

Community and Public Health Advisory Committee Minutes

MEETING DETAILS											
Time and Date	2:00pm, Wednesday, 18 November 2009										
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom										
2	ATTENDANCE AND APOLOGIES										
	<p>Committee Members</p> <table> <tr> <td>Dr Brian Fergus (Chair)</td> <td>Susan Buckland</td> </tr> <tr> <td>Harry Burkhardt</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Pat Snedden</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Seiuli Dr Juliet Walker</td> </tr> <tr> <td>Rev Alfred Ngaro</td> <td>Lynda Williams</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Hilda Fa’asalele – General Manager Pacific Health Aroha Haggie – Maori Health Gain Manager Celia Palmer – Clinical Leader, Planning & Funding Ian Bell – Board Administrator</p> <p>Apologies</p> <p>The Chair declared the meeting open at 2:04pm. Apologies had been received from Jo Agnew, Rob Cooper, Ian Ward, Farida Sultana and Taima Campbell. An apology for lateness was recorded for Pat Snedden</p>	Dr Brian Fergus (Chair)	Susan Buckland	Harry Burkhardt	Dr Chris Chambers	Dr Ian Scott	Pat Snedden	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Rev Alfred Ngaro	Lynda Williams
Dr Brian Fergus (Chair)	Susan Buckland										
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3	CONFLICTS OF INTEREST										
	There was no notification of conflicts of interest for any item on the agenda.										
4	CONFIRMATION OF MINUTES 20 OCTOBER 2009										
	<p>It was noted from the minutes that H1N1 was a notifiable disease but there were elements of non reporting. There were increased incidents in the US and there was preparation for a second wave and it was expected to be in the guidelines for vaccination next year.</p> <p>The Public Health Services funding had been discussed at the regional CEO meeting and a letter had been sent to the Ministry of Health as there is no resolution at this point. If funding was not available there would be cuts to services.</p> <p>Population Based Funding (PBF) did not take into account burdens of diseases in different parts of the country i.e. HIV, TB or move of older people into the Auckland area. This was not just a New Zealand issue but was also experienced in Florida and Mediterranean countries. There is no easy solution but with the formation of the National Health Board funding of national services may be held there. PBF is, however, probably the fairest way of funding but may need some small adjustments.</p> <p>With the universal newborn hearing screening programme there was appropriate treatment. While it has been difficult in getting funding for the programme because it was technologically expensive, \$200k had been found to fund appropriately.</p> <p>While ED had to take everyone, homeless were being invited to the clinics that had been set up in</p>										

	<p>the city.</p> <p><u>Moved Ian Scott; seconded Lynda Williams</u></p> <p><i>That the minutes of the Community and Public Health Advisory Committee meeting held on 20 October 2009 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
5	ACTION POINTS 21 OCTOBER 2009
	The clarification concerning Community Laboratory Services had been discussed at the previous Board meeting.
6.1	Planning and Funding Summary Report
	<p>There had been three successful EOI in the region. The governance of the Health+ Alliance PHO was spread and there could be challenges with the governance structure. The GAIHN recognised the amount of work to be done to do things differently at a time when there is preparation of the District Annual Plans (DAPs). Tamaki PHO is in the national Maori PHO Collective and GAIHN. There is collaboration with the three DHBs. Integrating and coordination of services as well as integrated family health centres would need to involve clinical leaders, planning and funding and contract some support. Funding had been suggested at \$1 per enrolled patient and there is an issue of how ADHB could provide support either in cash or kind. All business cases required DHB signoff by 14 February 2010 so it would be signed off at the February Board meeting or a special meeting.</p> <p>Pat Snedden joined the meeting at 2:30pm.</p> <p>It was noted that there could be an issue with communication with GPs in the short timeframe. The aim was to reduce duplication and streamline services and to avoid IDFs there may be a need to capitate across the region. There was a need to get responsiveness of funding and planning closer to delivery, get the governance structures right and be prepared to give up some DHB autonomy. One of the biggest challenges would be unpicking funding so that it is fair on DHBs and new providers. Originally \$600k had been provided to ADHB for planning for devolvement of services but when the EOI started this was taken back by the MoH. Devolution is to be clinical led as, to devolve or not rather than it being a financial decision should be a clinical decision although there could be a number of mechanisms i.e. risk sharing. With regards to Pacific there was concern around the process and more exposure to providers with Pacific providers particularly vulnerable with an unrealistic timeframe adopted.</p> <p>Funding for Eating Disorder Services had finally been resolved with a funding line for 4 years of between \$4.6m - \$4.8m per annum for the region although there was a risk at the end of the period. There was a process for inpatient services through an NGO provider with Starship catering for under 15s with increased clinical support. Having the funding coming to ADHB dilutes regional support so a regional governance group had been established to manage led by Ian McKenzie managing implementation with the ADHB funding shifted to NDSA so ADHB is not seen to be at an advantage. This was a move away from the concept of lead DHBs for regional services. The Committee asked for an updated paper and that the consumer group are communicated with.</p> <p>There was considerable interest in the heart failures telehealth pilot with \$15k being used to pilot with 14 people. Work was continuing regionally on Auckland Regional Public Health services to have a new structure from 1 July 2010 with now focus on regulation rather than health promotion which was a rational response to funding constraints. There was still concerns and disappointment with HCNZ regarding Home Based Support Services.</p>
6.2	Planning and Funding Indicators Exception Report
	The rise in the number of non TAB disease investigations was partly due to changes in health regulations and notification requirements for swine flu, measles and whooping cough. While diabetes annual checks were ok for Maori, Pacific and Indian, the European population was not doing as well.

6.3	Planning and Funding Indicators
	The improved immunisation rates for 2 year olds was partly due to improvement of data with the national register now operating properly so the rates previously may have been better than thought. Pacific were the best in the country.
7.1	DAP Projects Report
	<p>The one orange indicator was retinal screening. This had been updated to the Maori Health Advisory Committee in that a preferred provider with a network of optometrists and a mobile service to meet the gaps feeding into one database was the preferred solution.</p> <p>The Maori DNA project group had presented to the Clinical Board putting in texting, reply texting, transport and other strategies before patients came in. They would be reporting back to the Maori Health Advisory Committee in the new year and it was asked that there be comparisons with Counties Manukau and nationally.</p>
8	FEEDBACK FROM MAORI HEALTH ADVISORY COMMITTEE AND PACIFIC HEALTH ADVISORY COMMITTEE
	<p>Maori</p> <p>The Committee had discussed the issue of Maori provider sustainability with a need for a Maori providers sustainability framework. The review of contracts needed to ensure Maori health gains are not compromised and with the Maori Health Equity Framework there needed to be a strategic vision and measures to see what is being achieved.</p> <p>Pacific</p> <p>Faith Mahoney, who is leading the evaluation team of HVAZ, had presented to the Committee on the six month report which included social network analysis with leadership and resourcing support key to networking. The Pacific communities measure of success were sought to ensure that measuring is in the right areas and collection of data is being promoted for self collection within groups. The network was growing with Heart Beat churches joining.</p>
9.1	Review of Funding Contracts – Results Framework
	<p>All funding contracts were being reviewed due to the financial situation to ensure that there is not duplication of effort, maximising effectiveness and obtaining value for money using the prioritisation tools. A whole picture view was being taken rather than cuts at the margin and included ensuring equity. The Committee asked that the prioritisation tool be distributed with the minutes. It was noted that constraints can affect employment within organisations. In mitigating risks there are external participants from the School of Population Health and Funding and Planning people.</p> <p><u>Moved Pat Snedden; seconded Ian Scott</u></p> <p><i>That the Community and Public Health Advisory Committee approves the suggested process for review of funding contracts so that the work can commence.</i></p> <p><u>Carried</u></p>
9.2	Acute Bed Blockages – Under 65 Population
	<p>Lisa Gestro was in attendance and reminded the Committee of the boundary issues between over/under 65 with under 65 being funded through MoH. The ongoing issue was to move under 65s from the hospital however there was several layers of bureaucracy in funding and placement. There had been recent publicity concerning placements of under 65 into aged care. There needed to be clear definitions with the Ministry and not have shifts of those definitions. There was a suggestion that there be a step down facility while there are discussions on funding and placement. The MoH had agreed to work on this in principle. It was suggested that this may just move the problem rather than getting assessments right. At present there is a funding pool which sits between the MoH/ADHB with access to the funds managed through Taikura. This applies to</p>

	<p>20-25 people per year. There were links to the ED project in terms of data with questions of getting the right model of care i.e. facilities or wraparound care.</p> <p><u>Moved Linda Williams; seconded Ian Scott</u></p> <p><i>That the Community and Public Health Committee:</i></p> <ul style="list-style-type: none"> • <i>Notes the current issues being experienced, and the budget implications that these are having on ADHB; and</i> • <i>Supports the proposal to develop a series of immediate steps to resolve the current situation, which would involve the Ministry of Health agreeing to some performance KPIs and agreeing on some operational policies such as funding definitions which are currently contributing to discharge delays; and</i> • <i>Agrees that in the event that step two above is unsuccessful then a more sustainable remedy will be sought, which may include the establishment of a step down facility, the ADHB over 65 NASC being able to assume the Need Assessment function when Taikura Trust are not able to comply with preset KPIs, or the remodelling of assessment services within ADHB to align to that of other DHBs, which is to have one NASC for all ages.</i> <p><u>Carried</u></p>
<p>9.3</p>	<p>2010-2011 Planning Process and Update of Review of 2006/2010 District Strategic Plan</p>
	<p>Tony O'Connor and Julie Helean were in attendance.</p> <p>The District Annual Plan and SOI for 2010/2011 overlaps with the Strategic Plan Review and would be a workload for the Committee in February with the first draft District Annual Plan being due on 5 March 2010. Parameters were tighter funding, need to break even and meet national health targets so there would be an emphasis on financial management. The period was one of considerable change and there was a need to get regional agreement to wording on primary care and regional services. The intention was to produce one draft and not have an iterative process. Efficiency and additional savings would need to be written in. There were organisational processes and ongoing projects to imbed change. With the District Strategic Plan the MoH wanted a draft that had been out for public consultation by September 2010. It was cautioned that primary care was becoming overloaded with change and processes at the moment.</p> <p>There were a number of items coming up being EOI draft business cases and DAP with a suggestion that there be a meeting about 10 February 2010 to meet the timeline of 14 February 2010 with some submissions to the 2 and 3 February Financing Committee and Board. Management was asked to produce a timetable.</p> <p><u>Moved Pat Snedden; seconded Ian Scott</u></p> <p><i>That the Community and Public Health Advisory Committee:</i></p> <ul style="list-style-type: none"> • <i>Notes the new requirements contained in the planning package</i> • <i>Allocates time in February 2010 meeting to discuss the draft DAP and SOI, and to provide feedback</i> • <i>Notes that both the DAP and SOI be approved at the March 2010 meeting of the Board as a prerequisite to submitting to the Ministry</i> • <i>Approves that all financial and non-financial information submitted in March 2010 to meet the Ministry of Health deadline; and</i> • <i>Notes the Ministry of Health requirement for DHBs to produce a draft Strategic Plan by September 2010.</i> <p><u>Carried</u></p>

	NEXT MEETING
	The meeting closed at 4:10pm The next meeting is scheduled for 2:00pm, Wednesday, 20 January 2010 Marie Hosking Room Level 7, Building 14 Greenlane Clinical Centre Epsom
CONFIRMED CHAIR: DATE:	