health sector role or current approach within whanau ora and alignment to TPK-led Whanau Ora provision; the key issues in whanau ora implementation within the health sector; and, how best to advance whānau ora from a health sector perspective. At the initial Manawa Ora meeting held on 17 August 2011, the members requested more information on whanau ora including the level of activity occurring with the Auckland and Waitemata DHB regions. A specific whanau ora stocktake and review will provide a clear conceptual basis for Auckland DHB and Waitemata DHB to advance whanau ora locally within the context of the range of current whanau ora policy, provision and activity. The review will be completed in March 2012.

Whanau Ora - Waitemata District Health Board

Te Whanau O Waipareira Trust's Whanau House will be a "flagship" Whanau Ora Centre located in Henderson's central business district, occupying 5,500 square metres over five levels. It will provide a range of services across the health, social services, and education sectors. The majority of Waipareira Trust services have been relocated to Whanau House along with a range of Waiora PHO services. Te Whanau O Waipareira is finalising a lease agreement with East Tamaki Healthcare, and the sale of Wai Health clinic.

In September 2011, Waitemata DHB received various lease options for space within Whanau House. Due diligence has been undertaken on the lease and this raised a number of considerations for the Board at its October meeting. We have since commenced negotiations for securing a ground floor lease of the premises as our preferred option.

Waitemata DHB is also in the process of lease negotiations for the New Lynn Integrated Family Health Centre which includes consideration of the location of whanau ora within this facility.

Whanau Ora – Auckland District Health Board

Various whanau ora work streams are currently underway within Auckland DHB. The first is the development of a Whanau Ora Centre within the Auckland DHB region in either the eastern (Glenn Innes) or central corridor (Avondale/Mt Roskill). Preliminary discussions with iwi representatives, providers in Glenn Innes, the Ministry of Health and the Auckland/Waitemata DHB primary care team have occurred to rally support for the project. The development of a Whanau Ora Centre will also run adjacent to, and be supported by, a project looking to identify and devolve services that could potentially be provided in the Whanau Ora Centre.

The He Kamaka Oranga Provider Arm Team has established an advisory committee which will oversee the development of a whanau ora assessment tool. The tool will be piloted in Starship Children's Hospital wards selected for their high Maori utilisation rates. It will allow Provider Arm staff to identify exactly what services, advice and support the patient and their whanau require once they have been discharged from hospital, in order for them to remain well. This will require cross sector coordination to address socio-economic determinants of health to keep Maori whanau out of hospital.

The secondment of two He Kamaka Oranga staff to the National Hauora Coalition (NHC) concluded in December. The two staff members worked with the NHC for five months to support the implementation of their whanau ora business case.

3.2 Waitemata and Auckland District Health Board Collaboration Initiative – Maori Health

The appointment of Naida Glavish to the joint role of Chief Advisor Tikanga and Dr Dale Bramley as Lead CEO - Maori Health across both DHBs, signalled Phase 1 of a broader initiative to merge Maori Health services across the two DHBs. Recruitment of a public health physician for Maori health across both DHBs has also commenced.

Since this time, a broader organisation-wide collaboration initiative across Auckland and Waitemata DHBs has been agreed and announced. The continuing phases of Maori Health collaboration are expected to fall generally under the principles, approach and co-ordination agreed for the broader bi-lateral collaboration initiative between the DHBs.

Following the decision to combine both Maori Advisory Committees, the individual DHB plans have been combined into one. This draft joint plan has also been submitted to MHAC for review at its January 2012 meeting. The joint Maori Health Plan recognises that aligning

respective DHB priorities where appropriate, and agreeing where joint work can add value, will maximise Maori specific resources to support regional Maori Health Gain.

The first Auckland DHB-Waitemata DHB Collaboration Project Team meeting for Maori Health Services across both DHBs is being held on January 23. This involves the Lead Chief Executive for Maori Health, joint Chief Advisor Tikanga, senior staff from both DHBs and representation from iwi partners (Te Runanga o Ngati Whatua). It is intended to be run as an introduction presentation and then workshop session in order to discuss and develop an optimal model of operation for a merged Maori Health Service between ADHB and WDHB.

3.3 Iwi Relationships

Auckland and Waitemata DHBs have been working with Te Kahupokere to facilitate input into key priority areas as identified by our manawhenua partners. This includes information sharing, strategic advice and input into DAP and MHAP objectives and exploring sustainability options. Further to this the Chief Advisor Tikanga has been working with the Te Runanga o Ngati Whatua health forum to explore development opportunities and implement a Ngati Whatua health network across the rohe of Ngati Whatua.

At the Maori Health Gain Advisory Committee meeting on 25 January, the Committee will be asked to endorse the recommendation to review the current Memoranda of Understanding (MoUs) between Te Runanga o Ngati Whatua (Te Runanga) and both Auckland and Waitemata DHBs.

In 2001, Te Runanga o Ngati Whatua signed two MoUs with Auckland and Waitemata DHBs to partner on matters that include planning, funding and delivery of health services for Maori health gain in the respective DHB regions. Both agreements were premised, in part, on the recognition of Ngati Whatua as tangata whenua (people of the land), and the recognition by all parties of their obligations to Te Tiriti o Waitangi and its principles. Perhaps the most important catalyst that brought these parties together was the overwhelming health inequities experienced by Maori in comparison to non-Maori. The acknowledgement by all parties that work is required to address health inequities is evident throughout both documents, and underpins the importance of a relationship between the DHBs and iwi to drive Maori health gain.

A review of both documents is requested jointly by the Te Runanga and both DHBs. It has been a number of years since both MoUs were signed and in this time there have been a number of new and emerging developments within health and other sectors (e.g. social services). This includes the whanau ora initiative where opportunities for iwi and DHB partnership are numerous. Other areas that have undergone significant change include primary care, notably the Better, Sooner, More Convenient initiative, devolution, integrated family health centres and locality planning, and the rise of the Non-Government Organisation sector where iwi play a more ad hoc role in comparison to the DHBs' role.

3.4 National Hauora Coalition (NHC) (ADHB only)

The Alliance documentation has been agreed and signed by the five partner DHBs and is now with the NHC for signing.

On 14 November, the NHC and the partner DHBs met to agree and set the PHO Performance Programme targets for the 2012 year. National targets have been set wherever these are applicable and there may be some further discussion regarding these as they require a large performance increase, specifically in the areas of smoking cessation.

A process of national integration is also underway between the locality providers and the national organisation. Te Hononga O Tamaki Me Hoturoa is undergoing an internal restructure which should be completed by December 1st. Tereki Stewart stood down as CEO in November

2011 and Marion Hakaraia commenced as General Manager in December 2011. In December the NHC held their first ALT meeting after reconfiguring their ALT structure. The NHC has formed two ALTs, one for Tamaki area and the other for the Waikato area.

3.5 Health target and priority area progress

In relation to both national health priority areas and indicators for Maori health, both Waitemata and Auckland have made some progress, however inequalities remain in a number of priority areas. Our progress against each of the targets is presented in Appendix 2. These reports show the respective DHB's results in addition to the gap between Maori and other. There is some variance in the targets between the two DHBs. This variability reflects different targets being set for each DHB with the Ministry or where a specific target for Maori has been set locally which is different to the national target.

3.5.1 Summary of Results

Target Area	Q4 2011						Q1 2012							
	WDHB	Target		ADHB	Target		WDHB	Target		ADHB	Target			
Immunisations	87%	90%	☒	89%	85%	☑	90%	95%	☒	↑	86%	95%	☒	↓
CVD Risk Assessment	72%	70%	☑	74%	73%	☑	75%	90%	☒	↑	76%	90%	☒	↑
Diabetes Checks	67%	49%	☑	60%	55%	☑	65%	67%	☒	↓	56%	67%	☒	↓
Diabetes Management	64%	65%	☒	67%	72%	☒	62%	67%	☒	↓	56%	72%	☒	↓
Better help for smokers	86%	90%	☒	75%	90%	☒	97%	95%	☑	↑	81%	95%	☒	↑
Breast screening	64%	60%	☑	-	60%	-	62%	70%	☒	↓	65%	70%	☒	-
Cervical Screening	46%	60%	☒	50%	75%	☒	46%	75%	☒	↔	50%	75%	☒	↑
Breast feeding	14%	27%	☒	22%	28%	☒	-	-	-	-	-	-	-	-
PHO enrolment	74%	75%	☒	74%	75%	☒	74%	80%	☒	↔	75%	90%	☒	↑

Good progress is being made in the following areas

- Better help for smokers to quit, with Waitemata achieving the Q1 target and good improvement at Auckland DHB
- Immunisation, with Auckland DHB achieving their Q4 2011 target and good improvement at Waitemata DHB. The increased target for the current year will be a challenge to achieve for all groups
- CVD risk assessment with both Waitemata DHB and Auckland DHB achieving the Q4 2011, target and improvement at both DHBs against the higher target for the current year
- Diabetes checks were achieved for both DHBs for Q4 2011, however a declining performance for both DHBs for Q1 2012. This is no longer being reported as a National Health Target from Jan 2012.

The remaining areas continue to be a challenge for both DHBs. Additional commentary is provided below in all areas where the targets have not been met and include Immunisations, diabetes management, cervical and breast screening coverage, breastfeeding and PHO enrolment for both DHBs and better help for smokers to quit for Auckland DHB.

Reporting against specific actions within the joint Maori Plan is summarised in Appendix 3.

3.5.2 Waitemata DHB Strategies

Immunisation

Waitemata DHB has worked closely with individual practices with high Maori children and lower coverage to identify individual children who have not been immunised. We have worked closely with practice nurses to ensure families of these children receive three timely recall letters and if no response they are followed up by our outreach service.

A large data matching project between the GP practice management systems and the National Immunisation Register (NIR) identified data discrepancies which have now been rectified.

Processes have been put in place to ensure children enrolled in a practice are linked to the provider and in the event they transfer provider, the NIR record is updated in a timely manner to ensure accuracy. This has enabled early follow up for timely immunisation.

With the changes to the health target for 2012/13, we are currently exploring the merits of text reminders linked to the NIR for timely reminders.

Diabetes Management

The Diabetes Get Checked programme will no longer exist as of 1 July 2012 as a free annual review. In January 2012, the health target for CVD was changed to now report cardiovascular risk assessments only. Annual diabetes review and management will still need to be reported through the Annual Plan.

Initial meetings with the two PHOs in the Waitemata district and other stakeholders have generated an agreement that the funding previously for the free annual diabetes check will be utilised for a targeted approach for priority Maori, Pacific, Asian and other patients with poorly managed diabetes. There is also an agreement that the major approach will be multidisciplinary. These discussions are yet to be finalised through the relevant decision making processes for the DHB. There is agreement that a consistent approach between both Auckland DHB and Waitemata DHB is required. The major risk is the current disparity in funding between the two DHBs.

Maori Women's Cervical Screening Coverage

From 1 January 2012, Waitemata DHB will fund through the two PHOs, 1,144 free smears for Maori, Pacific and Asian women. This volume is expected to increase to 2,200 for the 2012/13 financial year. This initiative is to reduce the variance between priority women. There is evidence elsewhere in NZ that when the cost barrier is removed then there is increased attendance.

We are also working with the National Cervical Screening Programme and the greater Auckland DHBs to develop a coordination function which will be funded by the National Screening Unit. This function has been funded elsewhere in the country and has been identified as important for increasing coverage.

Maori Womens Breast Screening Coverage

The focus of activities is aimed at improved identification of Maori women not screened and working with both PHOs and providers to agree how best to jointly recruit and support Maori women to screening.

A Heads of Agreement with ProCare Network North and Waitemata PHO has been signed to enable data sharing and cleansing. Meetings have been held with:

- Identified GP Practices from PHO data sharing and cleansing project, to agree how best to jointly recruit and support Maori women to screening.
- National Hauora Coalition and HealthWEST to discuss how to recruit and support Maori women to screening.

Invitation letters will be sent to all unscreened Maori women and follow up with phone calls to coincide with the launch of the new BSA advertising campaign which will occur in February.

Breastfeeding

A contract was entered into on 1 September 2011 with Waipareira Trust to deliver a Maori Lactation Consultant service for the district. The service establishment phase has been

completed and a Lactation Consultant recruited. Service delivery started in mid-January 2012. Waipareira Trust is also continuing to provide monthly antenatal breastfeeding education classes.

3.5.3 Auckland DHB Strategies

Diabetes Self Management

- New Diabetes Self Management Education contract commences and Pacific Self Management Facilitator employed (0.5 FTE) to initiate roll out of Stanford programme for Pacific populations in ADHB.
- LTC Coordinators working with primary care to better identify and manage their population.

Cardiovascular risk screening

- The Cardiology HSG is developing its strategic document of which screening is a key part, as is equity. Furthermore the Regional Cardiology Group has a small working group that is looking at delivery systems and interventions to increase screening and also improve management.
- Support the uptake of an electronic CVD tool
- Training and information system support for electronic tool
- IT help line for GPs for risk assessment tool
- Increase the cumulative incentive payments for achieving both good assessment and good management together
- Review and reshape incentives to link with PPP targets
- Enhance links to Green Rx and maximise primary care uptake
- Continue to work in various workplaces to enhance CVD risk assessment for men
- Link in with research looking at ways to optimise Pacific males participation in health self management.
- Work regionally to have similar focus on incentive goals.

Percentage of two year olds Immunised

- Practice level reporting available
- Primary care Immunisation Co-ordinators funded ongoing
- ADHB Immunisation Strategy approved
- Funding application made to Starship Foundation to fund social marketing programme was not approved.
- Data cleansing project in primary care approved and funded
- Scoping project for multiagency engagement in promoting immunisation to high needs families
- Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices. Results from audit included over 6,000 immunisation events being manually entered on NIR
- Letters sent to all parents who are noted on the NIR as having declined immunisation for their child to check that this is correct. Follow up activity planned for November 2011 to include phone calls by practices if decline not certain, to confirm the situation.
- Health promotion activities including posters and DVDs displayed in all Community Link sites across Auckland. Health education delivered in 8 PD sites supported by Corrections.

PHO Enrolments

- Review of all PHOs' plans:
 - a) SIA (Services to Improve Access)
 - b) Health Promotion
 - c) Maori Health
- Engage more proactively with PHO CEO Forum

Breast Screening Coverage

Primary care is incentivised to increase the proportion of high needs women, which includes Maori, to uptake breast cancer screening through the PHO Performance Programme. The metro Auckland PHOs are being pushed to incrementally increase their high need population uptake of breast screening to reach the national target of 70%; there are financial rewards for reaching the target or making significant improvement. The targets set across Auckland DHB PHOs by June 2012 range from 59-67%. There has been steady increase in Maori. HKO is working with the BSARG to adapt strategies that work with the nature of the Maori population, particularly in relation to transience, taking a Whanau Ora approach, targeting organisations such as WINZ to provide opportunistic referrals. The group is also seeking to shift from health promotion to a more recruitment and retention role, however face to face work in communities is to continue, but language will be aligned to the recruitment and retention framework.

Cervical Screening Coverage

There have been issues with the funding from the MoH for high needs cervical screening and there has been a change of provider which will impact on service delivery this year. These additional screenings from the exited provider are now being made available through PHOs and so we would expect to see an increase in high needs cervical screening for the latter half of 2011/12 financial year.

The National Screening Unit (Ministry of Health) and HKO have formed a working party to look at opportunities for targeted initiatives e.g. increased screening in Primary care, timely reporting.

Better help for smokers

Percentage of hospitalised smokers offered advice to quit:

- Greenlane Surgical Centre recording of ABC on day of surgery implemented and being monitored weekly. Immediate Actions to improve performance by 13%.

Focus on short stay/high volume areas to achieve 5-8%:

- Continued auditing and 1:1 coaching in AED and APU
- To reduce the “not asked/ documented” option in the Electronic Discharge Summary in AED from 27% to 10%.

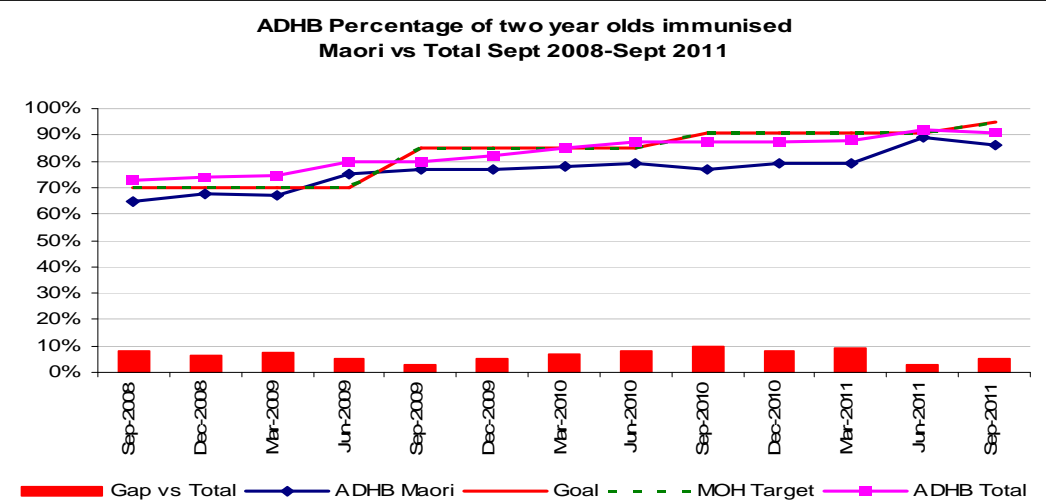
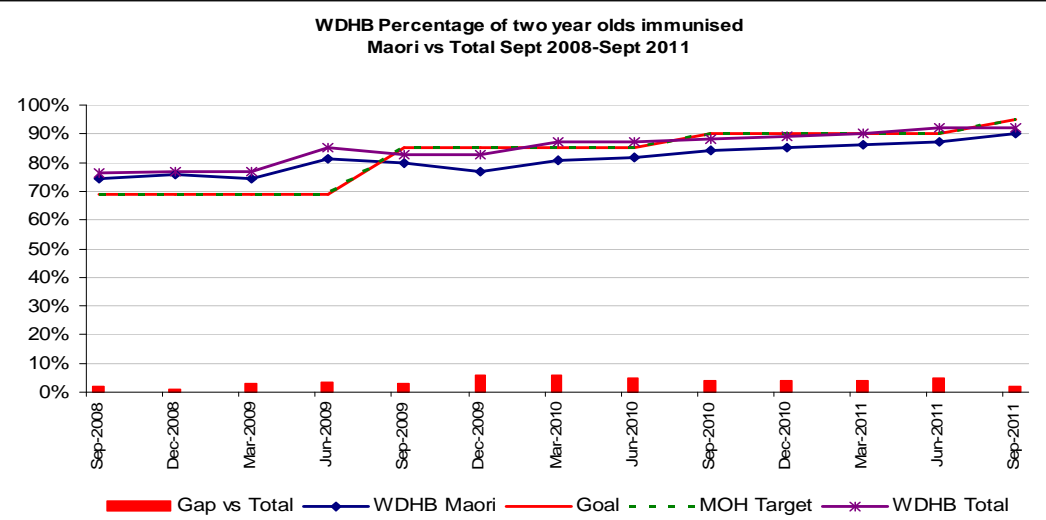
Improve engagement of clinical workforce to achieve 3-4%:

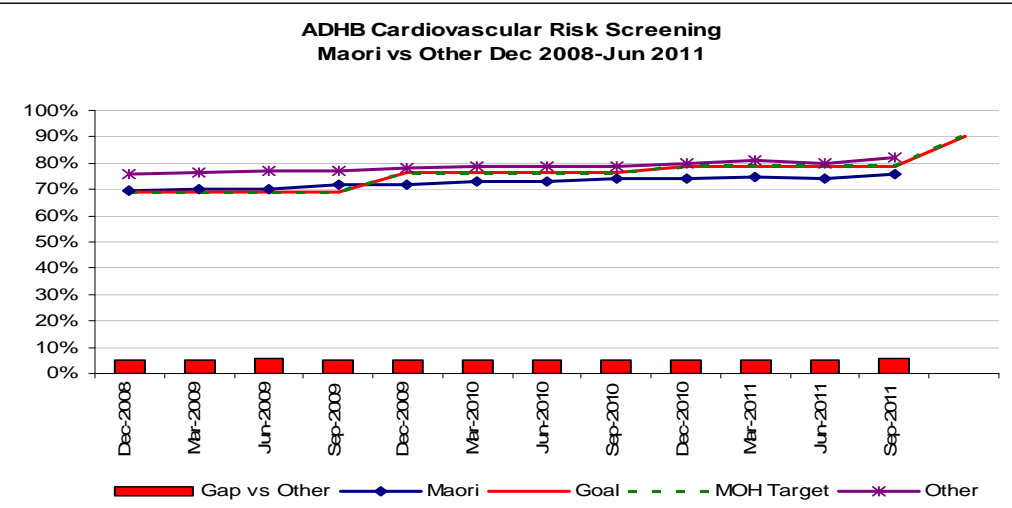
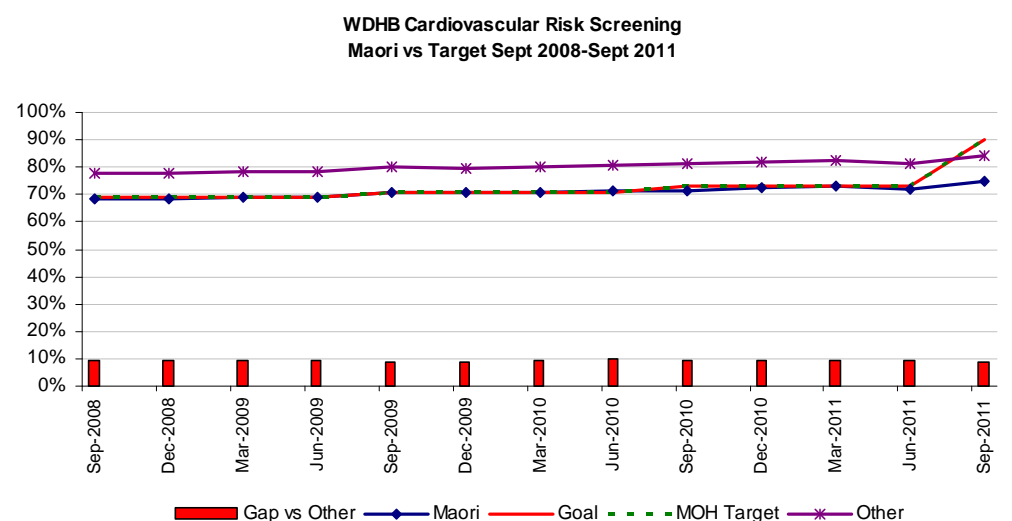
- Data on target now distributed weekly to senior leadership
- Best Practice Guidelines to be distributed to wards and updated weekly
- To work with Registrars to determine barriers and support mechanisms to assist junior doctors complete the ABC in clinical documents and Electronic Discharge Summary.

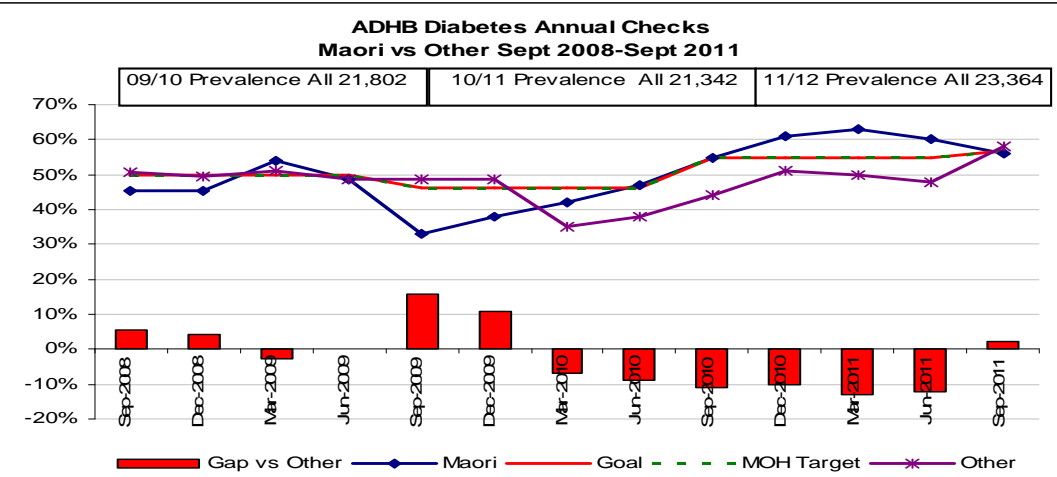
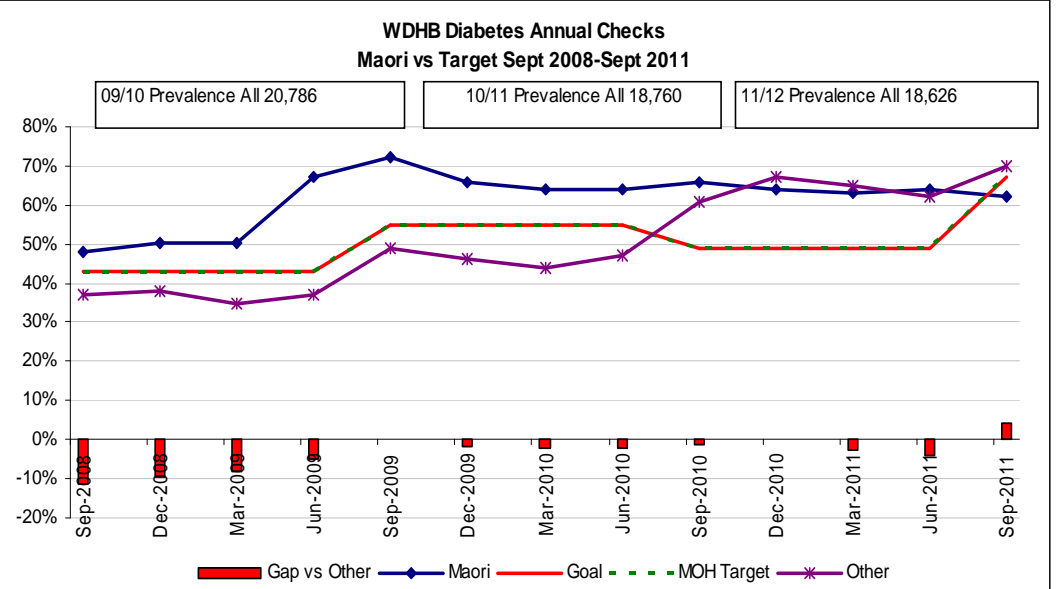
4. Conclusion

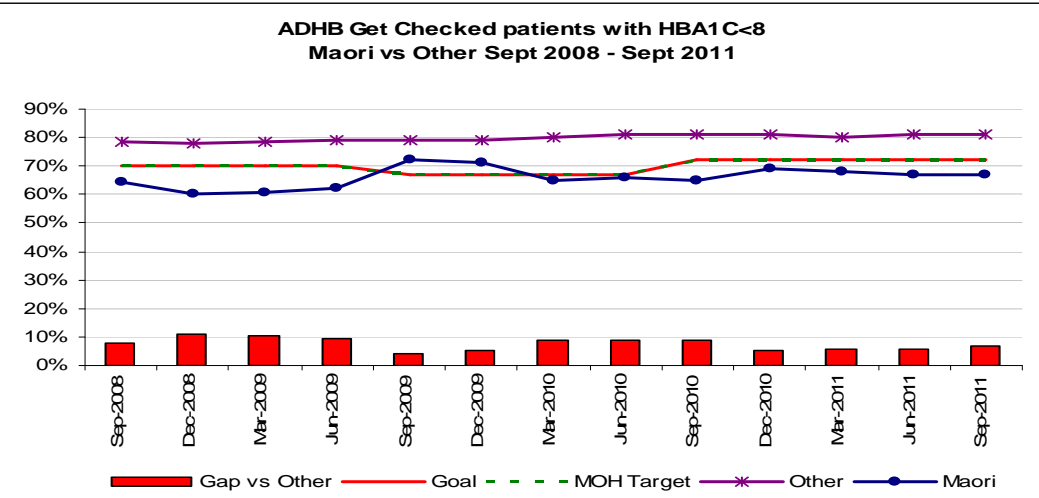
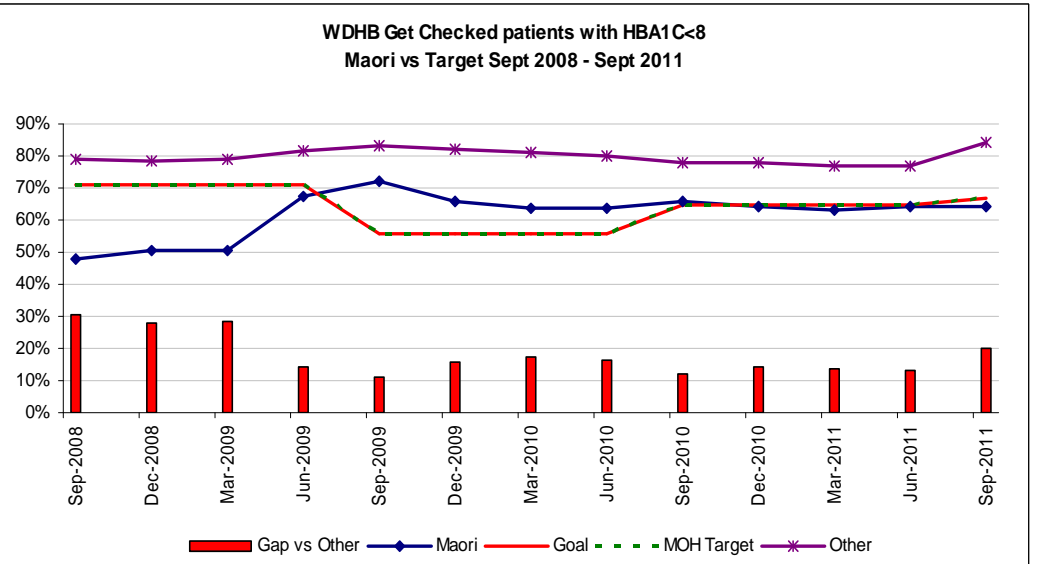
Maori Health staff from both Auckland and Waitemata DHBs are working closely to reconfigure Maori health services and align strategies and consolidate workforce across Auckland. There are some areas where Auckland DHB does better than Waitemata and vice versa. This is a great opportunity for innovation and will provide a strong focus on reducing inequality and improving Maori health gain for our respective populations.


National Health Targets

Actions- Government Health Targets	Waitemata DHB	Auckland DHB	2010/11 & 2011/12 Year End Targets
<p>Child health - Immunisation</p>  <p>ADHB Percentage of two year olds immunised Maori vs Total Sept 2008-Sept 2011</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 87% of Maori children are fully immunised at two years of age.</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 89% of Maori children are fully immunised at two years of age.</p>	<p>WDHB Target 90% of Maori children will be fully immunised at two years of age.</p> <p>ADHB Target 85% of Maori children will be fully immunised at two years of age.</p>
 <p>WDHB Percentage of two year olds immunised Maori vs Total Sept 2008-Sept 2011</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 90% of Maori children are fully immunised at two years of age.</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 86% of Maori children are fully immunised at two years of age.</p>	<p>95% of Maori children will be fully immunised at two years of age.</p>

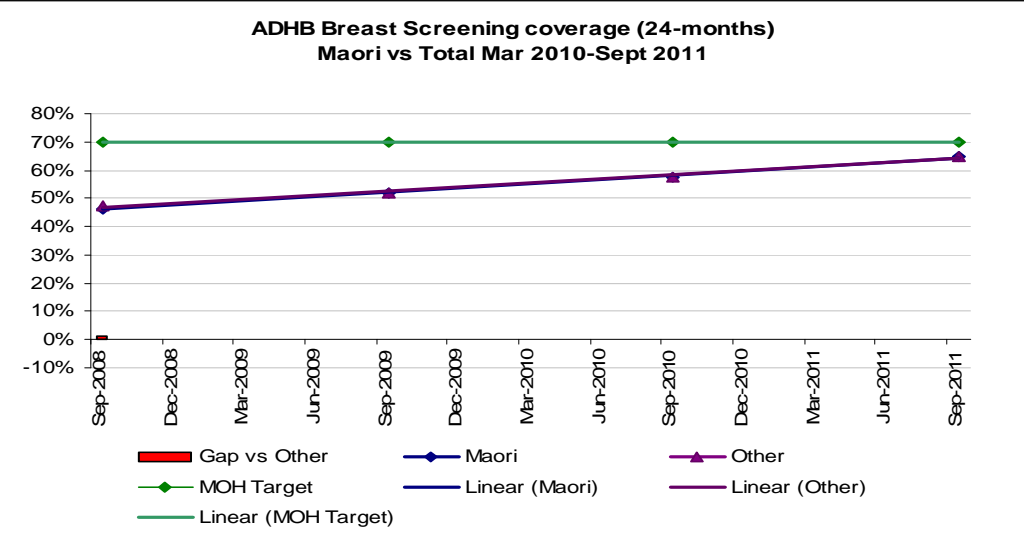
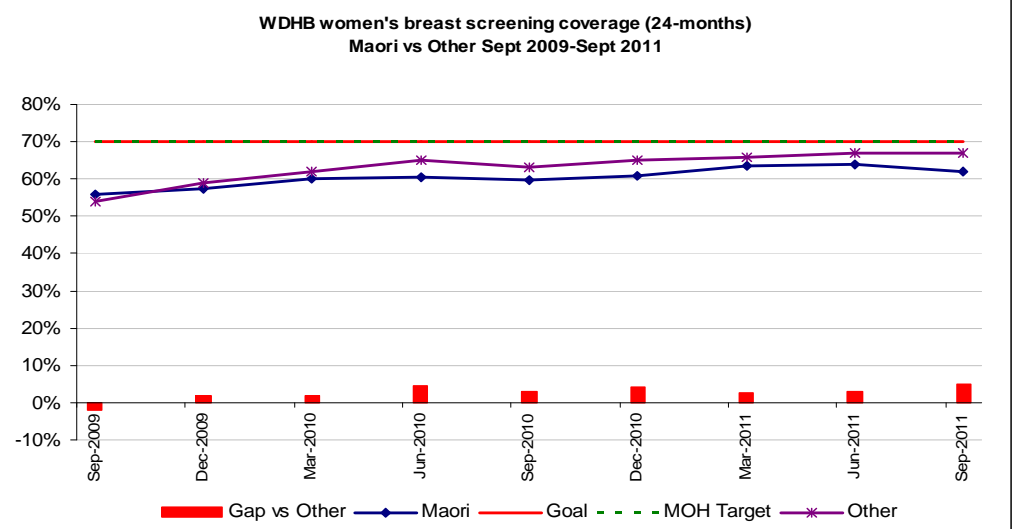
Actions- Government Health Targets	Waitemata DHB	Auckland DHB	2010/11 & 2011/12 Year End Targets
<p>Cardiovascular disease - Risk assessments</p>  <p>ADHB Cardiovascular Risk Screening Maori vs Other Dec 2008-Jun 2011</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 72% of Maori people have been CVD risk assessed in the last 5 years.</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 74% of Maori people have been CVD risk assessed in the last 5 years.</p>	<p>WDHB Target: 70% of Maori people have been CVD risk assessed in the last 5 years.</p> <p>ADHB Target: 73% of Maori people have been CVD risk assessed in the last 5 years.</p>
 <p>WDHB Cardiovascular Risk Screening Maori vs Target Sept 2008-Sept 2011</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 75% of Maori people have been CVD risk assessed in the last 5 years.</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 76% of Maori people have been CVD risk assessed in the last 5 years.</p>	<p>WDHB Target 90% of eligible Maori people will be risk assessed.</p> <p>ADHB Target: 90% of Maori people have been CVD risk assessed in the last 5 years.</p>

Actions- Government Health Targets	Waitemata DHB	Auckland DHB	2010/11 & 2011/12 Year End Targets
<p>Diabetes - Free annual checks</p>  <p>ADHB Diabetes Annual Checks Maori vs Other Sept 2008-Sept 2011</p> <p>09/10 Prevalence All 21,802 10/11 Prevalence All 21,342 11/12 Prevalence All 23,364</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 67% Maori diabetic patients access diabetes free annual checks.</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 60% Maori diabetic patients access diabetes free annual checks.</p>	<p>WDHB Target: 49% Maori diabetic patients access diabetes free annual checks.</p> <p>ADHB Target: 55% Maori diabetic patients access diabetes free annual checks.</p>
 <p>WDHB Diabetes Annual Checks Maori vs Target Sept 2008-Sept 2011</p> <p>09/10 Prevalence All 20,786 10/11 Prevalence All 18,760 11/12 Prevalence All 18,626</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 65% Maori diabetic patients access diabetes free annual checks</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 56% Maori diabetic patients access diabetes free annual checks.</p>	<p>WDHB Target: 67% Maori diabetic patients access diabetes free annual checks.</p> <p>ADHB Target: 57% Maori diabetic patients access diabetes free annual checks.</p>

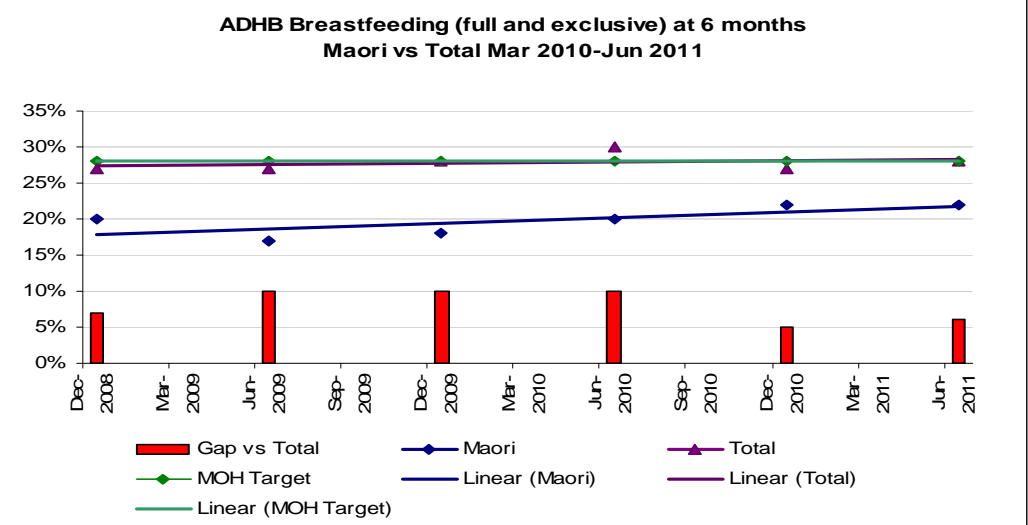
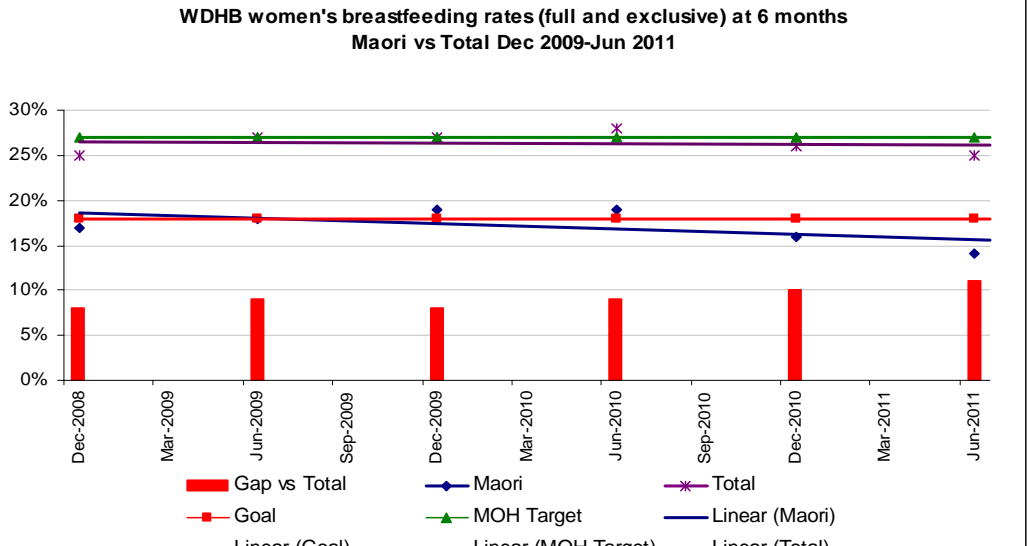
Actions- Government Health Targets	Waitemata DHB	Auckland DHB	2010/11 & 2011/12 Year End Targets
<p>Diabetes - Management</p>  <p>ADHB Get Checked patients with HBA1C<8 Maori vs Other Sept 2008 - Sept 2011</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 64% of Maori people with good or satisfactory diabetes management.</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 67% of Maori people with good or satisfactory diabetes management.</p>	<p>WDHB Target: 65% of Maori people with good or satisfactory diabetes management.</p> <p>ADHB Target: 72% of Maori people with good or satisfactory diabetes management.</p>
 <p>WDHB Get Checked patients with HBA1C<8 Maori vs Target Sept 2008 - Sept 2011</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 62% of Maori people with good or satisfactory diabetes management</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 67% of Maori people with good or satisfactory diabetes management.</p>	<p>WDHB Target: 67% of Maori people with good or satisfactory diabetes management.</p> <p>ADHB Target: 72% of Maori people with good or satisfactory diabetes management.</p>

Actions- Government Health Targets	Waitemata DHB	Auckland DHB	2010/11 & 2011/12 Year End Targets																																																																																					
<p>Better Help for Hospitalised Smokers to Quit</p>  <p>ADHB Percentage hospitalised smokers offered advice to quit Maori vs Total Sept 2009-Sept 2011</p> <table border="1"> <caption>ADHB Data (Estimated)</caption> <thead> <tr> <th>Month</th> <th>Maori (%)</th> <th>Total (%)</th> <th>Goal (%)</th> <th>MOH Target (%)</th> </tr> </thead> <tbody> <tr> <td>Jun-2009</td> <td>55</td> <td>48</td> <td>80</td> <td>80</td> </tr> <tr> <td>Sep-2010</td> <td>65</td> <td>65</td> <td>90</td> <td>90</td> </tr> <tr> <td>Dec-2010</td> <td>65</td> <td>65</td> <td>90</td> <td>90</td> </tr> <tr> <td>Mar-2011</td> <td>72</td> <td>72</td> <td>90</td> <td>90</td> </tr> <tr> <td>Jun-2011</td> <td>78</td> <td>78</td> <td>90</td> <td>90</td> </tr> <tr> <td>Sep-2011</td> <td>80</td> <td>80</td> <td>95</td> <td>95</td> </tr> </tbody> </table> <p>WDHB Percentage hospitalised smokers offered advice to quit Maori vs Total Sept 2009-Sept 2011</p> <table border="1"> <caption>WDHB Data (Estimated)</caption> <thead> <tr> <th>Month</th> <th>Maori (%)</th> <th>Total (%)</th> <th>Goal (%)</th> <th>MOH Target (%)</th> </tr> </thead> <tbody> <tr> <td>Sep-2009</td> <td>5</td> <td>5</td> <td>80</td> <td>80</td> </tr> <tr> <td>Dec-2009</td> <td>22</td> <td>18</td> <td>80</td> <td>80</td> </tr> <tr> <td>Mar-2010</td> <td>40</td> <td>32</td> <td>80</td> <td>80</td> </tr> <tr> <td>Jun-2010</td> <td>60</td> <td>58</td> <td>80</td> <td>80</td> </tr> <tr> <td>Sep-2010</td> <td>68</td> <td>68</td> <td>90</td> <td>90</td> </tr> <tr> <td>Dec-2010</td> <td>75</td> <td>72</td> <td>90</td> <td>90</td> </tr> <tr> <td>Mar-2011</td> <td>72</td> <td>72</td> <td>90</td> <td>90</td> </tr> <tr> <td>Jun-2011</td> <td>85</td> <td>85</td> <td>90</td> <td>90</td> </tr> <tr> <td>Sep-2011</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> </tr> </tbody> </table>	Month	Maori (%)	Total (%)	Goal (%)	MOH Target (%)	Jun-2009	55	48	80	80	Sep-2010	65	65	90	90	Dec-2010	65	65	90	90	Mar-2011	72	72	90	90	Jun-2011	78	78	90	90	Sep-2011	80	80	95	95	Month	Maori (%)	Total (%)	Goal (%)	MOH Target (%)	Sep-2009	5	5	80	80	Dec-2009	22	18	80	80	Mar-2010	40	32	80	80	Jun-2010	60	58	80	80	Sep-2010	68	68	90	90	Dec-2010	75	72	90	90	Mar-2011	72	72	90	90	Jun-2011	85	85	90	90	Sep-2011	95	95	95	95	<p>Q4 2010/11 <input checked="" type="checkbox"/> 86% of hospitalised Maori smokers received help to quit</p> <p>Q1 2011/12 <input checked="" type="checkbox"/> 97% of hospitalised Maori smokers received help to quit</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 78% of hospitalised Maori smokers received help to quit</p> <p>Q1 2011/12 <input checked="" type="checkbox"/> 81% of hospitalised Maori smokers received help to quit</p>	<p>90% of hospitalised Maori smokers received help to quit</p> <p>95% of hospitalised Maori smokers received help to quit</p>
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Sep-2011	95	95	95	95																																																																																				

Maori Specific Health Targets

Actions - Other Targets	WDHB	ADHB	June 30 2012 Target
<p>Women's Health -Breast Screening</p> 	<p>Q4 2010/11 <input checked="" type="checkbox"/> 64% of eligible Maori women are screened</p>	<p>Q4 2010/11 No data of eligible Maori women screened</p>	<p>60% of eligible women are screened</p>
	<p>Q1 2011/12 <input checked="" type="checkbox"/> 62% of eligible Maori women are screened</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 65% of eligible Maori women are screened</p>	<p>70% of eligible women are screened</p>

Actions - Other Targets	WDHB	ADHB	June 30 2012 Target																																				
<p>Women's Health -Cervical Screening</p> <p>ADHB Cervical Screening coverage (36 month) Maori vs Total Mar 2010-Sept 2011</p> <table border="1"> <caption>ADHB Cervical Screening coverage (36 month) - Maori vs Total</caption> <thead> <tr> <th>Month</th> <th>Maori (%)</th> <th>Total (%)</th> <th>Gap vs Total (%)</th> </tr> </thead> <tbody> <tr><td>Mar-2010</td><td>49</td><td>69</td><td>20</td></tr> <tr><td>Jun-2010</td><td>50</td><td>69</td><td>19</td></tr> <tr><td>Sep-2010</td><td>51</td><td>70</td><td>19</td></tr> <tr><td>Dec-2010</td><td>51</td><td>70</td><td>19</td></tr> <tr><td>Mar-2011</td><td>50</td><td>69</td><td>19</td></tr> <tr><td>Jun-2011</td><td>50</td><td>69</td><td>19</td></tr> <tr><td>Sep-2011</td><td>50</td><td>70</td><td>20</td></tr> </tbody> </table>	Month	Maori (%)	Total (%)	Gap vs Total (%)	Mar-2010	49	69	20	Jun-2010	50	69	19	Sep-2010	51	70	19	Dec-2010	51	70	19	Mar-2011	50	69	19	Jun-2011	50	69	19	Sep-2011	50	70	20	<p>Q4 2010/11 <input checked="" type="checkbox"/> 46% of eligible women screened</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 50% of eligible women screened</p>	<p>WDHB Target: 60% of eligible women screened</p> <p>National Target: 75 % of eligible women are screened</p>				
Month	Maori (%)	Total (%)	Gap vs Total (%)																																				
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Actions - Other Targets	WDHB	ADHB	June 30 2012 Target
<p>Percentage of PHO Enrolments</p> <p>ADHB Percentage of PHO enrolments Maori vs Total Sept 2008-Sept 2011</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 74% Percent of Maori enrolled in PHOs.</p>	<p>Q4 2010/11 <input checked="" type="checkbox"/> 74% Percent of Maori enrolled in PHOs.</p>	<p>Target 75% Percent of Maori enrolled in PHOs.</p>
<p>WDHB Percentage who are enrolled with a PHO Maori vs Other Sept 2008-Sept 2011</p>	<p>Q1 2011/12 <input checked="" type="checkbox"/> 74% Percent of Maori enrolled in PHOs.</p>	<p>Q1 2011/2012 <input checked="" type="checkbox"/> 75% Percent of Maori enrolled in PHOs.</p>	<p>WDHB Target 80% of Maori enrolled in PHOs.</p> <p>ADHB Target 90% of Maori enrolled in PHOs.</p>

Appendix 2 – DHB Scorecards against Joint ADHB Maori Health Plan

1. Waitemata District Health Board – Progress against Maori Health Plan Project Activity Areas

Waitemata DHB & Auckland DHB Maori Health Strategic priorities	Article 1 – Kawanatanga - Health System Performance					Article 2 – Tinorangatiranga - Maori Participation and Leadership		Article 3 – Oritetanga - Achieving health equity		
	Quality Data Ethnicity Data Collection	Whanau Ora Development BSMC	Chronic Care	Primary Care	Child Health	Inter and/or intra sectoral Collaboration/ Regionalization	Clinical Leadership Work force Development Tikanga Best Practice	Improve Maori Access to Secondary Care	Improve Maori access to primary care	Improve mental health and youth health services
Maori Health Plan Ref										
Waitemata DHB 2011/12 Key Actions										
Implement Ethnicity Auditing Framework	x					Delivery of the Kia Ora Hauora Maori workforce development programme	✓	Develop a public health registrar project to investigate ethnic inequalities in access to Primary Mental Health Options for Maori, including youth service development.	✓	
Improve Maori Access to POAC	x					Engagement of Maori Public Health Expertise to provide advice to clinical advice across a range of projects specifically Cancer (for WDHB & ADHB)	✓	Establishment of a Community Youth Hub to provide services for young people in Waitemata district , successful provider has been announced	✓	
Implement Maori Community Lactation Service	✓					Work with other Northern Region DHBs and regional clinical networks to develop a Maori engagement framework for optimising regional clinical networks' engagement with Maori stakeholders.	x	Collaborate, interact and integrate with Auckland DHB – He Kamaka Oranga.	✓	
Implement Coronary Revascularisation Project	✓					Support the development of Hato Petera's Health Science Academy	✓	Shared successful DHB initiatives/ strategies for improving access	✓	
Participate in the development and Implementation of the Diabetes Improvement Programme	✓					Development of a best practice Tikanga Framework was approved at the October 2011 MHGAC meeting.	✓	Development of a targeted programme to reduce Māori FSA DNA rates at NSH	✓	
Implement a stock take of whanau ora models in Waitemata and Auckland DHBs	✓					Development of core competencies for Maori Providers of DSME	✓	Implement cervical screening services via PHO contract agreements	✓	
Implement Mobile Breast Screening Unit	✓					Implement a Maori Clinical Nurse Specialist Framework	✓	Implement reduced unplanned admissions programme - (focus on Māori)	✓	
Implement cervical screening service via PHO agreements	✓					Maori Work force development plan first draft completed – joint project with Work force development team and the Health Campus (Careers adviser)	✓			
Redesign Smoking Cessation Resources in Te Reo Maori	✓					Whanau Oranga Hinengaro - Northern Regional Maori Mental Health and Addictions Strategy and Implementation Plan 2010 – 2015.	✓			
Implement Smoking Cessation training for General practices with a high Maori enrolled	x									
Implement strategy to improve Immunisation coverage for Maori	✓									
Implementation of the Pictorial Asthma Management Plan(PAMP) in primary care	x									
Establishment and Launch of Whanau Ora Centre – progressing the lease agreement	✓									
Implement reduced unplanned admissions programme - (focus on Maori)	✓									
Development of an individual risk equation to predict future admission for COPD, validation of the equation	x									
Implement Kaupapa Maori Nutrition and Physical Activity	x									
Key Achievements:					Key Achievements:					Key Achievements:
<ul style="list-style-type: none"> Maori coverage for Immunisation has improved over the last 2 years, from 80% to 93 % (in Dec 2011); the gap between Maori and non Maori is now 1%. Maori Community Lactation Service has been established , Lactation consultant has been appointed and the strategy for district wide coverage has been agreed between Manawhenua and Matawaaka Whanau Ora Centre was established and launched in West Auckland Joint DHB Draft Maori Health Plan has been completed and will go to the Maori Health Gain Advisory Committee on the 25th January 2012 for sign off The Readmissions Project - October was devoted to ensuring the staff, systems and processes were all in place and ready for the Project Intervention to 'go live' on 1 December 2011- Met with Maori Nurses working in Maori Provider organisations to establish follow up protocols and referral pathways for Maori. 					<ul style="list-style-type: none"> Kia ora Hauora programmes on track contract to be extended In the process of recruiting a Public Health Physician to work in Maori Health Working with Hato Petera to develop their Health Science Academy Director of Nursing currently developing a Clinical Nurse Specialist framework for Maori nurses The inaugural Maori health grand round series has commenced; the first one was very successful the second one will be held in February 2012. First draft of Maori Workforce Development strategy completed. This is a joint collaboration between, the Workforce Development Team, the Health Campus, and Planning and Funding. Northern Regional Maori Mental Health and Addictions Strategy and Implementation Plan was agreed by RFF and MaGAC in October 2011. 					<ul style="list-style-type: none"> Youth Hub establishment now under way Developing referral protocols between Primary Care and Secondary Care , with focus on Maori Providers to follow up Maori patients referred from the Readmissions Project New contract agreements with Waitemata and ProCare PHOs to improve access and coverage for cervical screening. We have worked together to develop a joint Maori Health Plan.
Remedial plans where deliverables off track:					Remedial plans where deliverables off track:					Remedial plans where deliverables off track.
<ul style="list-style-type: none"> Once the Clinical Nurse Specialist Framework for Maori nurses is established, work will begin on development of an individual risk equation to predict future admission for COPD Ethnicity Auditing Framework is now back on track with a revised project plan, including new timelines has been received from WPHO Currently assessing the Energise Physical Activity and Nutrition Programme - to be delivered in Maori Kura , across WDHB Whanau Ora Stocktake analysis in progress due for completion by the end of the month Whanau Ora Health Impact Assessment of Gateway Assessment process will be completed in March. 					<ul style="list-style-type: none"> Work with other Northern Region DHBs and regional clinical networks will begin once a Public Health Physician has been appointed, to develop a Māori engagement framework for optimising regional clinical networks' engagement with Māori stakeholders. Establishing criteria for application of the HEAT tool to assess new initiatives. 					

Auckland District Health Board – Progress against Maori Health Plan Priority Areas

Article 1 – Kawanatanga - Health System Performance				Article 2 – Tinorangatiranga - Maori Participation and Leadership			Article 3 – Oritetanga - Achieving health equity			Article 4 – Ture Wairua – Rights to beliefs		
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Quality Data Ethnicity Data Collection	Whanau Ora Development BSMC	Chronic Care Child Health	Improving Access to Primary Care	Inter and/or intra sectoral Collaboration/ Regionalization	Clinical Leadership Work force Development	Improve Maori Access to Secondary Care	Improve access to primary care and	Improve mental health and youth health	Tikanga Best Practice			
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Auckland DHB 2011/12 Key Actions

No.	Priority	Progress	No.	Priority	Progress	No.	Priority	Progress	No.	Priority	Progress
4.1/ 4.2a	Accuracy of ethnicity reporting in PHO registers	X	4.6a/b	Reduce Cancer morbidity and mortality	✓	4.2a	Improve Maori access to primary care	X	6.4	Tikanga Best Practice	✓
4.3	Improve Child and maternal health	✓	4.9	Increase Maori participation in the DHB workforce at all levels and in a range of roles to support equitable health outcomes for Maori	✓	4.2b	Improve access to primary care	✓	6.8	Improve staff competency and commitment to implementing the Tikanga Best Practice Policy/Guidelines	✓
4.4a/ b	Reduce morbidity and mortality through improved cardiovascular access and care	✓	5.1	Increase Maori participation and reduce inequities in cancer morbidity and mortality	X	4.7a/b	Reduce Cancer morbidity and mortality and improve respiratory health through reducing smoking rates	X			
4.5a/ b	Reduce morbidity and mortality through improved diabetes care	✓	5.2	Strengthen regional clinical networks	✓	4.8a	Improve Child Health	✓			
5.3	Better Sooner More Convenient Services	✓	6.1	Improve Maori mental health NGO services	✓	4.8b	Improve the health of older people	X			
5.5	Regionalisation	✓	6.5	Reduce the incidence of rheumatic fever for Maori in ADHB	X	4.8b	Work with Māori media to increase visibility of Māori influenza immunisation and access to primary care.	X			
6.2	Address Whanau Ora	✓	6.6	Promote and prevent SUDI	✓	5.4	Increase Maori access to outpatient services	X			
6.3	Equitable Maori health outcomes – Health Expenditure	✓	6.7	Maori participation and engagement in planning of services within ADHB	✓						
			6.9	Effective implementation of the MOU with TRoNW	✓						

<p>Key Achievements:</p> <p>4.3 Increase in Maori staff trained as peer breastfeeding educators.</p> <p>4.4b The first cut of recent data is now available for discussion. Scoping for the evaluation of two cardiac rehabilitation programmes has been drafted and sent out for feedback.</p> <p>5.3 Support for the project has been received from key ADHB managers, and consultation with iwi and local providers has also produced strong support for the project.</p> <p>5.5 Draft plan has been developed and is being presented for MHGAC meeting Jan 2012. Informal collaborative working environment established with formal arrangements occurring through phase 2 ADHB/WDHB Maori health collaboration.</p> <p>6.2 Reference group and team to lead the project are agreed. Preliminary meetings have occurred.</p> <p>6.3 A review of the Maori Health Spend for 2009/10 has been completed. Planning and Funding with HKO are working on an annual review of ADHB Māori health expenditure for the period 11/12 following the format developed. This will provide the basis for determination of Māori health expenditure targets for the ADHB by HSG.</p>	<p>Key Achievements:</p> <p>4.6A Provision of Strategic Maori advice to strengthen Breast Screen Auckland's responsiveness to Maori.</p> <p>4.9 Currently have 14 rangatahi programme cadets on work experience, placed 9 Maori new nurse grads (5 in primary care), 9 P2HC cadets, 6 secondary school pupils received A+ Trust scholarships (bringing the total number to 24 recipients currently working within ADHB), and the workforce development team is supporting Hato Petera College's science camps. 5 of their students will be given places within the rangatahi programme.</p> <p>5.2 Preliminary discussions have occurred with the northern region Maori GMs</p> <p>6.1 Key positions within the service have been filled. Governance, working and stakeholder committees are fully operational, and work is progressing well with iwi endorsement.</p> <p>6.7 Being progressed through the primary care and Maori health groups.</p> <p>6.9 HKO is actively working with iwi on initiatives including Maori provider development (e.g. provider forum and new Mahitahi Trust contract) and mainstream service enhancement (e.g. development of Maori health plans for ADHB mental health providers). Work is progressing well.</p>	<p>Key Achievements:</p> <p>4.8a Development of a new relationship with Maori Women's Welfare League Regional Immunisation Co-ordinator and new Plunket relationship manager. Development of GIS Maps as part of Toi Oranga Whanau for use across a range of Maori health planning.</p>	<p>Key Achievements:</p> <p>6.4 Agreement has been reached with Quality regarding the components of the Healthcare Excellence Framework that will be utilised for review and criteria for the framework are in development.</p> <p>6.8 Scoping for the evaluation has been finalised.</p>
<p>Remedial plans where deliverables are off track:</p> <p>4.1/ 4.2a Progress to date has been slow. Plan in place with Planning and Funding and Procure PHO on strategies to turn this around by June 30 2012. PHOs have been provided with some leniency in the delivery of their Maori Health Action Plans, SIA Plans and HP Plans due to the work being undertaken around the BSMC business cases. Direct action requesting that these matters be addressed has taken place.</p> <p>4.4a Working through the targets, project in place.</p> <p>4.5a DAR being replaced with PPP targets.</p> <p>4.5b Diabetes targets are being replaced, reporting as usual until the cut off dates.</p>	<p>Remedial plans where deliverables are off track:</p> <p>4.6 a/b Progress is only meeting half of target. Plan in Place.</p> <p>5.1 Progress has been slow. HKO with the NRCN Māori Leadership Group is reviewing the current model seeking to provide greater clinical leadership and Maori health research expertise to better both regional and national cancer Maori health leadership related activities.</p> <p>6.5 Progress is only meeting half of the intended target. Plan in place.</p>	<p>Remedial plans where deliverables are off track:</p> <p>4.2a Progress has been slow. Plan in place to address this with HKO and Planning & Funding working in partnership with Procure PHO in developing strategies and initiatives to increase Maori enrolment in PHOs.</p> <p>4.7a/b Progress is only meeting half of the target. Plan in Place</p> <p>4.8b Little progress. Plan in place.</p> <p>5.4 The team to lead the project is agreed and DNA data by HSG is complete. However, work to bring the metro-DHBs together is yet to occur with meetings planned for February, which will bring the project back on track.</p>	<p>Remedial plans where deliverables are off track:</p>

4.2 Pacific Health Report

Recommendation:

That the Committee receive this update on the implementation of the Waitemata DHB and the Auckland DHB Pacific Health Action Plans.

Prepared by: Hilda Fa'asalele (General Manager Pacific Health, Auckland DHB), Lita Foliaki (Pacific Planning and Funding Manager, Waitemata DHB), Dr John Huakau (Epidemiologist, Waitemata DHB) and Leani O'Connor (Pacific Planning and Funding Manager, Auckland DHB)

Glossary

BP	- Blood Pressure
CFA	- Crown Funding Agreement
CPN	- Certificate in Pacific Nutrition
CVD	- Cardiovascular Disease
CVDRAM	- Cardiovascular Disease risk assessment and management
DSME	- Diabetes Self Management Education
HbA1c	- Glycated hemoglobin
HVAZ	- Healthy Village Action Zone
MoH	- Ministry of Health
PHO	- Primary Health Organisation
Q1	- Quarter 1
Q4	- Quarter 4

1. Executive Summary

This report is a combined report from Waitemata and Auckland DHBs. National Health Targets and other targets that we have in common are reported jointly and activities specific to each DHB are reported separately. In relation to the targets we have in common, we report on 2010/11 Q4 results and 2011/12 Quarter 1 result.

In relation to the national health targets, 2010/11 Q4 targets were met for immunisation and cardiovascular disease risk assessments for both DHBs. The breast screening target was also met by both DHBs.

Support to quit smoke for Pacific hospitalised smokers was at 97% at end of Q1 2011/12 for Waitemata DHB.

As of end of September 2011, good progress is being made towards achieving the 2012 end of year target of 95% for immunisation. The breast screening target of 70% continues to be exceeded by both DHBs. CVD risk assessment and management (CVDRAM) for Pacific people at Waitemata DHB is at 58.8% making the new *More Heart and Diabetes Checks* target of 60% for 2011/12 Q4 likely to be achieved.

The greatest challenge for both DHBs continues to be good management of diabetes.

Although both DHBs met their *Get Checked* targets, the targets were lower than for non-Pacific people, and in terms of the management of diabetes, the results for both DHBs worsened during the 2010/2011 year. The percentage of well managed diabetics at Auckland DHB decreased from 64% to 60% and for Waitemata DHB it decreased from 58% to 54%.

Cervical screening continues to be a challenge for both DHBs, but more so for Waitemata with coverage decreasing slightly from 55% to 54%, but increasing for Auckland DHB by 4% from 60% to 64% during the 2010/2011 year.

2. Introduction/Background

Waitemata District Health Board updated its health needs assessment covering all its residents in 2009. Following this publication more detailed analysis was undertaken of the Maori, Pacific and Asian populations resulting in specific health needs assessments for the respective groups. A Pacific Health Action Plan was developed to respond to the needs identified in the Health Needs Assessment. The Pacific Health Action Plan was approved by the Board at its June 2010 meeting.

Auckland District Health Board has a Pacific Health Action Plan 2010-2014 to address identified health needs amongst Pacific people in its area. Five key priorities for action were agreed, namely:

- Improving management of chronic conditions among Pacific communities
- Building Capacity and Capability of the Pacific workforce
- Enhancing health service access and responsiveness for Pacific people
- Fostering the health of Pacific children and young people
- Strengthening and Consolidating Flagship Pacific Programmes and Services.

Implementation of these priorities is delivered as much as possible within the diverse Pacific ethnic communities via Healthy Village Action Zones. The partnership between ADHB, Primary Health Organisations and Pacific communities is challenging but instrumental in supporting Pacific communities to develop their own solutions to their health priorities.

In relation to this report, other than reporting on targets, we describe the community development projects that both DHBs undertake, because they attempt to address the risk factors for diabetes and CVD.

3. DHB Specific Projects

In terms of specific projects, we describe the Waitemata DHB Enea Ola Project and Auckland DHB's Healthy Village Action Zone Project. Both are community development projects that attempt to influence lifestyle change working through churches and community groups. They are especially important because they attempt to reduce the risk factors for obesity and CVD. Waitemata DHB also reports on progress regarding the implementation of the bowel screening programme in relation to engaging Pacific people in the programme.

3.1 Waitemata DHB Specific Projects

Enea Ola Project - Background

One of the major projects that Waitemata DHB has implemented in the last three years is the Enea Ola Project. The Project is funded by the Ministry of Health as part of the implementation of its Healthy Eating Healthy Action (HEHA) Strategy. It is a church - and community - based project for Pacific peoples residing in the WDHB area. It utilises the concept of community action to address obesity issues related to nutrition and physical activity amongst the Pacific population. Thirty church and community groups participate in the project which started in 2008 and continues to June 2012. The Project is guided by a Steering Group that meets bi-monthly. The Steering Group consists of 21 church and community leaders from West Auckland and North Shore representing Samoan, Tongan, Niue, Cook Islands, Fiji, Tuvalu and Kiribati communities. The churches/groups are supported by two Enea Ola coordinators: one in West Auckland (through West Fono Health Trust) and one in North Shore (through Pasefika Integrated Health Care). Other providers such as the Heart Foundation, Sports Waitakere and Harbour Sport, also sit in the Steering Group.

Project Objectives

Through these activities, the Enea Ola programme aims to achieve the following objectives:

1. Increase physical activity levels
2. Improve nutrition
3. Reduce obesity
4. Improve the church/group's health promoting environment or culture

Project interventions include

- Establishing a health committee in each participating church/group.
- Undertaking physical activity sessions for a minimum of 30 people
- Running monthly nutrition classes.
- Train-the-trainer activities that include Netfit community coach training (for physical activity) and Pacific nutrition training and more

Evaluation

A formatively-based process and immediate outcomes evaluation of the programme has been conducted by the Centre for Health Services Research and Policy and Pacific Health section from the School of Population Health at the University of Auckland. Only 12 of the participating churches/groups were involved in this evaluation and this was due to funding constraints.

The evaluation seeks to determine whether Enea Ola has achieved its intended objectives and whether this has had any apparent effects on the church and group environment. A process and immediate impact evaluation was performed using the Centre for Disease Control and Prevention (CDC) Evaluation Framework for Public Health Initiatives (1999). A community participation model has been utilised to ensure that data are collected in the appropriate manner.

Results

What follows are the adult results from 2009 to 2011 collected from 12 participating groups. The results illustrate the demographics of the adult population captured in database and also the weight, waist circumference and BMI change of the sample over this three-year period.

Sample Demographics

Of the 1151 participants in the Enea Ola (EO) database, 739 were adults and 225 were youth (aged 18 years or under). The age of the remaining 187 participants was unknown; these individuals were included in the adult sample analysed (n=926). The majority of the adult sample were female (61%, n=569), 31% were male (n=286) and the gender of 8% of the sample (n=71) was unknown.

Weight Change Analysis

Repeated weight measures were available for 57% of participants in 2009 (n=264), 66% of participants in 2010 (n=374) and 46% of participants in 2011 (n=72).

Of the participants who were weighed twice during 2009, 43% maintained their weight, 38% lost weight and 19% gained weight. Of those weighed twice during 2010, 34% maintained their weight, 41% lost weight and 25% gained weight. Of the participants who were weighed twice during 2011, 40% maintained their weight, 45% lost weight and 15% gained weight. Across the three years, the proportion of participants who gained weight fluctuated but was always smaller than the proportion of participants who maintained or lost weight.

Of those adults who recorded weight loss following three years of participation in the programme (n=48), 33% lost more than 5% of their body weight (n=16) and 12.5% lost between 4% and 5% of their body weight (n=6).

Each year the total number of kilograms lost by participants far exceeded the number of kilograms gained. In 2009, records showed 329 kilograms were lost and 177 were gained; in 2010, 566 kilograms were lost and 312 were gained, and in 2011, 96 kilograms were lost and 30 were gained.

The large differences in total kilograms lost or gained between the years represent differences in the number of people measured each year.

Workforce Development

During the course of the Project, about 100 participants undertook physical activity training and 30 graduated with an AUT Certificate in Pacific Nutrition. These participants now run the physical activity and nutrition training in the churches/groups.

Smoke Free Church and Community Environments

In the current year, the development of smoke free policies and implementation of the policies in church and community owned sites were added to the Enuu Ola contract. Workshops were held with churches and community groups to explain the harmful effects of smoking. Additional workshops were undertaken with participants who were prepared to be smoke free champions in their church or community. Their function is to continue to provide information and refer smokers from their church/community to quit smoke services. The workshops were run collaboratively by the Waitemata DHB smoke free co-ordinator, the Pacific smoke free team from the Heart Foundation and the Pacific Quit Smoke Service. Six workshops have been held and two more will be held by June 2012.

Future of Enuu Ola

The funding for this project is through a CFA agreement with the Ministry of Health and this contract expires on 30 June 2012. The results are encouraging, but the Project needs a process of re-thinking, re-energising and re-designing to include the latest evidence with regard to obesity prevention. This re-thinking, re-design process will follow the community action and community empowerment model on which the Project is based, so it will include the Enuu Ola Steering Group, the health committees in the churches/groups, the evaluators, other organisations involved with the Project, academics involved in obesity prevention, and learning from Auckland DHB's HVAZ and Counties Manukau DHB's Lotu Mo'ui programs. This re-design process will be premised on two options, one that the funding will continue and the other that there will be no available funding as of July 2012. This process will occur in March/April 2012.

3.2 Bowel Screening

Agreement has been reached with West Fono Health Trust to undertake the following functions in relation to the bowel screening programme for the Pacific population in West Auckland:

- Health education to create awareness of the programme and how to participate in it
- Follow-up telephone calls or home visit to Pacific people who do not send their sample to the laboratory
- Provide support for those who need colonoscopy
- Refer those diagnosed with cancer to the Pacific cancer navigation service.

Agreement has been reached with Pacific Integrated Healthcare to provide health education to create awareness and participation in the programme for Pacific people living on the North Shore. Training for community health educators from both organisations has been undertaken.

3.3 Auckland DHB Specific Projects

Healthy Village Action Zones (HVAZ) - Background

Launched in 2007, three Primary Health Organisations (AuckPac, Tongan Health Society and ProCare Network Auckland) were contracted to deliver Parish Community Nursing services in Pacific churches and communities within seven geographical zones in the ADHB district.

These zones are now reconfigured to five geographic zones: Grey-Lynn/ Ponsonby, Avondale/Mt Roskill, Onehunga, Otahuhu and Glen Innes/Panmure.

Through this initiative, ADHB aimed to:

- Identify target Pacific families through churches
- Utilise and enhance access to currently funded health services
- Support and facilitate improved health outcomes for Pacific peoples. Health Village Action Zones is the framework which enables and supports health activities to be developed and delivered to and by Pacific communities.

There are now 42 participating Pacific churches and their communities and a workforce of 11.5 FTEs. All except two of the FTEs are based with the PHOs /Providers and each provider works with 14 churches. These FTEs form the 'HVAZ Operational Team' and whilst employed by separate PHOs, work collaboratively as a 'virtual team'.

Goals

The four goals of HVAZ Action Plan 2010-2015 are:

1. Empower and equip Pacific communities with knowledge and resources to take greater control over their own health and wellbeing
2. Increase Pacific individual and family access to holistic, quality and comprehensive primary health care
3. Build a strong sustainable infrastructure to support the implementation of health promoting activities
4. Reduce health inequalities for Pacific peoples, with a focus on priority conditions.

What makes HVAZ unique is its integrated model of working with churches using community action and self-determination to deliver improvements in the health of Pacific families. The uniqueness of HVAZ is also a source of many challenges.

Parish Community Nursing

Parish Community Nurses (PCN), with a Parish Community Worker (PCW) work across the 5 zones. It is a partnership model with the church to establish and support Pacific church health committees. They develop and co-ordinate health plans and health promotion programmes for parishioners.

HVAZ Update on programmes

There are numerous projects in progress that are led by the HVAZ team or the churches. We have included only a few of these in the update. It should be emphasised however, that there has been a lot of engagement, interaction and work between primary care, secondary care, NGOs and other agencies to develop and support this work. Running alongside this work is the HVAZ evaluation (by the School of Population Health, University of Auckland team) which concludes in June 2012. The Final Report will be available then.

In 2011, eight Self Management Education Courses were delivered. The SME workshops had retention rates of over 80% of church participants. In total 89 people successfully completed the (6 weeks – one day per week) course. The courses are delivered either in the Samoan and/or English languages. The high attendance and completion rate of each workshop can be attributed to the courses being held in the churches, with the active participation of church leadership (Church minister/pastor and or the church health committee leaders), and delivered in Samoan or English (Tongan translation has not yet been funded). An ethnic specific approach is most appropriate and effective in the delivery of this programme.

All HVAZ churches have two or more exercise instructors delivering exercise programme two times weekly. A total of 115 people completed the Pacific Heart Beat's 2 Days Nutrition Programme, and 23 people completed the Certificate in Pacific Nutrition (9 Days). The Pacific Youth Advisory Committee (representatives from five zones) was recently established to

support working with Pacific Youth. There is an ongoing work focused on the Health of Older people. Zone work continues, bringing together churches in a zone to consider collaborative further activities or to share successful stories.

The Healthy Eating Awards Programme where Churches agree to implement Healthy Eating Policies during Church events has been in place for three years. Currently, seven Churches have achieved the Gold Award (implementing all fifteen Healthy Eating Guidelines), 29 achieved Silver Award (implement seven) and six on Bronze (implementing three Healthy Eating Guidelines).

There has been change observed in nearly all of the churches regarding attitudes towards eating healthy food. This is evident in church functions where menus have changed and church policy encourages healthy food options. The role of the HVAZ Nutritionist has contributed significantly to the successful changes implemented.

The discussion part of the report describes and suggests interventions that can be implemented within the resources presently available to respond to those targets that continue to be not met.

4. Targets

For a summary of 2010/2011 Quarter 4 and 2011/2012 Quarter 1 results as against national and DHB health targets refer to Appendix 1.

5. Discussion

This discussion relates to those targets that were not met as of end of 2010/11 financial year being diabetes, cervical cancer, smoking and breast feeding.

5.1 Diabetes

Diabetes Prevalence

Diabetes is one of the most important health issues for Pacific people affecting 10% of Pacific people and four times the rate for the total New Zealand population. Pacific people are also diagnosed with diabetes 10 years earlier than European New Zealanders and have higher rates of mortality and complications.

Diabetes Management

In terms of diabetes management, as referred to in the beginning of this paper, the results for both Auckland and Waitemata DHBs worsened during the 2010/2011 year as previously described in this report.

A cross-sectional study on the primary care provided for Pacific people with Type 2 diabetes in South and West Auckland (Robinson et al., 2006¹) found that “usual care” (number of consultations, regular examination and investigations) was similar across ethnic groups but Pacific people were not achieving the same outcomes because they presented with other risk factor conditions, being smokers (18% prevalence compared to 13% European), having an HbA1c greater than 8% (56% compared to 23% European) and having microalbuminuria, protein in urine (59% compared to 27% European). The study recommended changes to “usual care” and more specific intensive care for Pacific diabetic patients to address the co-morbidity conditions that worsen diabetes.

¹ Robinson T, Simmons D, Scott D, Howard E, Pickering K, Cutfield R, Baker J, Patel A, Wellingham J, Morton S. **Ethnic differences in Type 2 diabetes care and outcomes in Auckland: a multiethnic community in New Zealand.** *N Z Med J.* 2006 Jun 2;119(1235)

A 2008 analysis of the *Get Checked* programme (Elley et al., 2008²) looked at CVD risk assessment across ethnic groups and found that Pacific people were receiving similar rates of appropriate CVD and preventative renal drug therapy to Europeans (in 2004), but they had worse CVD and diabetes risk profiles. Among those participating in the programme, Pacific people had higher levels of obesity, poorer glycaemic control and early renal damage compared with Europeans. Later work from this group found that although many Pacific people with diabetes progress to macrovascular and microvascular disease, the rate of progression was the same as for Europeans after adjusting for the higher levels of initial risk factors.

Waitemata DHB Interventions - Pacific Diabetes Self Management Education

As well as “usual care”, *Get Checked* and CVD risk assessment, a diabetes self management education (DSME) contract was entered into with West Fono Health Trust. The contract requires 30 courses to be run (with an attendance of between 12 – 15 per workshop) by June 2012. The courses are delivered by nurses in Samoan, Tongan, Niuean, Tuvalu and English languages. As of June 2011, 23 courses had been held, attended by 245 participants.

HbA1c measures of participants were taken prior and after attending 15 of the courses that were held between January 2011 and June 2011 and in relation to the participants of these particular courses

- 187 people with diabetes (and 16 supporters) attended
- 113 had HbA1c measures taken before and after the courses
- 75 (66%) had improved HbA1c levels
- HbA1c levels stayed the same for 5 participants and
- HbA1c levels increased for 33 (29.2%) of the participants.

The majority of people who were invited and attended the workshops are patients of West Fono. Notwithstanding this, engaging these patients with poorly managed diabetes was challenging. A total of 883 people were invited and 245 or 27.7% of these attended and completed the courses. Engagement included invitation by letter, telephone follow-up (sometimes in the first language of the patient) and home visit as last resort.

The present courses include three half days and most are held during normal work hours. West Fono is likely to meet the number of patients required by their present contract, but feedback from previous participants suggest that the 12 hour course is too long and that the courses need to be available outside normal working hours.

International evidence show that diabetes self management education does improve clinical outcomes for people with diabetes and the results from West Fono show that it is also effective for Pacific people. However, it is probably necessary to deliver the courses in the first or preferred language of the patients and by nurses/clinicians who understand the economic and social/cultural reality of Pacific people so that information/knowledge is contextualised and suggested behavioural change is accepted and is “doable” by patients.

Suggested Changes to Get Checked

The *Get Checked* program as a free annual check will cease as of 1 July 2012. Initial meetings with the two PHOs in the Waitemata district and other stakeholders have generated an agreement that funding from the cancelled *Get Checked* program be utilised for a targeted approach that priorities Maori, Pacific, Asian and other patients with poorly managed diabetes. There was also agreement that the major approach be nurse-led multidisciplinary teams working alongside GP practices. However, these discussions are yet to be finalised through the decision making processes of the two DHBs. From a Pacific patients’ perspective, this high level agreement from the key stake holders is encouraging and may better address the needs of

² Elley CR, Kenealy T, Robinson E, Bramley D, Selak V, Drury PL, et al. **Cardiovascular risk management of different ethnic groups with type 2 diabetes in primary care in New Zealand.** *Diabetes Res. Clin. Pract.* 2008;79(3):468–473

Pacific diabetic patients, especially those that are not enrolled with West Fono or other Pacific providers.

Responses to Risk Factors - Obesity

The Enea Ola Project is a community action response to obesity and smoking. The results are encouraging but over the three years, the third year shows a decrease in the number of participants and those that had their weights measured. The Project, if funding continues, may need to develop a stronger weight reduction focus for people with high clinical risks. The community action/empowerment principles may need to be retained with the people for whom the programme is targeted taking a central role in designing a programme that suits and will work for them, with professional advice alongside. The West Fono DSME participants may take a leading role in doing this. If/when the diabetes multidisciplinary teams come into being, they also can actively refer patients to the Enea Ola Project.

Evidence Regarding Effective Interventions

Primary care team changes, patient education, clinician education and self management education are all shown by evidence to improve diabetes clinical outcomes.

Recommendations for Improved Diabetes Management

The following are recommended actions that can be met from within present resources:

1. Renew the DSME contract with West Fono but reduce the length of the course and make it available outside normal working hours
2. Reconfigure a portion of the funding from the cancellation of the *Get Checked* program to focus on Maori and Pacific patients with moderate to high clinical needs
3. Establish nurse-led multidisciplinary diabetes teams that can effectively engage and deliver care and education to Maori and Pacific patients as well as other patients
4. Actively link Pacific diabetic patients to programs such as Enea Ola, HVAZ, Green Prescription or other lifestyle change support programmes
5. Increase number of smokers referred to quit smoke services, especially those that DNA the Waitemata outpatient smoke free service
6. Further implement the WDHB Enea Ola smoke free environments
7. Train Pacific diabetic nurses (from Pacific workforce development funding).

5.2 Cervical Screening

Coverage

Cervical screening continues to be a challenge for both DHBs but more so for Waitemata with coverage decreasing slightly from 55% to 54%, but increasing for Auckland DHB by 4% from 60% to 64% during the 2010/2011 year.

Intervention

In the last quarter of 2010/11, the Ministry of Health provided funding to Auckland DHB which allowed the DHB to fund free smears for high needs women through general practices. This may be one of the reasons why coverage for Auckland DHB increased in the 2011/11 year.

Waitemata DHB will fund the two PHOs in this district to provide free smears for 1144 high needs women starting from 1 January 2012. This is in addition to the contract that the Ministry of Health has with West Fono Health for the same purpose. There is evidence reducing the cost barrier to women increases uptake.

5.3 Smoking

The support to quit for Pacific hospitalised smokers increased from 54% at the beginning of the 2010/11 year to 87% at the end of the year and by the end of the first quarter 2011/12 it had reached 97%, exceeding the 95% target. However there is a high DNA rate for smokers who are referred to the hospital outpatient clinic. To respond to the high DNA rate, the Pacific Support Service at Waitakere and North Shore hospitals will make contact with the patients who DNA

and ask for their permission to be referred to the Pacific Quit Smoke service who are able to visit them at their homes. We will monitor whether this increases access to quit smoke services.

The smoke free workshops that have been held in Enuā Ola churches have increased referrals to the Pacific Quit Smoke Service from these churches. Referrals from Waitemata DHB primary care providers to the Pacific Quit Smoke Service have been low and PHO smoke free co-ordinators reported that there is a preference by PHOs to provide their own quit smoke support service, which is an option provided they have the language/cultural competence to effectively engage with Pacific people who smoke.

Between July 2010 – December 2011, the rate of advice given to Pacific hospitalised smokers at ADHB increased from 65% to 88%. These rates show the same general trend or are slightly higher than other or the total population. A working relationship has been established with the Pacific Quit Smoke Service and Pacific patients are offered the choice of being referred to the service for follow up support. Referrals to this service continues to increase.

Community

The Pacific Quit Smoking service targets and delivers services to Pacific people across Waitemata and Auckland District Health Boards. The service currently operates from the Auckland Regional Public Health Service, Greenlane and actively seeks to enrol Pacific people in the community at Pacific community events, workplaces, through networks and church programmes for example Healthy Village Action Zones, Enuā Ola.

A total of 178 clients were enrolled with the service from 1 July to 31 December 2011, 49% of the minimum annual target. Enrolments for ADHB are tracking at 63% of the minimum annual target of 144 clients. WDHB enrolments are tracking at 40% of the minimum annual target of 216 clients.

5.4 Breast Feeding

Coverage

Breastfeeding rates are low for Pacific women and are not improving. Exclusive breastfeeding rates at discharge from NWH by ethnicity (2004–2010) show an apparent increase for all ethnicities, and this is in line with the Government's focus on improving breastfeeding among Maori and Pacific mothers. It is disappointing however, that exclusive breastfeeding rates among Pacific women are lower than those among European and Maori mothers (2010, NW's Annual Clinical Report). The barriers for breastfeeding are well documented, however there has been a growing change, in particular for NZ-born Pacific mothers who are returning to work earlier, mostly for financial reasons, and there are limited options to encourage and maintain breastfeeding in the workplace.

Interventions

Waitemata DHB has a contract with West Fono to provide an education programme for 90 pregnant women on the importance of breast feeding and other related issues. The programme is not making a measurable difference. It is important that we gain a better understanding of the barriers that women experience before a better response is implemented.

ADHB has a contract with Plunket for the Community Breastfeeding Service (CBS) which employs Maori, Pacific and Asian breastfeeding support workers and a lactation consultant. The service provides support both ante and post natally to women and their families; for the first six months of 2011/12 519 Pacific women enrolled with the service. There has been a small increase in Pacific breastfeeding rates at six weeks since this service was established (February 2009), however whether this is a trend and the reasons for it are not known.

La Leche League breastfeeding peer counselling training was funded and four Pacific Peer Counsellors from the Tongan Health Society and Health Star Pacific were trained in 2008 and 2009. ADHB had a contract in 2008/9 with Tongan Health Society to deliver breastfeeding peer

support sessions. However, the La Leche League peer counselling model was not particularly successful in a range of communities including Pacific and is not a focus in our current breastfeeding actions.

ADHB is also supporting Plunket to achieve Baby Friendly Community Initiative (BFCl) accreditation; an accredited service is one that promotes, protects and supports breastfeeding. The process of accreditation includes training all staff and policy implementation. An offer to open the training for Pacific Provider staff to attend has been taken up by Tongan Health Society. This will mean the Baby Friendly Hospital Initiative (BFHI) accreditation achieved by National Women's is continued in the community. It would be of value to support and encourage more Health Providers to achieve BFCl accreditation in the future.

6. Conclusion

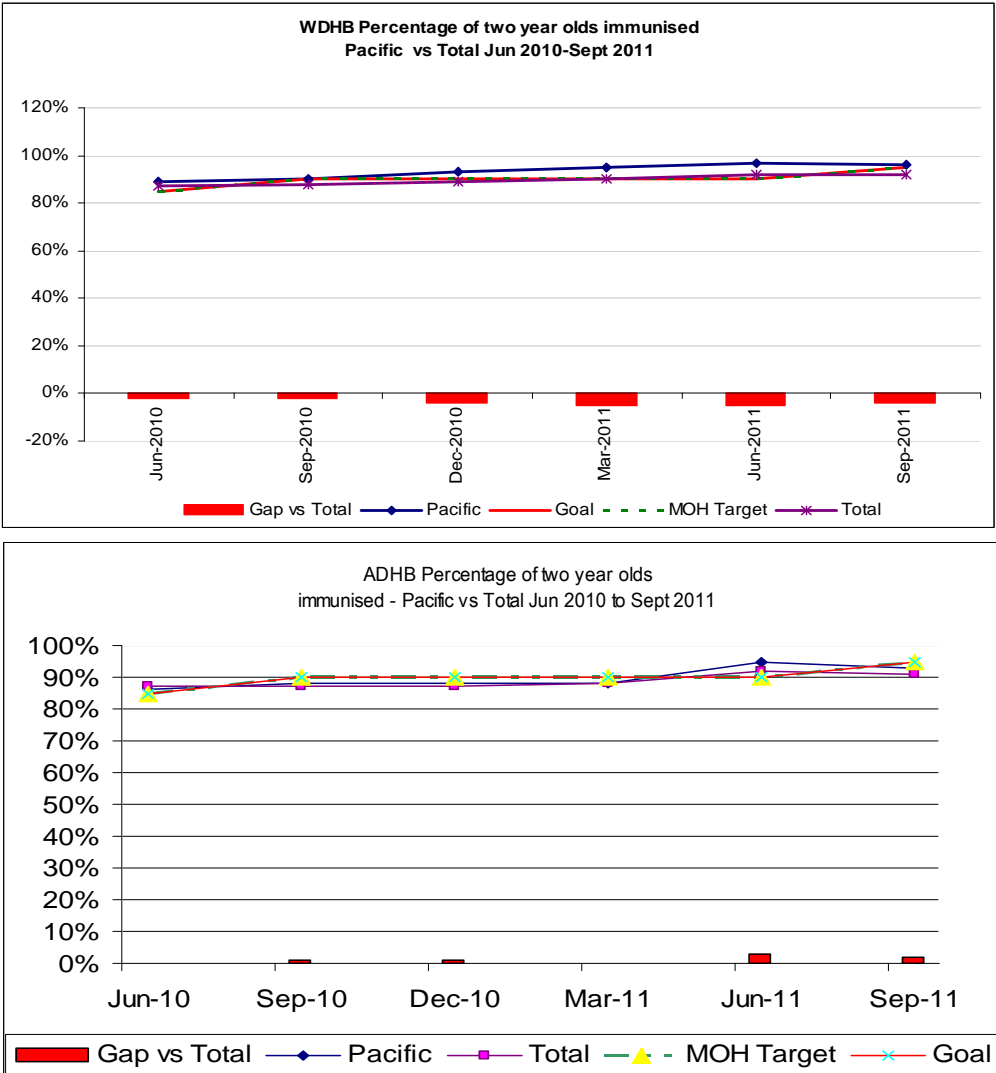
The Pacific Health Action Plan is not intended to be stand-alone plan for addressing Pacific health needs, rather it is a component of an integrated planning package which includes the Northern Regional Health Plan and our District Annual Plans, as well as other Pacific health strategies and plans (e.g. Pacific Mental Health and Addiction Service Development Plan). Whilst there are some encouraging results especially in relation to immunisation, CVD risk assessment, breast screening, the Enea Ola program and Healthy Village Action Zones, major challenges remain in diabetes management, cervical screening, smoking and breast feeding.

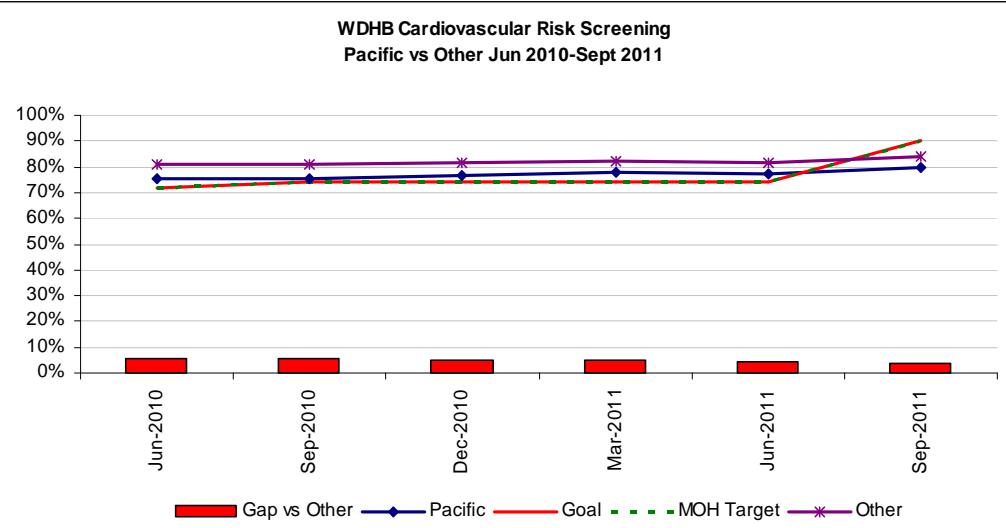
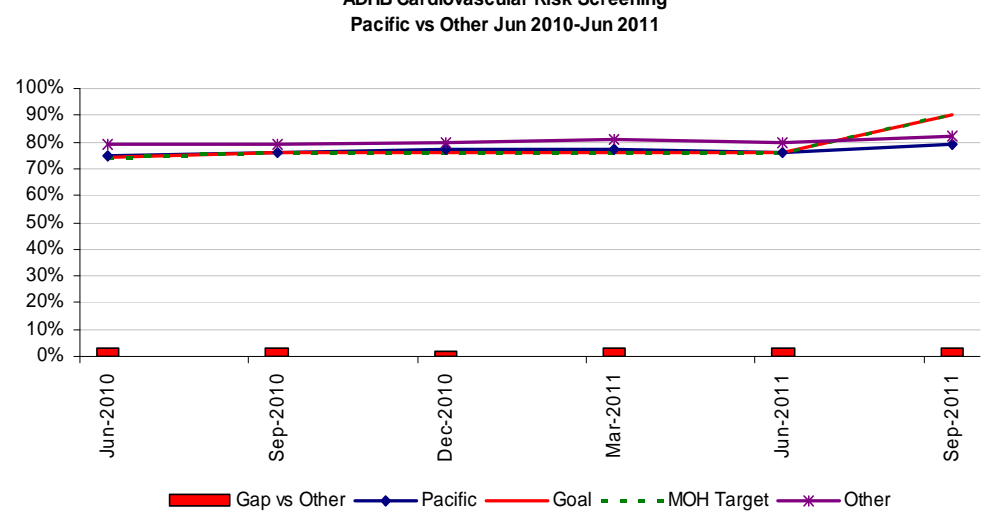
The Auckland and Waitemata DHBs' Pacific teams have commenced collaborative projects and plan to continue to look at future collaborative opportunities in the 2012/13 year. Work has commenced to recruit new Pacific graduates to support the increase in the recruitment of our Pacific workforce development to work in priority areas of identified high need for Pacific peoples.

The future health and wellbeing of Pacific peoples is dependent on improving nutrition, reducing the proportion of the population who are overweight, reducing the prevalence of smoking, and changing the pattern of alcohol consumption. Failure to improve the health status of children and young people will perpetuate the current state of Pacific health inequalities.

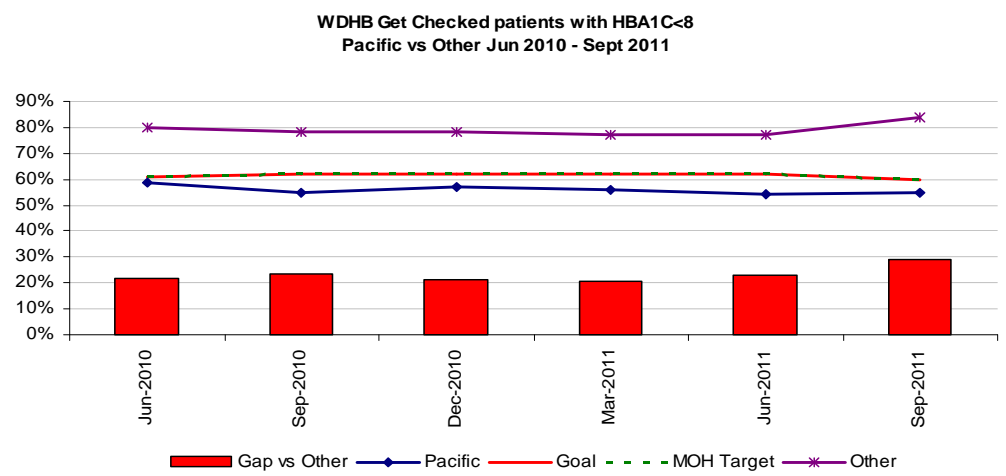
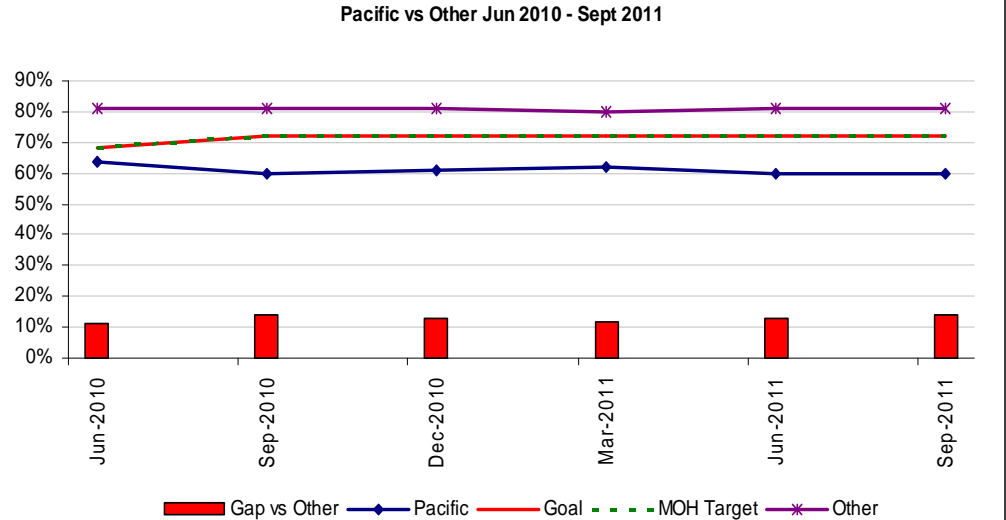
There are some areas where Auckland DHB does better than Waitemata and vice versa. We intend to further explore the reasons why this may be so, so that learning will benefit the Pacific population of both DHBs.

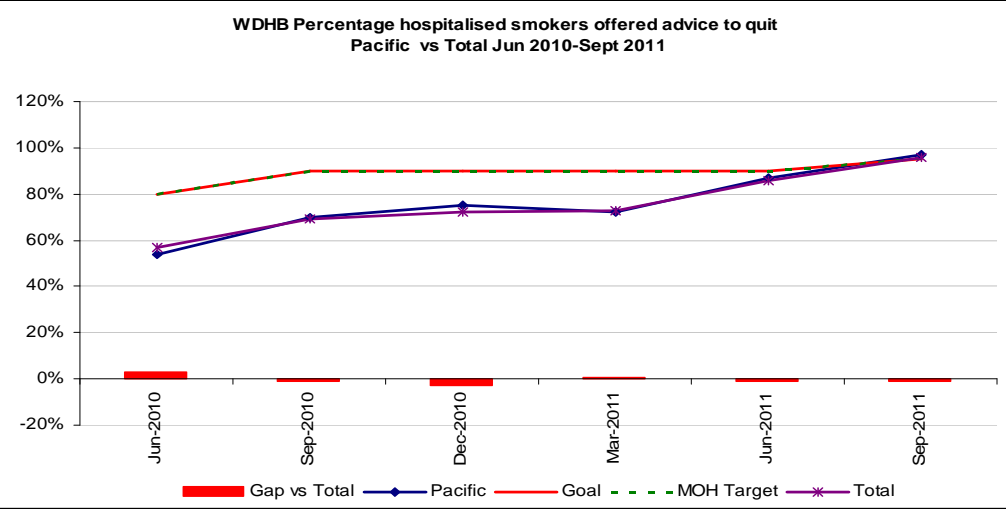
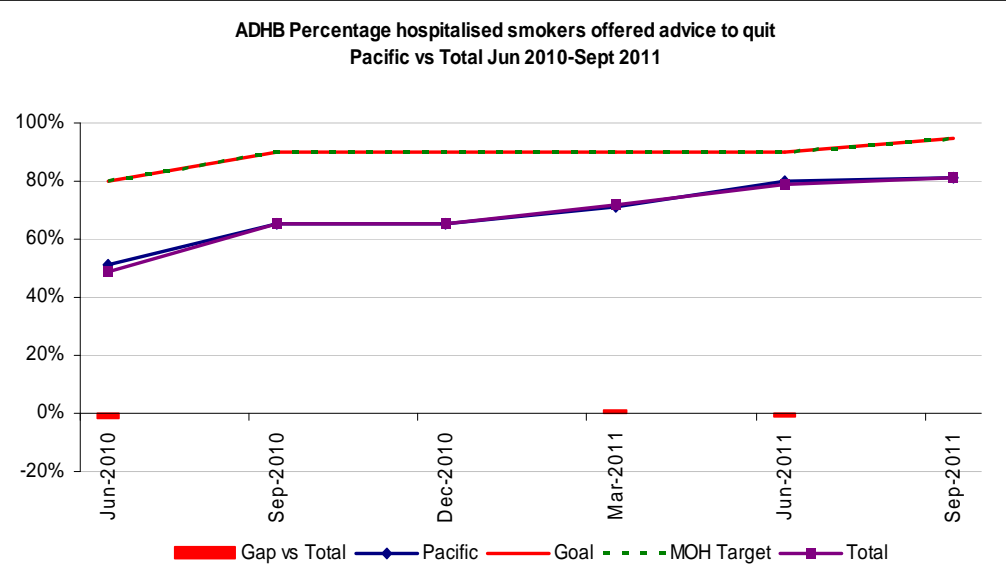
Appendix 1 - National Health Targets

Actions- Government Health Targets	Waitemata DHB	Auckland DHB	End of Year 2010/11 and 2011/12 Targets																																																																						
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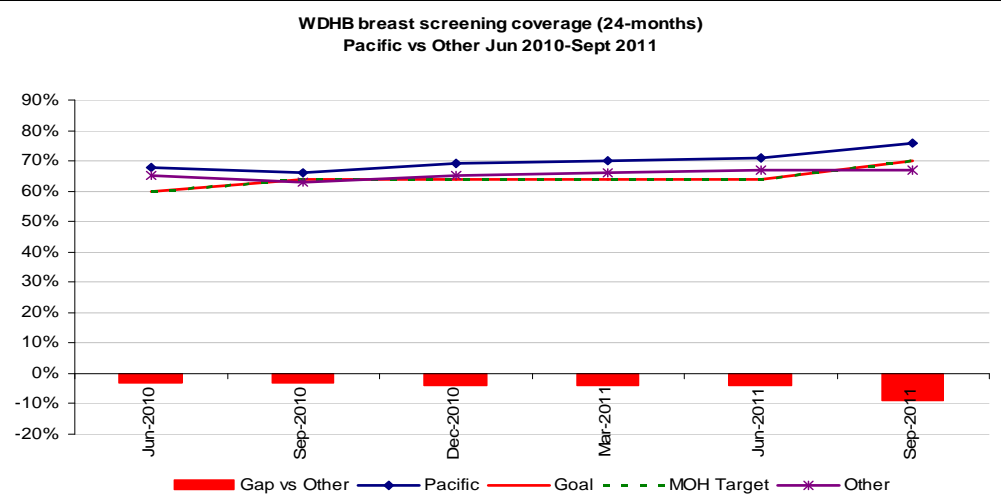
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<p>ADHB Cervical screening coverage (36-months) Pacific vs Total Mar 2010-Sept 2011</p> <table border="1"> <caption>ADHB Cervical Screening Coverage Data</caption> <thead> <tr> <th>Month</th> <th>Pacific (%)</th> <th>Goal (%)</th> <th>Total (%)</th> <th>Gap vs Total (%)</th> </tr> </thead> <tbody> <tr> <td>Mar-2010</td> <td>59</td> <td>70</td> <td>70</td> <td>11</td> </tr> <tr> <td>Jun-2010</td> <td>60</td> <td>70</td> <td>70</td> <td>10</td> </tr> <tr> <td>Sep-2010</td> <td>62</td> <td>70</td> <td>70</td> <td>8</td> </tr> <tr> <td>Dec-2010</td> <td>62</td> <td>70</td> <td>70</td> <td>8</td> </tr> <tr> <td>Mar-2011</td> <td>63</td> <td>70</td> <td>70</td> <td>7</td> </tr> <tr> <td>Jun-2011</td> <td>64</td> <td>70</td> <td>70</td> <td>6</td> </tr> <tr> <td>Sep-2011</td> <td>64</td> <td>70</td> <td>70</td> <td>6</td> </tr> </tbody> </table>	Month	Pacific (%)	Goal (%)	Total (%)	Gap vs Total (%)	Mar-2010	59	70	70	11	Jun-2010	60	70	70	10	Sep-2010	62	70	70	8	Dec-2010	62	70	70	8	Mar-2011	63	70	70	7	Jun-2011	64	70	70	6	Sep-2011	64	70	70	6					
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4.3 Asian Health Planning and Funding Update

Recommendation:

That the Committee receives the report.

Prepared by: Sue Lim (Asian Health Services Manager, Waitemata DHB), Laura Patterson (Refugee Health Collaborative Project Manager, Auckland DHB), Howard Dawson (Team Leader/Programme Manager, Mental Health & Health of Older People, Asian Health, Waitemata DHB), Lifeng Zhou (Epidemiologist, Waitemata DHB) and Annette Mortensen (ARSS Migrant Health Project Manager, NDSA)

Glossary

ADHB	- Auckland District Health Board
ARSS	- Auckland Regional Settlement Strategy
CALD	- Cultural and Linguistic Diversity
CVD	- Cardiovascular Disease
DAP	- District Annual Plan
DNA	- Did not attend
KPI	- Key performance indicator
PHIP	- Primary Health interpreting pilot
PHIS	- Primary Health Interpreting Service
PHO	- Primary Healthcare Organisation
SPROUT	- Sport and Recreation Outdoors Trust
WATIS	- Waitemata Auckland Translation and Interpreting Service
WDHB	- Waitemata District Health Board
WSN	- Waitemata Stakeholders Network

1. Executive Summary

This paper is the first Auckland and Waitemata DHBs' joint paper advising the Board on progress in Asian Health planning and funding implementation.

Key deliverables or milestones in the annual plans have six-monthly or annual targets, and this paper focuses on those targets with results from the first quarter of reporting.

A reporting template has been developed to monitor progress and Waitemata DHB and Auckland DHB's progress reports are attached along with a regional progress report.

All reports currently show that all actions are currently on track.

2. Auckland DHB Update

Currently, all actions are on target for completion by the end of the financial year.

Within Auckland DHB, an Asian Breastfeeding Support Worker is employed with the Community Breast Feeding Services and visits mothers in their own homes. The service has good engagement with Asian communities highlighted through high enrolment rates of Asian mothers. Asian breastfeeding rates have increased since the service has been established: 6 weeks 57% (2008/09) to 62% (2010/11); 3 months 55% to 58%; 6 months 24% to 28%. Asian

children maintain the highest rates as a population group for children being immunised. The Indian population attendance rate for diabetes annual review is above target for all ethnicities.

The Refugee Health Collaborative project (working with nine general practices in Auckland) continues to work alongside practices to improve primary care services, specifically targeted to refugee groups which include some Asian populations. The Collaborative project promotes the use of interpreting services within primary care, which has seen a marked increase in interpreter use from participating practices. Practice staff have completed 52 CALD courses during the project period, increasing their awareness of CALD populations. The project has also been improving the identification of population, recording of ethnicity, and awareness of patient rights and expectations of health care, all of which seek to improve service delivery, the patient experience of primary health care and health outcomes of the population. This project is being evaluated Jan-March 2012.

3. Waitemata DHB Update

The Asian Health Governance Group has been established to govern the actions from the Asian, Migrant and Refugee section of the 2011/12 District Annual Plan (DAP) and the Asian Health Action Plan developed in 2010.

Currently, all actions are on target for completion by the end of the financial year.

The Healthy Lifestyles initiative continues to support Asian communities with projects being run for South Asian, Chinese and Korean communities. In addition, antenatal breast feeding classes are being delivered using a translator.

Recently, the DHB has successfully tendered a cross-cultural agency to develop a media strategy/campaign focussing on improving Asian enrolment rates in PHOs. In addition, work is also happening on increasing awareness of the Bowel Screening pilot in the Asian population in Waitemata DHB.

Waitemata DHB continues to work with the PHOs to improve the data for CVD and Diabetes. This will allow better analysis of results and more accurate understanding of outcomes from this initiative.

The screening rate for breast cancer has been increased from 70% to 72% and the DHB is on track to comply with this target.

4. Asian Health Support Services

Waitemata Auckland Translation and Interpreting Service (WATIS)

Secondary Care Interpreting Service

WATIS provides a 24 hour 7 day a week service covering up to 84 languages for all the WDHB mainstream services on a fee for service basis. The KPI target 'Did Not Attend' (DNA) rate for non-English speaking patient appointments is 2 percent, and the service has achieved 1.73 percent (94) out of 5,448 interpreting episodes for the 6 month period ending 31 December 2011.

Primary Health Interpreting Service (PHIS)

WATIS also provides a time restricted service (Monday to Friday 8am to 7pm) to primary health care services funded by the NDSA Auckland Regional Settlement Strategy (ARSS) Contract. The service primarily provides telephone interpreting service and only provides face to face interpreting service subject to meeting criteria. All general practices and PHOs belonging to

WDHB have registered for the service. PHIS service is also available to community pharmacies, allied health services offered by PHOs, community-based retinal services, community laboratory services, community radiology services, independent midwives, Plunket, pre-school oral services, home-based services, accident and medical clinics.

PHIS has achieved

- DNA rate of 1.71 percent (7) out of 408 face to face and telephone interpreting episodes for the 5 month period ending 30th November 2011
- 181% increase in PHIS utilisation for the same reporting periods in 2010 and 2011 i.e. 552 for Jul 11 – Dec 11 compared with 196 episodes for Jul 10 - Dec 10.

Asian Patient Support Service

Asian patient support referrals are increasing i.e. Jul 10 – Dec 10 referrals was 810 compared with Jul 11 – Dec 11 referrals of 998 (averaging 166 per month against a target of 120). This is due to increased awareness of the service by clinical teams and Asian clients through service promotion.

Asian Mental Health Cultural Support Coordination Service

The cumulative referral total for this service from 15 Sept 2007 to 31 Dec 2010 was 351. It has gone up to 503 as at end of Dec 2011, which is an increase of 152 referrals (43%) over the 12 month period. This is due to increased awareness of the service by clinical teams and Asian clients through service promotion.

The Cultural and Linguistic Diversity (CALD) Cultural Competency Training Courses and Resources

The following are the suite of CALD courses developed and made available to primary and secondary care workforces in the metro-Auckland DHB area.

- CALD 1: Culture and Cultural Competency (available both online and face to face)
- CALD 2: Working with Migrant (Asian) patients (available both online and face to face)
- CALD 3: Working with Refugee patients (available both online and face to face)
- CALD 4: Working with Interpreters (available both online and face to face)
- CALD 5: Working with Asian Mental Health clients (available face to face only)
- CALD 6: Working with Refugee Mental Health clients (available face to face only)
- CALD 7: Working with Religious Diversity (available both online and face to face)
- CALD 8: Working with CALD Families – Disability Awareness (available both online and face to face).

Both online and face to face courses are receiving very good qualitative and quantitative feedback. The scores from the quantitative feedback are 80% and above for learning concept, delivery, overall ratings, learning comfort, sharing of knowledge and learning application.

The following shows the course uptake for the reporting periods. The face to face course uptake numbers are only referring to WDHB primary and secondary care participants, while the online course uptake numbers are referring to participants from the metro Auckland region.

NDSA Reporting Period	Face to Face Courses	Online Courses	Total
May 10 to Nov 10 7 month reporting	166	464	630
Dec 10 to June 11 7 month reporting	136	441	577
July 11 to Nov 11 5 month reporting	146	649	795
Total	448	1554	2,002

5. Regional Update

The Primary Health interpreting pilot (PHIP) was introduced in 2008 and completed in 2010. Sustainable Primary Health interpreting services are offered by Waitemata, Auckland and Counties Manukau District Health Boards. The implementation of the primary health interpreting service makes a significant contribution to delivering Better, sooner, more convenient primary health care to CALD populations in the Auckland region.

Utilisation rates from July 2011 to Jan 2012

% increase in total utilisation of primary health interpreting services

ADHB 60 % increase

CMDHB 66% increase

WDHB 48% increase.

Summary of utilisation reports by DHB

Waitemata DHB

- Compared to the Dec 2010-June 2011 report, the number of appointment confirmations has increased by 452%
- The number of face to face interpreting assignments provided has increased by 75%
- The number of telephone assignments has increased by 200%
- Uptake by General Practices continues to increase
- There is increased uptake by new-to-service-users including: community laboratories, community retinal screening services, hospices and Family Planning
- The top four most frequently used languages are: Mandarin, Korean, Cantonese and Burmese
- Significant increases in the utilisation of Burmese interpreters reflect increasing Burmese refugee resettlement in the WDHB region.

Auckland DHB

- Compared to the Dec 2010-June 2011 report, the number of appointment confirmations has increased by 59%
- The number of face to face interpreting assignments provided has increased by 61%
- The number of telephone interpreting assignments provided has increased by 55%
- The number of telephone assignments has increased by 118%
- There is increased uptake by new-to-service-users such as home based support providers, community hospices, breast screening and the Cancer Society
- The top four most frequently used languages are: Mandarin, Cantonese, Tongan and Afghani-Dari
- Mandarin and Cantonese languages are the most frequently used indicating better access to primary care for the large Chinese populations living in the ADHB locality
- The increase in uptake for Tongan, Burmese, Afghan (Dari) and Samoan indicate improved access to primary care for these smaller, high needs populations.

Primary health interpreting services are now available in the Auckland region to:

- All PHO services
- Retinal Screening services
- Psychological services
- Podiatrist services
- Physiotherapists etc
- General Practices
- Community based Retinal Screening services
- Pharmacy Services
- Community Laboratory Services
- Community Radiology Services

- Community Pre-school and School Oral Health Services
- Plunket Services (including Plunket Line)
- Accident & Medical Clinics
- Independent Midwives
- Home based support services
- Birthcare (ADHB only)
- Parent and Family resource centre (for parents and families of children with disabilities)
- Arthritis NZ
- Hospices
- NZ Family Planning Assoc (Auckland region only)
- Cancer Society (Auckland region only)
- Fertility Associates
- Hepatitis B Foundation
- Primary Health Interpreting services for Accident and Medical Clinics services.

Since September 2011, Aucklanders have been able to access a network of Accident and Medical (A&M) clinics in the evenings, weekends and public holidays until at least 10pm.

Primary Health Interpreting Services are available to clients of A&M clinics. Extended hours for Primary Health Interpreting Services for A&M clinics

- For general primary care service providers, the service runs from Monday to Friday 8.00am to 7.00pm except on public holidays.
- For Accident and Medical clinics, the service runs from Monday to Sunday 8am to 10pm including public holidays.

PHI services include:

- Telephone interpreting
- On site interpreting
- Appointment confirmation
- Telephone assignment (check that clients are taking medications and following instructions for prescribed treatments).

The service provides:

- A call centre number for booking urgent on-site and phone interpreting, appointment confirmation and telephone assignment services and also for service user enquiries
- An on-line booking system for scheduled-advance on-site and phone interpreting services or appointment confirmation/telephone assignment services
- The availability of confidential services for sensitive issues such as sexual health, termination of pregnancy, and communicable diseases
- Promotion of CALD cultural competency training including “How to work with interpreters” to primary health services.

6. Conclusion

Regional and local activities and targets are all on track to be completed by the end of the financial year. Local and regional networks are working well and providing good support to the initiatives.

With the closer collaboration between Auckland and Waitemata DHBs, Planners and Funders in partnership with the NDSA are beginning to explore areas where we can align and collaborate on Asian Health initiatives in the 12/13 financial year.

Waitemata DHB – Asian Health Action Plan 2011/2012 – Progress Report

Rep Person (Reporting person): BC =Bradley Clarke, LC=Leanne Catchpole; LZ – Lifeng Zhou; SL = Sue Lim; SM= Stephanie Muncaster

Integrated DHB/non-DHB Actions	Deliverable/Indicators of Achievement	Rep Person	Q1 25% Ach	Q2 25% Ach	Q3 25% Ach	Q4 25% Ach	Comments on deliverables
Promote Healthy Lifestyles	<p>a) Healthy lifestyles programmes for various Asian populations (including 40 weekly community based physical activity sessions and 4 community based nutrition for each programme annually);</p> <p>b) Delivery of 12 antenatal breastfeeding classes for Chinese women in a language and culturally appropriate way and provision of Korean, Southeast Asian interpreters or cultural support for general mainstream classes as required</p>	LC	√				<ul style="list-style-type: none"> ▪ Healthy life-style projects among South Asian and Chinese went well during 2010 and have been renewed for 2011/12 ▪ Korean Healthy Lifestyle project was launched in January 2011 ▪ Maternity services has a contract to deliver 18 Chinese and 6 other (with a translator) antenatal breastfeeding classes per annum
Improve Asian PHO Enrolment Rate and access to Primary Health Services	<p>a) At PHO Level: Increase the number of Asian PHO enrolments by 7% of the PHO's Asian enrollees;</p> <p>b) At DHB Level: Increase PHO enrolment rate (76% as at 2010/11) to 85%</p>	LZ	√				Waitemata Asian PHO Enrolment Reference/Working Group has prepared a media engagement plan. A paper summarising the plan was approved by SMT (Planning & Funding team) in principle. A contestable process would be employed for selecting the most appropriate cross-cultural agent for undertaking the project with Department of Communications of the DHB.
Increase the number of eligible Southern Asian people having a cardiovascular and diabetes risk assessment	CVD risk assessment increase to 60% of eligible Southern Asian population. Improving management rate of Southern Asian patients at high risk of CVD.	SM	√				<p>On track with screening target.</p> <p>Waitemata DHB has been working with Procure Networks Limited to receive a download of data for analysis. We received the data through to 30 September 2011 on the 22/11/2011.</p> <p>Waitemata DHB now has a complete set of CVDRAM data for the district. The preliminary analysis indicates 54.9% of the</p>

Waitemata DHB – Asian Health Action Plan 2011/2012 – Progress Report

Integrated DHB/non-DHB Actions	Deliverable/Indicators of Achievement	Rep Person	Q1 25% Ach	Q2 25% Ach	Q3 25% Ach	Q4 25% Ach	Comments on deliverables
							Southern Asian population in Waitemata had been screened as at June 2010. Blood pressure ($\leq 130/80$ mmHg): 51.7% for established CV, 52.1% for diabetics; Blood pressure ($\leq 140/85$ mmHg): 56.7% for those with high CV risk but without CV.
Improve access to diabetes services for Asians, particularly South Asians	Baseline data needs to be collected and analysed for Indian people regarding Get Checked, uptake of DSME, and podiatry and retinal screening. Note besides Indian, no other Asian-specific data is available (PHOs currently code to 2 number ethnicity data code only).	SM	√				Waitemata DHB requires each PHO to report the number of Indian people and total number of Asian people who have had their annual review and completed a self management education programme. To date Waitemata DHB has received a report from Procure on the Number of Indian people who have had an annual review. The Planning and Funding team have asked that each PHO completes the other data requirements and submits these with their quarter two reports due on the 20 January 2012.
Asian Workforce Development Action Plan (2009-2013) A3.1 To promote recruitment of Asian workforce into services/areas that are currently under-represented	Develop a report to look at the match of the ethnic mix of our workforce compared with the patient profile. Purpose: To drill down the Asian Workforce population further than the pan-Asian group that is currently reported. This will enable us to see where specific differences may exist. Measure: Report specific differences between ethnic-mix of workforce compared with patient profile by March	SL/BC	√				Project is underway and will be completed by March 2012

Waitemata DHB – Asian Health Action Plan 2011/2012 – Progress Report

Integrated DHB/non-DHB Actions	Deliverable/Indicators of Achievement	Rep Person	Q1 25% Ach	Q2 25% Ach	Q3 25% Ach	Q4 25% Ach	Comments on deliverables
	2012 to service groups to inform workforce under-representation in specific areas that may require recruitment focus Project Lead: Sarah McLeod						
Asian mental health & addiction plan (2011-2012) to address the specific mental health & addiction needs of Asian, migrant and refugee populations	(1) Action One: Workforce Development Measures: i) Increased CALD enrolments for mental health and addiction staff compared with last financial year – by end of June 2012 ii) Identified one mental health service which is currently showing under-representation of Asian workforce and developed a recruitment strategy plan for 2012-2013 – by end of June 2012 (2) Action Two: Provision of a more holistic and a wider, flexible, culturally sensitive and responsive continuum of care to accommodate the cultural diversities of the Asian people Measures: i) Completion of the Stocktake of Assessment and Screening Tools – survey of the mental health and addiction workforce at WDHB on the use of Assessment and Screening tools with Asian clients by Nov 2011 (3) Action Three: Improve access to Asian service users (action is aligned with the Child Youth and Family Workstream 2011-2012 actions) Measures:	SL	√				(1-i) Actively promoting CALD courses to NGOs and mental health and addiction services. 30 online course enrolments for the quarter averaging 10 enrolments per month. Compared with last year's average which was 9.25 enrolments per month. (1-ii) Bradley will provide an updated workforce report to help the governance identify one service – project will be underway to identify one service and assist with developing recruitment strategy and plan for 2012-2013 (2-i) Stocktake of Assessment and Screening Tools completed on 23 Nov 2011 with recommendations for further actions that will be discussed at the next governance meeting in Feb 2012 (3-i) Identifying one of the schools with high Asian student population 3-ii) Contacting school counsellors to discuss when suitable to provide CALD training and a session on working with different Asian cultures

Waitemata DHB – Asian Health Action Plan 2011/2012 – Progress Report

Integrated DHB/non-DHB Actions	Deliverable/Indicators of Achievement	Rep Person	Q1 25% Ach	Q2 25% Ach	Q3 25% Ach	Q4 25% Ach	Comments on deliverables
	<p>i) Provided 1 x seminar to one of the schools with high Asian student population to promote services and information about mental health by end of June 2012</p> <p>ii) Provided 1 x CALD training and session about how to work with different Asian cultures to school counsellors by end of June 2012</p>						
Improve breast cancer screening rate	<p>Increase breast cancer screening rate from 70% to 72%. AHSS to provide language and cultural support services by closely working with BreastScreen Waitemata/Northland, PHOs and other stakeholders.</p>	SL/LZ	√				On track with screening target.
Improve cervical cancer screening rate	<p>Cervical screening rate (currently 49% and the national target is 75% of eligible women screened). Waitemata DHB to work with Cervical Screening Unit (MoH), PHOs, NGOs (e.g. WONS) and other stakeholders to develop a work plan for improving Asian and ethnic cervical screening rates</p>	SM/LZ	√				<p>Cervical screening coverage as reported by the NCSP effective 30 September 2011 showed that 17,731 Asian women out of total population of eligible Asian women on adjusted for Hysterectomies (53.9%) have had a smear within the last five years. The Planning and Funding team continue to work with the other DHB's in the region and the NCSP to improve coverage through the development of a regional coordination role and use of Ministry of Health Funding to provider free smears to priority group women in the district.</p>

Auckland DHB – Asian Health Action Plan 2011/2012 – Progress Report

Integrated DHB/non-DHB Actions	Deliverable/Indicators of Achievement	Rep Person	Q1 25% Ach	Q2 25% Ach	Q3 25% Ach	Q4 25% Ach	Comments on deliverables
Cultural competency training for staff working in primary and secondary health services	See regional indicators	LP	√				
Increase the uptake of the Primary Health Interpreting Pilot	See regional indicators	LP	√				
Better diabetes and cardiovascular services	60% of people (all ethnicities) with diabetes attend free annual checks 77% of people with diabetes have satisfactory or better diabetes management (Indian 80%)	LD	√				<p>Diabetes Annual Review</p> <ul style="list-style-type: none"> Cumulative performance for Indian population as at Oct 2011: No. DAR to meet target = 671. Actual no. DAR is 723 (65%) (difference + 52) <p>Diabetes Management (HbA1c ≤ 8% or 64 mmol/mol).</p> <ul style="list-style-type: none"> Cumulative performance for Indian population as at Oct 2011: No. with HbA1c ≤ 8% = 564 (78% of Indian people receiving DAR)
Improving breast-feeding rates	Asian population target at 6weeks: 64% , 3months: 60% , 6months: 30%	KS	√				<ul style="list-style-type: none"> An Asian Breastfeeding Support Worker is employed with the Community Breast Feeding Services
Meet immunization targets, locally and regionally	Achieve a regional immunisation target of 95% of all 2 year olds fully immunised by July 2012	CS	√				<ul style="list-style-type: none"> Asian children fully immunised (as at 28 Nov11): 96%

Auckland DHB – Asian Health Action Plan 2011/2012 – Progress Report

Integrated DHB/non-DHB regional Actions	Deliverable/Indicators of Achievement	Rep Person	Q1 25% Ach	Q2 25% Ach	Q3 25% Ach	Q4 25% Ach	Comments on deliverables
Improve access for non-English speakers to Primary Health Organisation (PHO) services and Primary Care Organisation (PCO) Services by providing Primary Health Interpreting Services (PHI services)	(1) Action One: Increased PHI service utilisation i) PHI service utilisation increased by 5% per quarter (Achieving an annual increase of 20% primary health interpreting service utilisation in the 2011-2012 year based on the 2010-2011 data)	AM	√				PHI Services are linked to the Auckland Regional Settlement Strategy Migrant Health Action Plan which undertakes to provide interpreter services to PHO/PCO service providers in the Auckland region as per list of organisations/providers specified by the NDSA PHI Service providers are: <ul style="list-style-type: none"> ▪ Waitemata Auckland Translation and Interpreting Services (WATIS) ▪ Auckland District Health Board Interpreting Service (ADHB ITS) ▪ Counties Manukau District Health Board Interpreting and Translation Service (CMDHB ITS)
Enhance the Culturally and Linguistically Diverse (CALD) cultural competency of the health and disability workforce	(1) Action One: Increased uptake of CALD Cultural Competency Training Measures: i) 140 online course enrolments regionally for the quarter averaging 47 enrolments per month.	AM	√				The CALD cultural competency training services are part of the programme of work for the Auckland Regional Settlement Strategy Migrant Health Action Plan. The CALD cultural competency training service provided by WDH B Asian Health Support Services provides sustainable CALD cultural competency training on–line and face to face for Auckland region DHB/PHO/PCO workforces (as per the list of organisations/providers specified by the NDSA).

5.1 Primary Care Update - December

Recommendations

That the report be received.

Prepared by: Andrew Coe (Group Manager Primary Care, Auckland and Waitemata District Health Boards)

Glossary

ALT	- Alliance Leadership Team
ARC	- Aged Residential Care
BFG	- Better Sooner More Convenient Primary Care Funding Group
BSMC	- Better sooner more convenient primary health care
COPD	- Chronic Obstructive Pulmonary Disease
DAP	- District Annual Plan
DHB	- District Health Board
FFP	- Flexible Funding Pool
HP	- Health Promotion
IFHC	- Integrated Family Health Centre
NDSA	- Northern DHB Support Agency
OPF	- Operating Policy Framework
PDRP	- Professional Development and Recognition Programme
PHO	- Primary Health Organisation
PMH	- Primary Mental Health
POAC	- Primary Options for Acute Care
PPP	- PHO Performance Programme
RISSP	- Regional Information Services Strategic Plan
ROI	- Registration of Interest
SIA	- Services to improve access
TIA	- Transient Ischaemic Attacks

1. Introduction

This report provides an update on matters relating to Primary Care for December 2011. It includes progress on:

- The three BSMC business cases
- The regional annual plan projects to improve primary-secondary system efficiency
- Clinical networks
- Other key activity including PHO unspent funds, measles outbreak and Waitemata DHB Primary Care Nursing Workforce Developments.

2. Business Cases

A letter has now been drafted to request progress against business case deliverables and actual expenditure against budget from the business case chairs and will be sent by the BSMC Funding Group (BFG).

2.1 GAIHN

2.1.1 Progress since last month's update

The outcome of the ADHB and WDHB Audit and Finance Committee meetings regarding GAIHN's Investment Proposal has been sent in a letter to the Chair of GAIHN. A meeting of the senior GAIHN partners was held on Monday 16 January. This meeting was to prioritise the work of GAIHN and to identify the core GAIHN initiatives and others by clarifying who is interested and committed to each initiative. At the time of writing this report, the outcome of this meeting was unknown and a verbal update will be given at the meeting.

Waitemata PHO is still committed to GAIHN but is unable to contribute financially at this time. There has been no further update as to their business case affiliation.

The GAIHN Alliance Agreement has been signed by Auckland PHO, East Health and ProCare, Auckland DHB and Counties Manukau DHB and is now with Waitemata DHB for signing.

GAIHN met with the National Hauora Coalition on 6 and 20 December and discussed some common interest areas.

2.1.2 Progress in next reporting period

The National Hauora Coalition has been invited to attend and present at the January GAIHN Clinical Active Network meeting on 18 January. The meeting will focus on 'Vision'.

2.2 National Hauora Coalition (NHC) (ADHB only)

2.2.1 Progress since last month's update

All Alliance documentation including the PHO BSMC variation is now complete and active so the National Hauora Coalition is now able to move to the flexible funding pool (FFP). Half of the management fee savings have been paid by CMDHB on behalf of the partner DHBs. The transition plan has now been agreed. Meetings are still occurring regularly between NHC and the host DHB, as well as monthly partner DHB teleconferences to discuss progress and transitional activities. In November the NHC and the partner DHBs met to agree the PHO Performance Programme targets for the 2012 year. The NHC have reservations around the smoking cessation targets and there is still a discrepancy issue between MoH and PPP data for childhood immunisations. The targets have been submitted with the proviso that they may be reviewed after Q1 results are available. These concerns have similarly been raised by other PHOs, and as the metro Auckland process strives to ensure regional consistency and alignment with national targets, any changes will be replicated across the sector where relevant.

A national integration process was undertaken in November between the locality providers and the national organisation which was completed by December 1st. In December a first joint ALT meeting between Auckland and Midland was held.

2.2.2 Progress in next reporting period

The PPP targets for July to December 2011 are being measured against the historical PHO targets already set. These results will be available mid-February.

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

2.3.1 Progress since last month's update

AH+ are going through a change process to address some internal issues. Their board has been dissolved and an interim board has been established. Health Partners are supporting them through this process.

Counties Manukau DHB continue to work with AH+ to receive an update on their end of year accounts and the transition from Service to Improve Access (SIA) funded projects to the FFP.

AH+ are moving to an outcomes based framework from January 1st. Consequently AH+ request that the DHBs work with them looking forward to that end rather than retrospectively. However to fulfil MoH requirements, a broad overview of what historical SIA funded programmes are continuing, and what have ceased in the transition of FFP, is required.

The BFG agreed AH+ resource request which commits \$250K of the management fee savings to be paid to AH+ over the next two years, which is split by the DHBs based on enrolled population. 10% of the enrolled population is from WDHB although they have no contract with this PHO. Discussions are underway by the finance managers concerning including this in the PHO wash up process.

AH+ PPP targets have been agreed in discussion with CMDHB and in consultation with ADHB as partner. The DHBs have tried to ensure regional consistency around the targets wherever possible.

2.3.2 Progress in next reporting period

Auckland will continue meeting monthly with the PHO and host DHB. At the next meeting the DHBs hope to get further detail on the outcomes based framework and a progress report against the business case deliverables.

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

This section is contributed to by the various project managers which include DHB and GAIHN project managers.

3.1 Regional After Hours

3.1.1 Progress since last month's update

The Auckland Metro After Hours Network Service became operational from 5 September 2011. As part of this initiative, the DHBs, PHOs and A&Ms implemented reduced after hours copayments for high risk patients in the Auckland Metro area.

A substantial amount of work has been undertaken to reconcile the project funding until 20 June 2013.

Further progress on this new initiative includes:

- Development of clinical KPIs: A one-day workshop was held on December 1st with clinicians to develop clinical KPIs. A set of very comprehensive outcome measures for the project to enable NHI-level utilisation to be analysed across all after hours settings was agreed. A set of “frequent presentation” clinical indicators that will be monitored was also agreed.
- Reporting: the development of a reporting template will be undertaken by Synergia. This will include NHI event level data to help the clinicians to understand patient flows. For example, the clinicians are interested to see who is referred from A&M to ED and then who actually turns up. A confidentially agreement has been drafted by Synergia. The DHBs sought a legal review of the confidentially agreement as they are not comfortable with the agreement as it currently stands, with particular concerns around the privacy of patient information. The legal advisors strongly suggested using encrypted NHIs since patient identifiable data is being provided to a private organisation. The After Hours Taskforce was updated on the legal position at their meeting on Monday 12 December. It was suggested that the legal concerns around privacy have already been addressed through the Regional Information Services Strategic Plan process. The NHI encryption and the

patient privacy issues addressed through RISSP are currently being investigated. There will be a delay in data collection until the confidentiality agreement is signed off.

- **Project Management:** The After Hours Taskforce approved funding (\$199k) for project management until June 2012. This funding will cover continuation of a leadership and independent chair role but at a reduced level; continuation of a programme co-ordination and support role at a reduced level; an increased emphasis on getting the reporting on the programme well established (including the design of the reporting and scoping of a technical solution - both underway by Synergia and healthAlliance respectively) together with anticipated needs around building the desired solution and running the regular and ad hoc reports; the addition of a clinical leadership/facilitation role to drive on-going linkage and success of the programme with an emphasis on championing the clinical reporting and following up outputs from the reporting. This funding is being taken from the project management, risk pool and communications budgets.

3.1.2 Progress in next reporting period

Outcome reporting for the September-December period will not be available until the DHBs are comfortable with the confidentiality agreement and it is signed by all parties. The confidentiality agreement was presented to the DHB Regional Privacy Group for review who recommended that encrypted NHI was the safest method to share NHI event level data. The DHBs currently encrypt NHI data by sending it to the MoH. The DHBs have sought clarification from the A&Ms as to whether they are comfortable sending their data to the MoH for encryption.

A review of overnight services has been delayed due to delays in getting the contracts in place and Auckland and Waitemata DHBs will take the lead on this. Terms of reference and a workplan for the overnight review are currently being drafted. Once the DHBs are comfortable with both of these, they will be sent to the After Hours Taskforce for their information.

The Project Partnership Group is to be endorsed by the DHB Regional CEOs in December 2011. The CEOs will be asked to appoint DHB members to the Partnership Group which will include 1-2 members per DHB. Once the Partnership Group is in place and DHB representatives formally appointed it is expected that some of the governance and management issues previously highlighted will be resolved.

The implications of the Government's new policy of free after hours visits for under-6's still needs to be worked through and the DHBs are waiting on further advice from the Ministry of Health.

3.2 Access to Diagnostics

3.2.1 Progress since last month's update

The project is on track to achieve its 2011/12 DAP targets. As at 19 December, 64 CMDHB practices have had ProExtra installed and received training. A final quote for the programming work to update the Clinical Triage Criteria in ProExtra has been received from Enigma and signed off by GAIHN.

As previously reported, rollout of ProExtra into the remaining eligible CMDHB practices (approximately 28 practices) is now on hold until the Regional MedTech licensing contract negotiations are finalised. These contract negotiations are part of a wider discussion than just this project and have been ongoing for some time.

3.2.2 Progress in next reporting period

The steering group has initiated DAP planning for 2012/13. Enigma will aim to complete the programming work by end of February 2012. Following this, ProCare will commence testing the changes prior to wider deployment which should take approximately 2 weeks.

3.3 Minor Skin Surgery – Skin Lesions

3.3.1 Progress since last month's update

As at 30 November 2011, 381 of the 500 target volumes have been achieved, leaving a variance of -119. Following a comprehensive review of concerns expressed by the 118 GPs who responded to the GP opinion survey last year, the Steering Group agreed to a moderate price increase after one year of operation (April 2012). It is expected that this will increase the confidence in the referring GPs as well as attract more GPs into the scheme. A number of other options are also being explored by the Steering Group around widening the scope of the project to include referrals for pigmented and benign lesions.

The first Waitemata local peer review and training session was held on 1 December 2011, attended by majority of the contracted GPs. The GPs were provided with an analysis and qualitative feedback from patient questionnaires and analysis of their current contracted workload. Future peer review sessions are intended to cover case presentations as well as tuition in advanced skin surgery techniques and skin cancer management.

At the December CPHAC meeting, a summary of the clinical review processes for this project was requested. This is provided below.

Waitemata DHB led a formal Registration of Interest (ROI) process in October 2010 for the provision of Minor Skin Surgery on behalf of the Metro Auckland region. All responses (35) were evaluated with regard to the practitioner's training, service delivery requirements, appropriate experience within pre agreed timeframe, and ability to provide service at the agreed DHB price.

The ROI responses were assessed in two stages. Firstly, all ROI responses were assessed by the Chair of the Auckland Regional Minor Skin Surgery Clinical Governance Group against the clear yes/no criteria including: Infection control¹, availability of appropriate equipment², and training, qualifications and experience³. Secondly, the short-listed responses from the first stage were invited to submit a 'log book' of their most recent sequential 50 cases of skin surgery. The log books were collated, made anonymous and analysed according to the time taken to complete the 50 cases, malignancies of lesions, number and percentage of incomplete excisions and number and percentage of complications experienced. The log books were then assessed by the clinical review panel and the panel were able to unanimously recommend 16 preferred providers across 19 sites.

The contracted GPs are required to attend quarterly peer review and education sessions within their DHB area including one annual regional meeting. These sessions are intended to cover case presentations as well as tuition in advanced skin surgery techniques and skin cancer management. Professional trust between secondary care clinicians and the contracted GPs is likely to increase as a consequence of the peer review process, leading to better communication about difficult cases, and more informed and appropriate devolution of cases of varied complexity.

¹ The minimum requirement is infection control that equates to or exceeds the requirements for infection control as per the RNZCGP Aiming for Excellence infection control standards.

² The minimum requirement is availability of a uni-polar diathermy device and capability of cardiac defibrillation equal to or greater than an Automated Electrical Defibrillator Device (AED).

³ The minimum requirements for is completion of a minor skin surgery training course at the level of Auckland surgical skills training centre minor surgery course or greater; or completion of a general or plastic surgical training to the level of surgical training registrar or higher. In some instances when the respondent's training, qualifications and experience did not clearly meet the minimum requirements; the responses were collated by the ROI Secretariat and provided to the clinical governance group to advise on which training and qualifications meet the groups agreed standards.

Contracted GPs also provide clinical reports including diagnoses and complications of the DHB cases they treat. These are collated and analysed in a standardised format in a spreadsheet. GP facilities are also visited and assessed for their suitability and compliance with contracted standards.

3.3.2 Progress in next reporting period

None to report.

3.4 Clinical Pathways

3.4.1 Progress since last month's update

There are three key factors with the developing of clinical pathways: the importance of workflow integration (so pathways do not become reference documents that are not referred to), the difficulty in getting universal acceptance by clinicians, and the potential for these pathways to be developed on a national rather than regional pathway and funding. Pathways are expensive and the funding for the next round of pathways is under consideration of GAIHN's ALT.

Successes to date include;

- ADHB and CMDHB showed a 20% reduction in (inappropriate) Gastrosopes.
- Workstream memberships are complete for Gout and Depression pathways.
- Business cases for Chronic Obstructive Pulmonary Disease (COPD) and Transient Ischaemic Attacks (TIA) pathways are complete. The TIA pathway is regionally supported by services and Clinical Directors. This pathway has the potential to prevent up to 80 strokes per annum across the Auckland Region.

3.4.2 Progress in next reporting period

First meetings of the Gout and Depression pathways are scheduled for January 2012.

3.5 Pharmaceuticals – Optimal Prescribing (ADHB)

3.5.1 Progress since last month's update

This project supports GP cell groups with understanding their own prescribing techniques and employing best practice. It generates a number of bulletins on topical prescribing issues and is useful in counter-detailing manufacturers and pharmaceutical representative's claims. Cell groups in November have focused on use of bisphosphonates. Bulletins have been developed on the role of angiotensin II inhibitors in primary care, NSAIDs for acute pain and the risk of medicines with anticholinergic side effects in the elderly. The project is working the GAIHN group to ensure alignment of the project with GAIHN objectives.

There has been on-going communication between the programme's data analyst and DHB financial representatives to try and resolve the issue of a robust methodology that can measure the savings that this project has made. A budget formula was presented to the Governance Group and has been agreed upon. All data and analysis has been worked through. There still has been no agreement made on the 2011/12 contract despite being halfway through the year, due to differing expectations of alliancing versus DHB policy contractual requirements.

The Governance Group has also drafted up the workplan for the first six months and agreed some non-financial KPIs with a focus on quality initiatives in prescribing for the elderly, pain management and cardiovascular disease management. These KPIs will be reported against in future reporting.

The budget outcomes have been worked through between DHB financial management and the project's data analyst.

3.5.2 Progress in next reporting period

A final presentation to the steering group is still required so the savings for 2010/11 can be agreed. This is to be scheduled in January 2012.

3.6 Pharmaceuticals – Quality Use of Medicine (WDHB)

The Waitemata DHB target is to conduct medication reviews with a sample of age related residential care facilities, and to evaluate the impact of these medication reviews. Over 577 medication reviews have been completed to date and communicated to GPs. The data collection for evaluation is underway and initial 8 months results analysed.

A pilot of interim drug charts is progressing well with sample charts drawn up and circulated to all DHB ARC facilities, Gerontology Nurse Specialists, pharmacists, pharmacies and others connected to the project. Feedback has been correlated, the chart reformatted and new samples mailed to Orion, the software vendor. Orion is preparing a quote and a business proposal is in progress for funding.

The steering group is deciding whether to roll out Aged Residential Care (ARC) pharmacist input to other ARC facilities in Waitemata DHB.

3.6.2 Progress in next reporting period

Oceania Group need to approve ARC pharmacist input and if given the go-ahead, medication reviews to start February 2012.

3.7 Primary Mental Health

Perception studies to gain views of service providers and users were completed in early December. Approximately 60 providers and over 90 users give their views of current service.

The first meeting of the Steering Group (consisting of ADHB and WDHB Mental Health and Addictions Clinical Directors (joint chairs)), Primary Care Group Manager and Clinical Director, and Val Williams, Whanau Ora Facilitator for National Hauora Coalition) was held on 15 December. The meeting considered the findings from the project across WDHB and ADHB. The draft report on the project was circulated to the Steering Group prior to Christmas.

3.7.2 Progress in next reporting period

The second meeting of the steering group will be held in late January 2012 to consider options for the future direction of PMH services.

3.8 Summary of Annual Plan Targets

Initiative	Regional Volumes		Targets	
	Month Nov	YTD 30/11/11	YTD 30/11/11	To 30/06/12
Acute Demand / POAC	1,065 ⁴	10,101	10,101	20,000
Access to Diagnostics <u>DAP Target 1</u> Rate of referrals that do not meet the clinical triage criteria from GPs to radiology are <= to 20% by 30/06/12	N/A	N/A	31%	20%
<u>DAP Target 2</u> Volume of DHB-funded GP-requested diagnostic radiology procedures performed in the community will increase by 10% across the Metro Auckland DHBs, on 2010/11 volumes by 30/06/12	1,128	6,276	4,403	10,396
Minor skin surgery: 1200 procedures for people requiring minor skin lesion surgery in the community (Counties Manukau DHB 400, Waitemata DHB 500, Auckland DHB 300) by 30/06/12	90 ⁵	381	500	1,200 ⁶

4. Clinical Networks

4.1 West Auckland Health Network

4.1.1 Progress since last month's update

The West Auckland Health Network (WAHN) was established as a clinician lead committee with a focus on improving the health of those living in West Auckland. The geographic area covered by the WAHN includes Waitakere ward and the western part of the Albany and Whau wards of the Auckland Supercity. This covers a catchment of 250,000 representing a diverse and deprived population with both Maori and Pacific well represented within these numbers.

It was formed in August 2011 and membership of the network is open to all health service providers (primary and secondary) who deliver services in West Auckland with Whanau Ora providers and interests represented by Maori Clinical Directors and Iwi. It is currently chaired by Dr Jonathon Simons in his role as Chair of Healthwest.

The Network is meeting monthly and there has been early and strong clinical engagement at the coalface to the Network. The West Auckland Health Network will provide non-partisan, proactive clinical leadership, to support the delivery of an integrated health system with tangible gains in health benefits to the communities of West Auckland.

WAHN's aim is to maximise patients' health and wellbeing and WAIHN has accepted a stretch goal of increasing the average life expectancy of Maori and Pacific living in West Auckland by three years. They are looking to:

1. Develop new models of care and support the development of primary care infrastructure, including underlying contract structures to change health system delivery in West Auckland;

⁴ Preliminary Figures for December

⁵ Volumes are based on the referrals sent out during the month for Waitemata DHB and Auckland DHB and actual procedures completed for CMDHB.

⁶ Community based skin lesion procedures during 2011/12

2. Facilitate systemic infrastructure for models of care such as the development of electronic shared care and patient information sharing.
3. Long term conditions and in particular diabetes has been identified as an initial clinical focus. The aim is to put the current funding associated with long term conditions with the Network from July 2012.

Sapare (David Moore) are the contracted Implementation Support Group (ISG) to support the development of the Network and also the facilitation of the development of Integrated Family Health Centres in the West. They have recently undertaken a scoping exercise which involved interviewing a number of key stakeholders across the sector. This exercise has identified primary care are looking to DHBs to provide the leadership and direction in this area.

The findings have been presented to the Network and also to our two PHOs, Waitemata and Procure on December 1 2011. We are now working with Sapare and the Ministry of Health to finalise the scope of the next piece of work before January 31 to access the next tranche of Ministry funding.

4.1.2 Progress in next reporting period

Completed scope of work and signed contract between the Ministry and Sapare. This will include scoping the resourcing implications for both DHBs and PHOs to commit to the further development of the Network.

4.2 Integrated Family Health / Whanau Ora Centres

4.2.1 Progress since last month's update

The Primary Care team continues to progress leasing space at the New Lynn IFHC and Whanau House. It is being considered whether whanau ora centres should be co-located within IFHC's.

4.2.2 Progress in next reporting period

It is anticipated that both of these negotiations will be completed early in the new year.

5. Other

5.1 Unspent Funds

5.1.1 Progress since last month's update

Work is still continuing on the issue of the management and use of PHO cash reserves. Following on for the OPF report that was submitted to the MoH on 20 October, the PHO accounts have now also been requested and supplied where possible. There are a few still outstanding which are being actively followed up. Expenditure plans have also been supplied by ProCare (at specific MoH request) and Auckland PHO. We have not received any further direction from the MoH on this issue as yet, however a teleconference is scheduled for January to clarify MoH expectations.

The MoH responded to a New Zealand Doctor request under the Official Information Act on the 21 December in relation to this issue. Some information was withheld as it deemed commercially sensitive. For the same reason we are not able to provide detailed financial information to the CPHAC until such time as it has been agreed between the DHBs, PHOs and MoH.

An ADHB financial analyst has reviewed the supplied accounts. This process has revealed that the real issue is not relating to PHO Cash Reserves as defined by the MoH, but rather the increasing amounts of deferred income or income in advance the PHO receives from the MoH.

This is in relation to discretionary funding streams such as services to improve access (SIA) and health promotion activities.

Once the final amounts of deferred income are known and agreed for each PHO, the DHBs will agree their expenditure plans to reduce this funding over the next two years. Where there have been PHO amalgamations it will now be expected that new SIA and health promotion plans are developed with and approved by the DHB. Alternatively the funding can be directed at the business cases for funding initiatives such as after hours.

Old ADHB/WDHB PHO	New PHO	Response and/or expenditure received	Comment
Auckland PHO	N/a	Response and expenditure plan received.	Reporting process to be agreed at next PHO CEO forum (Jan/Feb 2012)
AuckPAC Tongan Health Society	Alliance Health +	Annual accounts received	Reporting process to be agreed at next PHO CEO forum (Jan/Feb 2012)
Coast to Coast PHO Harbour Health PHO Ltd Waioira Charitable Trust	Waitemata PHO	Forecast budget and confirmation any unspent funds to be transferred to W PHO (none expected)	Further information required regarding old accounts
Tamaki Healthcare Charitable Trust Te Hononga	National Hauora Coalition	No response from old entities but new entity has confirmed no funds have been transferred.	Letter and meeting scheduled for January 2012
HealthWEST	N/a	Discussions ongoing	Plan to be agreed by end of February 2012
ProCare North ProCare Central Te Puna	ProCare Networks Ltd	Response, financial statement and expenditure plan received. Te Puna's funds already allocated.	Plan requires more detail and to be agreed by end of February 2012

5.1.2 Progress in next reporting period

Expenditure plans have already been submitted by ProCare and Auckland PHOs. Further detail will be requested around these plans as well as from other PHOs. The expenditure plans and progress on the reduction of these funding streams will be reported quarterly to the finance and expenditure committee.

5.2 Measles

5.2.1 Progress since last month's update

The metro region response group is due to reconvene in mid-January to review the number of cases, impact of campaign to date and agree a strategy for 2012.

5.2.2 Progress in next reporting period

Future progress depends on the strategy agreed by the response group. This will be reported on in due course.

5.3 Waitemata DHB Primary Care Nursing Workforce Developments

A Primary Care Workforce Survey has been developed in conjunction with Waitemata PHO and Procure. The survey has been distributed to primary care nurses across the Waitemata region. The survey closes on February 13th and to date we have 189 responses. The aim of the survey is to provide a picture of current nursing activity, knowledge and skills and will inform workforce development planning. The survey will capture the contribution primary health care nursing is making to the health needs of the population and identify future opportunities.

On 23 December, 22 new graduate nurses completed the Nurse Entry to Practice (NeTP) Expansion Programme. These nurses have been employed in the Primary Care setting while completing the year long programme for new graduate Registered Nurses. All 22 nurses will remain employed in a Primary Care setting.

Regional Community Nursing and Allied Health integrated models of care.

A WDHB working group is being established to scope and develop a pilot for an integrated model of care in primary care for people with a complex or chronic lower leg wound. The pilot is a result of work completed by the Regional Community Nursing and Allied Health Steering Group together with a broad range of stakeholders to identify models of care to support Alliance Health+, National Hauora Coalition and GAIHN achieve their goals and objectives in relation to Better Sooner More Convenient care.

5.2 Planning and Funding Update

Recommendations

That the report be received.

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

Glossary

ADHB - Auckland District Health Board
DHB - District Health Board
HSGs - Healthcare Service Groups
NHB - National Health Board
WDHB - Waitemata District Health Board

1. Summary

This report updates the Committees on Auckland and Waitemata DHBs' Planning and Funding activity for the months of December 2011 and January 2012.

2. Summary of activities in common

2.1 Planning

The Annual Plan and Statement of Intent are being drafted with close collaboration between WDHB and ADHB. The intention is to have both DHB documents looking almost exactly the same where there is an overlap of content. Draft content will start being made available to Board members later in February. The draft annual plan will be provided to the March CPHAC meeting for approval prior to being submitted to the National Health Board to meet the 23 March deadline.

A paper has been presented to the January meeting of the Maori Health Gain Advisory Committee in order to ensure that Maori participate in the planning process and that opportunities for Maori health gain are maximised.

In January and February, the Boards will hold workshops to finalise Annual Plan priorities. The final set of national health targets and priorities are not confirmed, but this will be done via the Minister's Letter of Expectations, which is expected in early February. WDHB will also hold a workshop on 25 January for DHB clinical and management staff, providers and healthlinks/voice to consider the organisation's overall purpose and the priorities for 2012-13 and to enable the cross-DHB conversations to support innovation and business transformation.

The construction of a Statement of Forecast Service Performance, as contained within the Statement of Intent, continues to be a difficult exercise. A sensible set of measurable cornerstone indicators (being the outputs and impacts of DHB business as usual) is now under construction with a number of staff now involved across WDHB and ADHB. Our auditors will also be involved in early drafts of this work since they are in the best position to comment on

the quality of our work, specifically its ability to satisfy the requirements within the Crown Entities Act. The Statement of Forecast Service Performance continues to remain separate, and somewhat disjointed, from the Annual Plan and DHB key drivers.

While the Annual Plan and Statement of Intent documents fulfil our accountability requirements under the NZPHD Act and the Crown Entities Act, they do not function well as business planning tools. For this reason separate business plans for each DHB will be developed concurrently, using the same and additional content but drafted with management in mind. At ADHB, the business plan will continue with the driver diagram format and will concentrate on Healthcare Service Grouping given that HSGs are ultimately responsible for service delivery and development across the continuum of care. At WDHB the business plan will be based on the key divisions within the DHB.

2.2 Community Engagement

The oral submission on Auckland Council's Auckland Plan on November 29th was well received by Council members. Work is now underway to establish the kind, and level, of assistance the metro DHBs can provide to help implement the Auckland Plan.

The Public Consultation policies of WDHB and ADHB are being reviewed jointly. The existing policies of each DHB need to be aligned with the updated New Zealand Public Health and Disability Act legislation and the release of the Ministry of Health's revised Consultation Guidelines. A shared draft policy on Community Engagement and Consultation will be presented for CPHAC consideration in 2012.

3. Waitemata DHB Update

3.1 Funding

North Shore Hospice

North Shore Hospice has experienced a shortage of suitable medical practitioners to provide cover for their services. As a consequence, North Shore Hospice advised stakeholders that it would close four palliative care inpatient beds in its facility from 28 November 2011. The Hospice has maintained staffing levels to enable the continuation of the community service and five beds inpatient unit.

North Shore Hospice provided an update to stakeholders on 4 January 2012. This indicated that they would be able to open two beds in the IPU on 23 January 2012. The remaining two beds will be opened the following week, bringing the bed number back to nine from 30 January 2012. This has been achieved through the response of doctors to support the Hospice.

The Planning and Funding Team will continue to monitor the situation on a weekly basis to ensure the beds remain open over the period from 30 June to 1 April 2012, the interval the Hospice initially indicated they would have issues covering. We will then continue to monitor the service at a three monthly interval unless other matters arise.

SafeRx®

The Quality Use of Medicines Team are finalising an agreement with the Health Quality and Safety Commission, which will fund the roll out of the SafeRx® work programme that promotes the safe use of high-risk medicines in primary care. Currently, this initiative is available in Waitemata DHB; it will be expanded to the all of the Northern DHBs. Recent work has focused on the feasibility of integrating SafeRx® within general practice software systems, and confirming a budget for a database/application that can manage user information and distribute the SafeRx® resources. The project will be developed so it can be implemented nationally.

Bowel Screening Pilot Update

The bowel screening pilot commenced as scheduled at the end of October. A 'soft launch' of invitations to 500 people randomly selected from two WDHB practices provided the opportunity to trial all of the systems and processes. Four hundred and sixty-four (464) test kits were mailed out and 274 (59%) participants have sent a sample to LabPlus for analysis. Nine (9) of the samples have tested positive.

The first full batch of approximately 1500 invitations was sent between Christmas and New Year. This number of invitations will be despatched on a weekly basis for the four year term of the pilot. Mail out of full batches of test kits will commence during the third week of January.

Colonoscopy equipment and staff are in place. Seven colonoscopies have been performed to date with the remaining two scheduled for early February. No cancers have been detected.

Strenuous efforts are being made to ensure that General Practice teams are well informed and supported to participate as required in the pilot. Community awareness activities have been low key to date but will increase significantly from the middle of January and will continue throughout the pilot term. Pacific providers have been contracted to deliver awareness raising and targeted follow up services. Maori, Chinese and Korean staff have been employed to support participation from these population groups.

3.2 Funder Finance

The December consolidated core result for Funder was \$287k favourable to budget for the month and \$1.5m favourable to budget for the year to date. The substantial first quarter movement in enrolled populations that resulted from GP practices changing PHO membership was not replicated in the second quarter. The first quarter changes continue to be accounted for each month by way of inter DHB invoicing and in accordance with the Metro Auckland Collaborative Agreement.

NGOs

The December core result for Funder NGO was \$126k favourable to budget for the month and \$529k favourable to budget for the year to date. Included in this result is expenditure of \$12.0m for the settlement of PHO capitation services resulting mostly from the first quarter enrolment transfers to Auckland DHB. Similarly included is expenditure of \$2.1m relating to payments to Auckland DHB for the non capitation component of PHO services. These payments are as determined by the Collaborative Agreement methodology and are covered within the Funder NGO budgets. Also accommodated in this result is the additional cost of the Measles outbreak response although it is not yet able to be disaggregated. Utilisation trends relating to NGO demand services are tracking as expected and related expenditure is within budget.

IDFs

The December core result for Funder IDF was \$161k favourable to budget for the month and \$1.0m favourable to budget for the year to date. The favourable year to date position is mostly the result of a wash-up receivable accrual of \$947k relating to medical and surgical inpatients IDF utilisation. The increased IDF costs resulting from changes in PHO practice memberships and/or enrolments growth continue to be accounted for within NGO budgets.

4. Auckland DHB Update

4.1 Immunisation

Provisional NIR data as at 1 December 2011 shows 92% of all ADHB 2 year olds fully immunised. Maori coverage at 84% remains a challenge and a focus. Pacific coverage at age 2 years remains at 93%.

Coverage of other ethnicities at age two years is: Asian 96%, NZE 93%, and other 88%. Coverage rates have changed only minimally over the last five months despite significant effort from a range of stakeholders. It is expected that increased immunisation as a result of the current measles outbreak will soon be reflected in the NIR rates. As at 13 December there had been a total of 403 confirmed or probable cases of measles (all ages) notified in the Auckland region since May 30, 2011. The outbreak is being managed in primary care and a consequent rise in the number of children fully immunised at age two has been noted.

The ADHB-led Immunisation Operations Group will review strategies to improve coverage in the New Year.

4.2 Oral Health

The Child and Adolescent Oral Health Business Case is progressing according to plan with the build of fourteen new clinics (one a refurbishment) and purchase of four diagnostic mobiles. Two further diagnostic mobiles will be received in 2012. The two-chair treatment mobile has been cancelled due to successful discussions with a school for a fixed clinic in the Orakei area.

Five first-phase and five second-phase clinics have been completed and all are now treating patients. Official openings for two of these clinics will be scheduled in early 2012. Planning is underway for the four clinics in the final-phase, due for completion mid 2012. The Project Steering Team is still investigating a site in the Epsom/Greenlane area.

Summary of fixed clinics:

Clinic site	No. of chairs	Status
<i>Phase one</i>		
Sylvia Park	2	All treating patients
Pt England	4	
Otahuhu	3	
Stonefields	3	
Balmoral	2	
<i>Phase two</i>		
Avondale Intermediate	3	Now treating patients
Blockhouse Bay Intermediate	3	Opened 25 November 2011 and treating patients
Royal Oak Intermediate	3	Opened 14 December and now treating patients
Wesley Intermediate	2	Opening scheduled for the 1st school term 2012
Ponsonby Intermediate	3	Opening scheduled for the 1st school term 2012
<i>Phase three</i>		
Orakei Primary	2	Construction commences January 2012 The alternative site to Mt Roskill. The Outline Plan of Works (OPW) documentation lodged with Council has been rejected. Meetings have been held with Council and formal letters sent. ADHB is now waiting on the final decision by Council. If the OPW is not approved then the DHB will submit for resource consent
May Road Primary	3	
Epsom/Greenlane area	3	Options being examined
Waiheke Island	1	Construction to start January 2012

The final draft of the updated Service Level Agreement is being completed and will be sent to Waitemata DHB Auckland Regional Dental Service for final review and sign off.

4.3 Community Pharmacy

National Pharmacy Services Agreement

Following the DHB workshop in Wellington on Friday 25 November, a draft paper for GPs was developed by the national project team which gave an overview of the new service model for community pharmacy, planned to take effect from 1 May 2012. The paper seeks provisional endorsement to proceed, subject to financial modelling information being available in time for the DHB Board meetings in February 2012.

The new model focuses on patients as opposed to the volume-driven 'fee for service' funding, which has seen the costs of community pharmacy grow exponentially over the last few years. To date DHBs have agreed to a funding envelope which includes a demographic and cost pressure adjuster. Financial modelling, available next month, will provide further detail. Further financial support may be required to help transition to this model over the next few years, and this will be included within the funding envelope.

E-prescribing

An e-prescriptions funding paper was circulated on 22 December from the National Medication Safety Programme Steering Group & Graeme Osborne, Director, National Health IT Board requesting feedback and an indicative figure of the cost implications that DHBs should factor into their budget calculations for 2012-13. The paper does stipulate that this process is working in alignment with the new pharmacy contract and so these costs will need to be considered in line with the financial modelling when available.

Live Within Our Means: Month's Funding Issues

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

National Health IT Board Case Study

TXT2Remind dramatically improves immunisation rates

Raukura Hauora O Tainui is now a top performer as immunisation rates shift from 55 to 98 percent in just over a year.

Raukura Hauora O Tainui, an iwi charitable trust PHO with more than 20,000 clients, has dramatically improved its immunisation rates by utilising a common technology in an innovative way.

In January 2010, it implemented Vensa Health's TXT2Remind practice to patient text messaging system across its North Waikato district general practices.

The PHO was well below the national immunisation average rate of 88 percent but, after using TXT2Remind for just over a year, nationally it is now among the top performers. Now it averages 98 percent coverage, with four of the five clinics at 100 percent coverage.

Chief Executive of Raukura Hauora O Tainui, Wayne McLean, says, 'To improve health and prevent illness we need to be really smart about our time and resources to get the best performance we can. Every missed appointment is a missed opportunity to help someone. TXT2Remind has been a very effective tool to encourage people to access the services they need, when they need them.'

TXT2Remind fits with the National Health IT Board's drive to use technology to improve health outcomes. Graeme Osborne, Director of the Board says, 'This is a good example of delivering health benefits through smart use of mobile technology.'

Background

In late 2009, Vensa Health began working with Wayne McLean to understand the challenges the organisation faced with patient access to primary health care services. Wayne identified that the key issue was missed appointments, resulting in low immunisation rates and other lost opportunities to improve health outcomes.

The process of sending letters to patients is very time intensive, and many were not reaching the patient. Contributing factors included frequent changes of address and letters remaining unopened.

Challenges

The biggest challenge was the shift from a paper-based recall process to mobile phone text messaging. Staff took three to four months to become confident users of the new system.

Updating patient cellphone details was another challenge, and maintaining current numbers will be an ongoing challenge.

Benefits

Performance has also been lifted across other scheduled programmes that require reminders and follow-ups such as mammograms and cervical screening.

The TXT2Remind automated recall process has reduced costs and administrative time, and freed up clinical staff so they can focus more on following up hard-to-reach groups.

Raukura Hauora O Tainui has also used TXT2Remind to contact patients with diabetes and has seen a significant improvement with more patients attending appointments to review of their condition.

What is TXT2Remind?

Vensa Health's TXT2Remind is a text-messaging service that can be used for any services that allows for recall, pre-call and text notification. It is ideal for child immunisations, as texting is the preferred communication method for the target audience of young mothers and caregivers.

The system was first adopted by the McLaren Park Medical Centre in West Auckland in January 2007. Since then, Vensa has worked hard designing a system that meets the needs of clinicians.

How does TXT2Remind work?

TXT2Remind works with patient management systems used in general practices and hospital patient administration systems. Working directly with the patient management system database, it allows automation of appointment reminders, test results, pre-calls and recalls by mobile text messaging and other forms of electronic communication.

The system sends back an electronic receipt, so if a cellphone number is not valid, the practice is immediately alerted that the message has not reached the patient.

Next steps

Raukura Hauora O Tainui is now working with BreastScreen Midland to improve breast screening rates. Mobile breast screening caravans have been located at some Raukura Hauora O Tainui clinics. Screening coverage has already risen from 40 to 53 percent and is expected to increase further.

The Midland Health Network, a Better, Sooner, More Convenient business case group, has signed a regional contract to implement TXT2Remind across the entire Midland primary health sector.

The system can also be used in hospitals, for example, Whanganui District Health Board has implemented TXT2Remind in the hospital as well as primary health care.

District Health Boards in the Midland region are currently considering a regional approach to adopting TXT2Remind in all hospitals.

Project partners

The partnership between Wayne McLean, Chief Executive, Raukura Hauora O Tainui and Ahmad Jubbawey, Chief Executive, Vensa Health, resulted in the adoption of TXT2Remind.

The partnership was fully supported by Brett Paradine, General Manager, Funding and Planning, Waikato District Health Board who says, 'We've seen an impressive improvement in immunisation performance from Raukawa. We know that a key component in achieving and maintaining high immunisation rates is systematic precall and recall of vaccinations.'

Contacts

Wayne McLean
Chief Executive; Raukura
Hauora O Tainui

Email:
Wayne.Mclean@raukura.com

Ahmad Jubbawey
Chief Executive; Vensa Health
Email:
AJubbawey@vensahealth.com

7 Resolution to Exclude the Public

Recommendation:

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of the Minutes of the Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting with Public Excluded held on 14/12/11.	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	Confirmation of Minutes As per the resolution from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.

AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna

Time: 2.00pm

COMMITTEE MEMBERS

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

MANAGEMENT

Dale Bramley - WDHB, Chief Executive
 Garry Smith - ADHB, Chief Executive
 Debbie Holdsworth - WDHB, Acting Chief Planning and Funding Officer
 Denis Jury - ADHB, Chief Planning and Funding Officer
 Taima Campbell - ADHB, Executive Director of Nursing
 Hilda Fa'asalele - ADHB, General Manager, Pacific Health
 Paul Garbett - WDHB, Board Secretary
 Naida Glavish – ADHB and WDHB Chief Advisor, Tikanga
 Janice Mueller - ADHB, Director Allied Health – Scientific & Technical
 Andrew Old - ADHB, Medical Advisor – Funding Division

Apologies:

AGENDA

KARAKIA

DISCLOSURE OF INTERESTS

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

PART I – Items to be considered in public meeting

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

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

	1	AGENDA ORDER AND TIMING	
	2	CONFIRMATION OF MINUTES	
2.00pm	2.1	Confirmation of Minutes of the Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting held on 14/12/11	1
	3	DECISION ITEMS	
	4	ITEMS FOR INFORMATION	
2.05pm	4.1	Maori Health Action Plan	13
2.25pm	4.2	Pacific Health Action Plan.....	35
2.45pm	4.3	Asian Health Action Plan	55
	5	STANDARD MONTHLY REPORTS	
3.00pm	5.1	Primary Care Update	67
3.20pm	5.2	Planning and Funding Update.....	79
	6	GENERAL BUSINESS	
3.35pm	6.1	National Health Board IT Board Case Study – Txt2Remind (Committee Chair has requested an informal discussion of this).....	85
3.45pm	7	RESOLUTION TO EXCLUDE THE PUBLIC	87

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Professor of Leadership – University of Auckland Business School Chief Executive – New Zealand Leadership Institute Deputy Chair – Health Benefits Limited Independent Chairman – Tonkin & Taylor Chair – Auckland District Health Board Chair – Waitemata District Health Board Trustee, A+ Trust	25/05/11
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Board Member – Health Workforce New Zealand Board Member, AUT Millennium Ownership Trust Chair – Social Services Online Trust Board Member – The Rotary National Science and Technology Trust	28/09/11
Jo Agnew	Professional Teaching Fellow – University of Auckland Casual Staff Nurse – Auckland District Health Board	12/10/11
Peter Aitken	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd	10/12/10
Pat Booth	Consulting Editor – Fairfax Suburban Papers in Auckland	24/06/09
Susan Buckland	Self employed – Writing, editing and public relations services Professional Conduct Committee member – Medical Council of New Zealand Professional Conduct Committee member – Occupational Therapy Board Member - Northern Regional Ethics Committee	12/10/11
Chris Chambers	Employee – Auckland District Health Board (wife employed by Starship Trauma Service) Clinical Senior Lecturer – Anaesthesia Auckland Clinical School Associate – Epsom Anaesthetic Group Member – ASMS Shareholder – Ormiston Surgical	20/04/11
Sandra Coney	Elected Member – Chair, Parks Committee, Auckland Council	02/05/11
Rob Cooper	Board Member – Auckland District Health Board Board Member – Waitemata District Health Board Chief Executive - Ngati Hine Health Trust Advisory Board Member – James Henare Research Centre, University of Auckland Member – National Health Board Chair – Whanau Ora Governance Group	19/01/11
Warren Flaunty	Member of Henderson – Massey, Rodney and Upper Harbour Local Boards, Auckland Council Trustee - West Auckland Hospice Trustee - Waitakere Licensing Trust Shareholder - Metlifecare Shareholder - EBOS Group Shareholder – Pharmacy Brands Ltd Shareholder – Westgate Pharmacy Ltd Chair – Three Harbours Health Foundation Trustee – Trusts Community Foundation Ltd Member – Health Practitioners Disciplinary Tribunal	09/11/11
Lee Mathias	Managing Director – Lee Mathias Ltd Director – Midwifery and Maternity Providers Organisation Ltd Shareholder/Director – Pictor Ltd Director – John Seabrook Holdings Ltd Governance Advisor – AuPairlink Ltd Council member – NZ Council of Midwives Chair – Tamaki Transformation Transitional Board Chair – Health Promotion Agency Establishment Board	09/11/11

Robyn Northey	Project management, service review, planning etc. – Self employed Contractor Board member – Hope Foundation Northern Region Member – University of Auckland Human Participants Ethics Committee	14/12/11
Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Member - The Families Commission Director - The Transformational Leadership Company	02/02/11
Allison Roe	Shareholder – Optimisewellbeing.com Founding member – Breast Health Foundation Director – Spiritus NZ Trustee – Allison Roe Trust Founder – Takapuna 2020 Community Group Board member – North Shore Hospital Foundation	28/03/11

Co-opted Members

Dr Tim Jelleyman	Clinical Director, Paediatrics (Child Health Service) Member, Active Clinical Network (ACN) for the Greater Auckland Integrated Health Network (GAIHN) Project	08/09/10
Eru Lyndon	Ngati Whatua o Orakei Corporate Ltd Honorary Research Fellow – Auckland University Member – AUT Business School Industry Advisory Committee Te Mata a Maui Law	12/08/11

**Auckland and Waitemata District Health Boards
Community and Public Health Committees
Member Attendance Schedule 2012**

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

** absent*

^ leave of absence

** attended part of the meeting only*

absent on Board business

