Counties Manukau District Health Board
Community & Public Health Advisory Committee Meeting
Agenda

Wednesday, 15 April 2015 at 1.30pm – 4.30pm, Manukau Boardroom, Lambie Drive

Time	Item			Page No
1.00 - 1.30pm	**Cooking Masterclass** – Kitchen adjacent to the Manukau Boardroom			2
1.30pm – 1.35pm	**1.0**	**Welcome**		
1.35pm – 1.45pm	**2.0**	**Governance**		
		2.1	Attendance & Apologies	3
		2.2	Disclosure of Interests/Specific Interest	4-8
		2.3	Acronyms	9
		2.4	Confirmation of Public Minutes (4 March 2015)	10-16
		2.5	Action Items Register Public	17
	3.0	**Presentations**		
1.45pm – 2.00pm		3.1	Strategy Refresh Update – Marianne Scott	18-29
2.00pm – 2.30pm		3.2	Integrated Care – Marae Clinic, Waiuku – Jo Eustace, Jackie Burton & Pam Morley	-
2.30pm –3.00pm	**4.0**	**Director of Primary Health & Community Services Report** – Benedict Hefford		
		Glossary/Contents / Executive Summary/Actions from previous CPHAC meeting/s		30-33
		4.1	National Health Targets	34-41
		4.2	Primary Health	42-44
3.00pm –3.10pm		4.3	Child Youth & Maternity – Carmel Ellis	45-50
3.10pm – 3.20pm		4.4	Mental Health & Addictions – Tess Ahern	51-54
		4.5	Adult Rehabilitation & Health of Older People	55-60
3.20pm – 3.30pm		4.6	Intersectoral Initiatives – Jude Woolston	61-63
		4.7	Progress with Systems Integration	64-67
		4.8	Locality Reports	68-75
		4.9	Financial Report	76-77
3.30pm – 3.45pm	**Afternoon Tea**			
3.45pm – 4.00pm	**5.0**	**For Information**		
		5.1	Auckland Region Public Health Service Update – Jane McEntee & Julia Peters, ARPHS	78-83
	6.0	**Resolution to Exclude the Public**		84
	7.0	**Confidential Items**		
4.00pm –4.05pm		7.1	Confirmation of Confidential Minutes (4 March 2015)	85-93
4.05pm – 4.10pm		7.2	Action Items Register Confidential	94

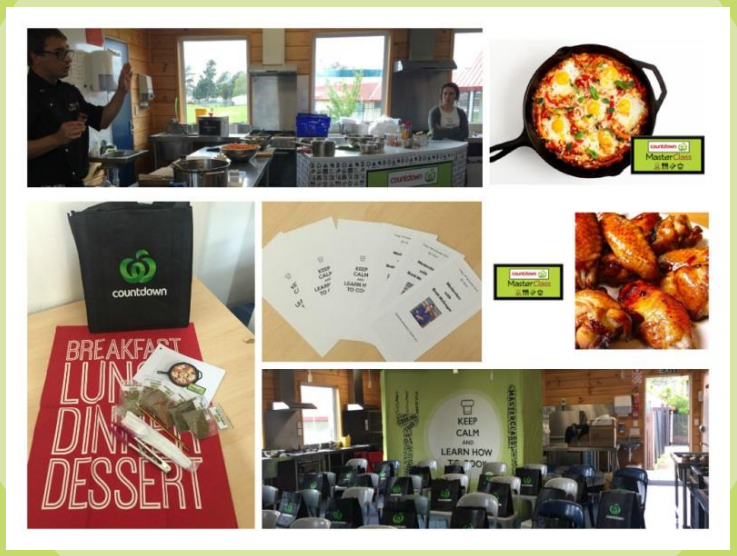
Next Meeting: Wednesday 27 May 2015, Lambie Drive

countdown MasterClass

NZ's 1st MasterChef

Are you ready for your very own MasterClass with Brett McGregor?

Introducing Countdown MasterClass is a free fun and motivational cooking show with celebrity chef Brett McGregor taken directly to schools in South Auckland.



Sample tasters, goodie bags, audience participation, recipes for simple, healthy and affordable meals along with nutrition and cooking advice will also be provided at the show!

BOARD MEMBER ATTENDANCE SCHEDULE 2015 – CPHAC

Name	21 Jan	Feb	4 Mar	15 Apr	27 May	June	8 July	19 Aug	30 Sept	Oct	11 Nov	16 Dec
Lee Mathias (Board Chair)	✓	No Meeting	✓			No Meeting				No Meeting		
Colleen Brown	✓		✓									
Sandra Alofivae (CPHAC Chair)	✓		✓									
David Collings	✓		✓									
George Ngatai	X		X									
Dianne Glenn	✓		✓									
Reece Autagavaia	✓		✓									
Mr Sefita Hao'uli	✓		✓									
Ms Wendy Bremner	X		✓									
Mr Ezekiel Robson	✓		✓									

COUNTIES MANUKAU HEALTH

BOARD MEMBERS' DISCLOSURE OF INTERESTS 15 April 2015

Member	Disclosure of Interest
Dr Lee Mathias, Chair	• Chair Health Promotion Agency • Deputy Chair Auckland District Health Board • Director, Pictor Limited • Director, iAC Limited • Advisory Chair, Company of Women Limited • Director, John Seabrook Holdings Limited • Chairman, Unitec • External Advisor, National Health Committee • Director, Health Innovation Hub • Director, healthAlliance Ltd • Director, healthAlliance (FPSC) Ltd • MD Lee Mathias Limited • Trustee, Lee Mathias Family Trust • Trustee, Awamoana Family Trust • Trustee, Mathias Martin Family Trust
Wendy Lai, Deputy Chair	• Board member and partner at Deloitte • Board member Te Papa Tongarewa, the Museum of New Zealand • Chair, Ziera Shoes
Arthur Anae	• Councillor, Auckland Council • Member The John Walker 'Find Your Field of Dreams' • Chairman, NZ Good Samaritan Heart Mission to Samoa Trust
Colleen Brown	• Chair, Disability Connect (Auckland Metropolitan Area) • Member of Advisory Committee for Disability Programme Manukau Institute of Technology • Member NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • Chair IIMuch Trust • Director, Charlie Starling Production Ltd • Member, Auckland Council Disability Advisory Panel

Dr Lyn Murphy	• Member, International Society for Pharma-coeconomics and Outcomes Research (ISPOR). • Member of the New Zealand Association of Clinical Research (NZACRes) • Senior lecturer in management and leadership at Manukau Institute of Technology • Member, ACT NZ • Director, Bizness Synergy Training Ltd • Director, Synergex Holdings Ltd • Associate Editor NZ Journal of Applied Business Research • Member Franklin Local Board
Sandra Alofivae	• Member, Fonua Ola Board • Board Member, Pasefika Futures
David Collings	• Chair, Howick Local Board of Auckland Council • Member Auckland Council Southern Initiative
Kathy Maxwell	• Director, Kathy the Chemist Ltd • Regional Pharmacy Advisory Group, Propharma (Pharmacy Retailing (NZ) Ltd) • Editorial Advisory Board, New Zealand Formulary • Member Pharmaceutical Society of NZ • Trustee, Maxwell Family Trust • Member Manukau Locality Leadership Group, CMDHB • Board Member, Pharmacy Guild of New Zealand
Dianne Glenn	• Member – NZ Institute of Directors • Member – District Licensing Committee of Auckland Council • Life Member – Business and Professional Women Franklin • Member – UN Women Aotearoa/NZ • Vice President – Friends of Auckland Botanic Gardens and Member of the Friends Trust • Life Member – Ambury Park Centre for Riding Therapy Inc. • CMDHB Representative - Franklin Health Forum/Franklin Locality Clinical Partnership • Vice President, National Council of Women of New Zealand
George Ngatai	• Arthritis NZ – Kaiwhakahaere • Chair Safer Aotearoa Family Violence Prevention Network • Director Transitioning Out Aotearoa • Director BDO Marketing • Board Member, Manurewa Marae

	• Conservation Volunteers New Zealand • Maori Gout Action Group • Nga Ngaru Rautahi o Aotearoa Board
Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Member, Auckland Council Pacific People's Advisory Panel • Member, Tangata o le Moana Steering Group • Employed by Tamaki Legal • Board Member, Governance Board, Fatugatiti Aoga Amata Preschool

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE MEMBERS
REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 15 April 2015

Director having interest	Interest in	Particulars of interest	Disclosure date	Board Action
Mr George Ngatai	CMH Quit Bus	Mr Ngatai is a Director of Transitioning Out Aotearoa who is a partner provider along with CMDHB and Waitemata PHO in the Quit Bus.	26 March 2014	That Mr Ngatai's specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.
Mr Sefita Hao'uli	Rheumatic Fever national campaign	Mr Hao'uli is currently undertaking some work with the Ministry of Health on the Pacific campaign on Rheumatic Fever.	Updated 21 January 2015	That Mr Hao'uli's specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.
Mr Geraint Martin	Renewal of the Regional After Hours Agreement	Mr Martin's wife is the Executive Director of Takanini Care Medical Services Limited Partnership. The company comprises 2 A&M clinics and 2 general practices at the same location.	21 May 2014 and 20 August 2014	That Mr Martin's specific interest is noted and the Committee agree that he may participate in the deliberations of the Committee in relation to this matter because he is able to assist the Committee with relevant information, but is not permitted to participate in any decision making.
Ms Colleen Brown	Richmond NZ Trust Ltd	Ms Colleen Brown has been involved with the family involved with this Trust.	22 October 2014	That Ms Brown's specific interest is noted and the Committee agree that she may remain in the room and participate in any deliberations of the Committee in relation to this matter because she is able to assist the Committee with relevant information, but is not permitted to participate in any decision making.

Director having interest	Interest in	Particulars of interest	Disclosure date	Board Action
Mr Sefita Hao'uli	Alliance Health+	Mr Hao'uli is currently undertaking some work for AH+.	4 March 2015	That Mr Hao'uli's specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.
Dr Lee Mathias	Otahuhu Boundary Change	Dr Mathias is the Deputy Chair of ADHB.	4 March 2015	That Dr Mathias' specific interest is noted and the Committee agree that she may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.

Glossary

ACC	Accident Compensation Commission
ADU	Assessment and Diagnostic Unit
ARDS	Auckland Regional Dental Service
CADS	Community Alcohol, Drug and Addictions Service
CAMHS	Child, Adolescent Mental Health Service
CNM	Charge Nurse Manager
CT	Computerised Tomography
CW&F	Child, Women and Family service
DNA	Did not attend
ESPI	Elective Services Performance Indicators
FSA	First Specialist Assessment (outpatients)
FTE	Full Time Equivalent
ICU	Intensive Care Unit
MHSG	Mental Health service group
MoH	Ministry of Health
MTD	Month To Date
MOSS	Medical Officer Special Scale
OHBC	Oral health business case
ORL	Otorhinolaryngology (ear, nose, and throat)
PACU	Post-operative Acute Care Unit
PHO	Primary Health Organisation
PoC	Point of Care
SCBU	Special care baby unit
SMO	Senior Medical Officer
SSU	Sterile Services Unit
TLA	Territorial Locality Areas
WIES	Weighted Inlier Equivalent Separations
YTD	Year To Date

Minutes of the meeting of the Counties Manukau District Health Board

Community & Public Health Advisory Committee
Wednesday 4 March 2015

held at Counties Manukau Health Boardroom, 19 Lambie Drive, Manukau
commencing 1.30pm

COMMITTEE MEMBERS PRESENT:

Dr Lee Mathias (Board Chair)
Ms Sandra Alofivae (Committee Chair)
Mr David Collings
Ms Colleen Brown
Ms Dianne Glenn
Mr Apulu Reece Autagavaia
Ms Wendy Bremner
Mr Ezekiel Robson
Mr Sefita Hao'uli

ALSO PRESENT:

Mr Geraint Martin (Chief Executive)
Ms Margie Apa (Director, Strategic Development)
Mr Benedict Hefford (Director, Primary Health & Community Services
Dr Campbell Brebner (Chief Medical Advisor, Primary Care)
Charlie Saunders, Franklin Family Support attended the Public section of the meeting.

APOLOGIES: Apologies were received and accepted from Mr George Ngatai and Ms Karyn Sangster.

WELCOME The Chair opened the meeting with a short prayer.

2.2 DISCLOSURE OF INTERESTS

The Committee noted that Ms Sandra Alofivae is no longer Chair of the Auckland South Community Response Forum (MSD appointment) and that Ms Dianne Glenn is no longer President of the Papakura/Franklin branch of the National Council of Women.

2.2 SPECIFIC INTERESTS

The Committee noted Mr Sefita Hao'uli 's interest in relation to Item 3.1 on this agenda and Dr Lee Mathias interest in relation to Item 7.3 on this agenda.

2.3 ACRONYMS

There were 2 items to be deleted from the Acronym list.

2.4 CONFIRMATION OF PREVIOUS MINUTES

Confirmation of the public minutes of the Counties Manukau Community & Public Health Advisory Committee meeting held 21 January 2015.

Resolution (Moved Dr Lee Mathias/Seconded Ms Dianne Glenn)

That the public minutes of the Counties Manukau Health Community & Public Health Advisory Committee meeting held on 21 January be approved.

Carried

2.5 ACTION ITEMS REGISTER

Resolution (Moved Ms Sandra Alofivae/Seconded Dr Lee Mathias)

That the Action Items Register of the Counties Manukau Health Community & Public Health Advisory Committee be received.

Carried

3. PRESENTATION

3.1 Healthy Families Initiative

Mr Alan Wilson & Ms Rachel Enosa-Saseve, Alliance Health+ took the Committee through their presentation. A copy of the presentation is available on the CMH website.

(Mr Ezekiel Robson arrived 1.36pm)

Healthy Families NZ, in a snapshot, is building on the Healthy Together Victoria Model – improving people's health where they live, learn, work and play and has five key focus areas:

- Good food choices
- Being physically active
- Sustaining a healthy weight
- Being Smokefree
- Alcohol in moderation

The Tamaki Healthy Families Alliance, Manukau and Manurewa/Papakura, has three partner organisations: Alliance Health+, the Southern Initiative (Auckland Council) and Nga Mana Whenua O Tamaki Makaurau.

Healthy Families is a long game, it's about demonstrating for people what health is and a what a healthy lifestyle looks like, changing mindsets. Overtime it will meld with our localities approach.

The Chair thanked the presenters. This is a real opportunity to drive cultural attitude and behavioural change and the flow-on effects from that.

(Mr Geraint Martin left at 2.50pm)

3.2 Values Refresh Strategy

Ms Margie Apa took the Committee through her presentation. A copy of the presentation is available on the CMH website.

'Living our Values Together' is a campaign to refresh our values, to help us make Counties Manukau DHB a consistently great place to receive healthcare and to work. It will involve the whole organisation for ownership and relevance building a change movement as it goes. We need to include every group, no-one is too important or not important enough. We need to be appreciative of the good things people already do and be honest about where we can be better, as teams and individuals. Working to the 29th July Board meeting to approve the strategic plan, action portfolios and values.

Listening Week commences 28 April – patient, family and staff events are scheduled. The Committee asked for a copy of the programme to be distributed to them.

The Committee asked that this presentation be added to the DiSAC agenda for 11th March for discussion/focus on how can people with disabilities participate/be part of the discussion.

4.0 DIRECTOR'S REPORT

Mr Hefford took the Committee through the Director's report.

4.1 Actions from Previous CPHAC Meetings

Vulnerable Adults –Mr Ezekiel Robson updated the Committee on a programme of work that the MoH in conjunction with the NZ Police with People First (a disabled person's organisation) are working on to create a national standard and guideline around safe guarding vulnerable adults. This will be a multi-agency response to abuse of disabled people that has expanded to cover any other adult who is vulnerable for whatever reason. ADHB has convened an older persons and vulnerable adults group to look at how ADHBs response to that gap is happening in practice. Mr Hefford was asked to link Mr Ezekiel Robson with the CMH Clinical Director of Safety & Quality and Mr Martin Chadwick in this regard.

4.2 National Health & IPIF Targets

Ms Louise McCarthy, acting Portfolio Manager took the Committee through this section of the Director's report.

Smoking – there has been a little slippage with this target since end June 2014. PHOs are aware of the drop and are focussed to prevent further slippage. Expect the target will be sustained.

Immunisations – will meet the target by end of the financial year.

Cervical Screening – Q1 result showed 74% based on the IPIF data and 71.5% based on the NSU data. The NSU denominator is based on an estimate of the census data and the IPIF data denominator is the enrolled PHO population. As such we are always going to see two different results. Our challenge is to get the women into the clinics or to a mobile screening unit to undergo the screen – the cervical screening programme is the only national screening programme that is not free so cost is a barrier for some women although the DHB does contract with PHOs for free smears for priority women (ie) Maaori and Pacific, high needs and those who haven't had a screen in the last three years.

Ms McCarthy noted that it was unlikely we would hit the target by 30 June this year as we would need to screen another 11,000 women. These are the women that traditionally don't access primary care regularly. Areas of focus are increasing the number of free smears, sorting out the screening data, some PHOs are providing incentives for women to have a screen and setting interim targets which the PHOs will be asked to agree to but probably not by June this year.

Dr Mathias reiterated that the intent is that this target will be fully met by 30 June.

4.3 Primary Health
The report was taken as read.

4.4 Child Youth & Maternity
Ms Carmel Ellis, Project Manager took the Committee through this section of the Director's Report.

Maternity – over the next six months the accountability for this project will be transitioned back into business as usual with the Director of Hospital Services and Director of Primary Health & Community Services but will continue to report through to the Board on a regular basis.

B4SC – slightly behind target by 15% at end January however, remain confident that the target will be met.

Children's Action Plan (CAP) – the South Auckland sites have been deferred until December 2015 due to the complexities of implementing large scale sites. Waikato will be the next site to go live around September 2015 and we will continue to work closely with Waikato to assist with the planning of our site/s.

Rheumatic Fever –Ms Ellis was asked to bring a finished safe sleeping box and pepi pod to the next CPHAC meeting for the Committee to view.

4.5 Mental Health & Addictions
The report was taken as read.

4.6 Adult Rehabilitation & Health of Older People
The report was taken as read.

4.7 Intersectoral Initiatives
The report was taken as read.

Referral Generation – total number of home visits completed post install 249 as end January 2015 compared to 789 homes insulated. Mr Hefford was asked to look into why we don't do a post-insulation install check after each install and to report back to the Committee.

4.8 Systems Integration

Mr Hefford took the Committee through this section of his report.

ARI now at 5,000 enrolled patients, target is 30,000 although don't expect to see all of them being actively managed at the same time.

The community health service integration work is progressing and expect this to come back to this Committee next month.

4.9 Locality Reports

Ms Lynda Irvine, GM Manukau Locality took the Committee through her presentation on the Unplanned Care Action Group. A copy of the presentation is available on the CMH website.

Ms Irvine gave the Committee an overview of the Unplanned Care Action Group whose objective is to use Manukau as a proof of concept for developing a systematic response to the increasing demand on the Emergency Centre – admitted and non-admitted presentations.

Resolution

That the Community & Public Health Advisory Committee receive the report of the Director Primary Health & Community Services

Carried

5.0 FOR INFORMATION

5.1 Stoptober Smokefree Campaign Evaluation

The paper was taken as read.

5.2 Integrated Mental Health & Addictions Leadership Group Expression of Interest

The paper was taken as read.

5.3 Establishing a Whaanau Ora Model of Care for CMH

The paper was taken as read.

High Needs Whaanau (page 84) - it was noted that what does not feature in the current ways of determining need is the inclusion of whaanau with a disability. This will require a systematic way of identifying whaanau with disability in the hospital patient information system which does not happen at present. This will be a good step forward.

5.4 The Kings Fund – Population Health Systems

The paper was taken as read.

6.0 RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved Ms Sandra Alofivae/Seconded Ms Colleen Brown)

That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, 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
7.1 Minutes of the CPHAC Meeting with public excluded 21 January 2015	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(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** For the reasons given in the previous meeting.
7.2 Annual Planning Update	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(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**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. [Official Information Act 1982 S9(2)(i)]
7.3 Otahuhu Boundary Change	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(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**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. [Official Information Act 1982 S9(2)(i)]

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
7.4 Appointment of Asian Representative to CPHAC	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)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]

Carried

3.58pm Public excluded session.

4.26pm Open meeting resumed.

Mr Apulu Reece Autagavaia closed the meeting with a prayer.

The meeting concluded at 4.28pm.

The minutes of the Counties Manukau Community & Public Health Advisory Committee meeting held 4th March 2015 be approved.

(Moved /Seconded)

Chair _____ _____

Ms Sandra Alofivae Date

Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

Community & Public Health Advisory Committee Meeting – Action Items Register – 15 April 2015

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
26.2.2014	4.0	Update from Auckland Regional Public Health Service every 6 months on current issues.	April	Mr Hefford		✓
20.8.2014	3.1	Follow-up presentation on the St John's 111 Clinical Hub	May	Mr Hefford	Postponed to May when a clinical audit of the trial will be available.	
22.10.14	4.0	Director's Report –The Committee would like to hear from some of the staff/people out in the community at the cutting end of change who are actually doing the work (ie) where they're at with their refreshed job descriptions, the changes in the traditional models, the authority and accountability that's come with this change - 20min presentations spread over a few months. Some examples given were: a nurse practitioner doing work on a marae, a district nurse, a practice nurse doing care coordination and how things are different in practices now.	April & ongoing	Mr Hefford/Ms Sangster		✓
26.11.2014	5.0	Mr Nia Nia to provide an update on the NHC integrated service agreement work.	Date TBC	Mr Hefford/Ms Apa	Deferred pending further work being undertaken.	
17.12.2014	3.1	Immunisation – Is there a group of older vulnerable people who would benefit from immunisation for Shingles & Whooping Cough (Varicella & Boostrix).	April	Mr Hefford/Ms Sangster	Included in Director's Report this month	✓
17.12.2014	5.1	Pacific Health Development – report back on Pacific Workforce development in relation to students not passing their examinations.	April	Ms Powell	This item moved to the Confidential Action Item Register	✓
4.3.2015	4.4	Director's Report – Ms Ellis to bring a finished safe sleeping box & pepi pod to the next meeting for the Committee to view.	April	Mr Hefford		✓

Counties Manukau District Health Board
Strategy Refresh Update

Recommendations

It is recommended that the Community and Public Health Advisory Committee:

- **Note** progress against project milestones are on track
- **Provide feedback, insights and advice** on the proposed Strategic Plan development approach (refer 4.1 & Attachment 1)
- **Review and feedback** on the draft Strategic Picture (refer Attachment 2)

Prepared and submitted by: Marianne Scott, Master Planner, Strategic Development

1. Purpose

To seek input on our developing CM Health Strategy that will outline our collective action focus from 2015 to 2020.

2. Executive summary

The Strategy Refresh was launched in early February as a companion project to the Values Refresh. Outcomes from both projects will be integrated in late May/early June to enable high-level inclusion in the 2015/16 Annual Plan.

Key achievements to date:

- engagement of sector leadership through established forums/committees
- initial briefing for the Ministry of Health in light of the national Health Strategy refresh
- draft Strategic Picture discussion document completed and available to support Strategic Plan co-creation with a broad range of stakeholders during April to May.

3. Key messages

- We will build on our current 'Best by 2015' strategy, i.e. continue to build on primary care as the healthcare home for our community, sustain high quality hospital/specialist services and acute care system while living within our means
- Replace the current Vision with a shorter statement of strategic intent that reflects our goal to be **'Healthy Together'** (refer Attachment 2)
- Confirm a goal that reflects our desire to measure in some way the impact on our community by restoring health and extending life by some measure of years and/or quality of life – that is able to be **translated with meaning** in multiple contexts e.g. service setting, target population group, individual staff, individual patient and/or their whaanau and family
- Replace the "Achieving a Balance" strategic framework with three Healthy Together **Mission statements** that build on the Triple Aim – Healthy People, Whaanau and Families; Healthy Communities; Healthy Services

- We will explicitly join up all of our strategic activities and plans across the district – including local and regional infrastructure, ICT, workforce, service development, SWIFT and others
- Values Refresh outcomes will be integrated into the final strategy by June 2015
- We have already briefed, and will continue to engage with, the MOH on CM Health's strategy refresh process and direction in light of the national strategy plan development
- Engagement over April to May will clarify and be more specific about what we really mean by each of the **three Missions** and what programmes of work or change that community/staff will see that reflects the intent. The specificity will refer to and build on existing work 'in flight'.

3. Progress to date

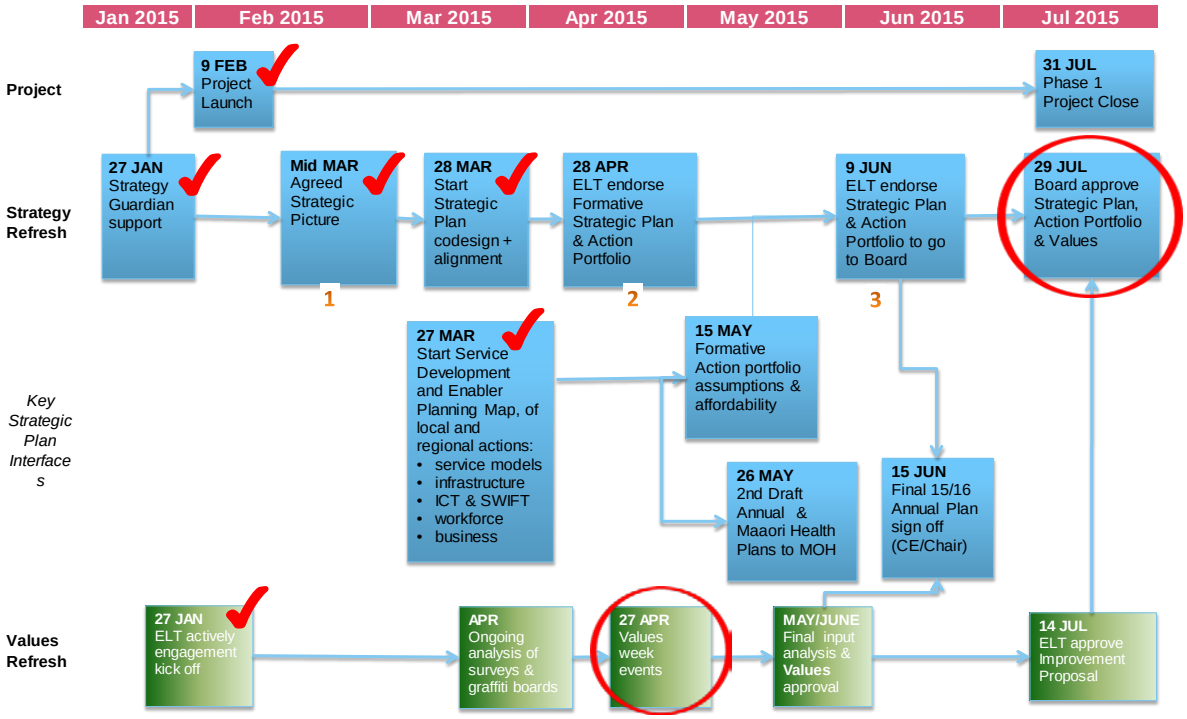
We are approaching this strategy refresh in three steps as outlined below.

Step	Action	Progress as at 2 April 2014
What will be different by 2020 (Feb-Mar)	Our **"Strategic Picture"** that speaks to what we will focus our actions on	**Completed draft Strategic picture to base engagement and input to plan completion** Existing forum briefings – to date about 500 people have been engaged, 34 through 1:1 meetings and 20 other forums; including the CEO Quarterly Staff Forum 1:1 meetings with key people as context/reality testing Strategy Guardians[1] agreement to change the current vision (simplify) and 3 missions (building on the Triple Aim – refer Attachment 2) Initial briefing for MOH
Making the big choices (Feb-Apr)	Our **"Strategic Plan"** – to make visible our current commitments and how to best align and join up our all our actions and plans	**In progress** Draft strategic plan in progress with forum engagements scheduled and tools in place to enable input from a broad range of stakeholders. Component planning: • *Infrastructure:* collated 10 year infrastructure requests and first planning workshop held 30 March • *Workforce:* Workforce and Committee charged with whole of system workforce plan oversight • *Service Development:* input from key programmes, notably ARI, Community Health Integration, Manaaki Hauora – Supporting Wellness and others • *ICT & SWIFT:* collated regional and local planning intentions ready for preliminary alignment
Making it happen (Apr-May)	Our **"Strategic Action Portfolio"** - a realistic and practical action plan that leaves room to adapt as we learn what works	**No action this month** Awaiting testing of what our strategic actions look like when joined up so that we can identify the most effective/beneficial arrangement and phasing of implementation resources.

[1] Sub group of the Executive Leadership Team comprising the Chief Executive, Deputy Chief Executive and Directors of Strategic Development, Primary and Community Health, Hospital Services and Ko Awatea. The Guardians are supported with clinical input through the Clinical Governance Group and ELT members.

The project milestone chart below shows that we are largely on track and have completed the first step with Strategy Guardian endorsement of the draft Strategic Picture to support engagement and co-creation of the strategic plan.

Figure 1: Strategy Refresh Milestone Chart



4. Next steps - Strategic Plan development approach

Planned engagement to co-create the Strategic Plan will clarify and be more specific about what we really mean by each of these **three Missions** and what programmes of work or change that community/staff will see that reflects the intent. The specificity will refer to and build on existing work 'in flight' and includes our Alliance Leadership team strategic priorities.

To achieve a completed plan for Board approval in July, this means concurrently collating and aligning all our strategic plans across CM Health. This is about getting practical and real about how we can sensibly join up actions across multiple plans. Some strategic plan components (see Figure 2 below) are well advanced in their planning and others will require more detailed input, discussion and alignment testing (e.g. workforce development). Regional capital intentions and service changes that are underway and planned are a key consideration - we are working closely with Northern Regional Alliance to align these activities.

Service and Model of Care changes planned in the next five year are at the heart of decisions around enabling actions such as workforce, ICT and infrastructure changes.

To make the best use of our available resources, the Strategic Plan development has been divided into parallel streams of plan development (refer Attachment 1 for further detail), i.e.:

- identification of high level actions for each component plan over March to early May with oversight provided by the appropriate forums, then
- strategic fit and alignment tested against the three Missions and high level action mapping;

- respecting some plans, e.g. infrastructure, will require a longer 10 year planning horizon, and
- supported by high-level implementation plan that will include year indicative 1 to 5 priorities, change framework, evaluation and strategy portfolio approach.

Figure 2: Strategic Plan components

Attachment 1: CM Health's draft Strategic Picture – A Discussion Document

STRATEGIC PLAN DEVELOPMENT	February/March	April	May	June	July –Dec (Phase 2)
Oversight					
Strategy Guardians	Endorse co-creation	Sponsor support	Agree Plan	Endorse Plan to Board	Ongoing accountability
ELT	Engagement/Input	Formative Plan input	Strategic Plan review	Endorse Plan	Ongoing oversight
Alliance Leadership Team	Engagement/Input	Formative Plan input	Strategic Plan review	Endorse Plan	Ongoing oversight
CMDHB Board Sub Committees	Engagement/Input	Formative Plan input	Strategic Plan review	Endorse Plan	Ongoing oversight
CMDHB Board	Engagement	Chair briefing	Chair briefing	Chair briefing	Review/Approval
Service / Model of Care Development	***... Oversight provided by key ELT Sub-Committees & Alliance Leadership Team (ALT)***				
Service development planning	Current plan collation	Align to missions/gaps?	Enabler mapping	Plan integration	Refinement Jul-Sep
ALT oversight	Engagement	5 year WF intentions	Endorse WF priorities	Endorse final draft plan	Ongoing oversight
ELT sub-committee oversight	Engagement	6 year WF intentions	Endorse WF priorities	Endorse final draft plan	Ongoing oversight
Workforce Development	***... Oversight provided by the Workforce and Education Committee (W&EC)***				
Workforce planning	Current commitments	Assess WF devel. needs	High level plan	High level integration	Refinement Jul-Sep
W&EC oversight	Agree to oversee plan	WF priorities review	Endorse draft plan	Endorse final draft plan	Ongoing oversight
Information & Communication	***... Oversight provided by the Information System Governance Group (ISGG)***				
Regional & NHITB commitments	RIS Plan review	Align intentions	Indicative costs by year	Plan integration	Refinement Jul-Oct
Project SWIFT	Quick wins	Align intentions	Indicative costs by year	High level integration	Refinement Jul-Oct
ISGG oversight	Engagement	Formative plan review	Endorse draft plan	Endorse final draft plan	Ongoing oversight
Infrastructure (2015-25)	***... Oversight provided by the Integrated Infrastructure Planning Steering Group (IIPG)***				
Locality service mix/master plan	Sapere collation	Sapere modelling	Financial testing	Plan integration	Refinement Jul-Sep
10 Year Infrastructure Plan	Request collation	Prioritisation	Indicative affordability	Plan integration	Refinement Jul-Oct
IIPG Workshop oversight	Principles/long list	Prioritisation	Endorse draft plan	Endorse final draft plan	Ongoing oversight
Strategic Action Plan	***...Oversight provided by the Strategy Guardians - supported by internal subject matter experts***				
Evaluation framework	Agree Triple Aim evolution	Framework input	Measure mapping	High level integration	Refinement Jul-Aug
Change framework	Ko Awatea framework	Engage re: aligned change	Engage re: plan actions	High level integration	Refinement Jul-Sep
Strategy portfolio approach	Align current to missions	Review formative plan	Transition plan	High level integration	Refinement Jul-Oct
Indicative Implementation	Engage stakeholders	identify and align actions	Map actions & enablers	High level integration	Refinement Jul-Nov

Note:
This approach has been developed in consideration of the current strategic programme initiative structures and ongoing roles of established committees/groups to oversee strategy implementation, progress monitoring and annual reviews.

COUNTIES MANUKAU HEALTH

HealthyTogether

Counties Manukau Health

DRAFT
Strategic Picture

A Discussion Document

So everyone can share their insights, input and advice on how we can be truly Healthy Together

Draft Strategic Picture

As we understand it the current strategic picture is as follows:

Healthy Together

Improving the health of all Counties Manukau communities and treating those that need us quickly, safely and with compassion.

This goal will also reflect CM Health's desire to measure the impact on its community by promoting, protecting and restoring health and extending life/improving quality of life.

While the measurable goal can be influenced by the healthcare system, CM Health will also translate this with meaning in multiple contexts eg. service setting - within and outside health, target population group, individual staff, individual patient and their whaanau and family.

We can be proud of our many achievements. These are the highlights of what people had to say:

> *We can be really proud of the many ways we have worked together with the patient as our focus, supported by clinically led safety and quality culture that has enabled high performance while at the same time innovating and co-designing services. This has made a significant 'whole of system' difference that has resulted in more proactive patient and whaanau centred services across our health system.*

While we are clear on the framework for Healthy Together, we need more insights, input and advice on the details of this draft Strategic Picture.

How do you advise we focus our actions to be truly Healthy Together?

To be Healthy Together we will focus our resources and expertise in actions based on three missions:

Key Messages

Counties Manukau can be Healthy Together

- Together we can involve **people, families and whaanau** as an active part of their health care team.
- Together we can help make healthy options the easy options for everyone and weave healthcare into the fabric of our **communities**.
- Together we can provide leading **services** that are well supported to treat those who need us quickly, safely and with compassion.

Together, we can improve the health and quality of life of people living in Counties Manukau.

While we're clear on the framework for Healthy Together, we're currently in the process of drafting the details of the refreshed strategy.

We believe it's important to honour our commitment to be Healthy Together, by working collaboratively with our people, communities and services to gather insight, input, advice and guidance to inform the complete plan.

Healthy Together.
We are all one team.

ACTIONED BY

HEALTHY PEOPLE WHAANAU AND FAMILIES

Together we can involve people, families and whaanau as an active part of their health care team.

- Reinforce general practice as the healthcare home and front door to the healthcare system by reorganising services in locality settings to support primary care
- Expanded At Risk Individual programmes to a wider group of vulnerable patients and their families beyond adults with long term conditions eg children, pregnant women, young people
- Establish Whaanau ora/Fanau Ola case management of families that works across the whole system
- Expanded Manaaki Hauora – self management programme
- Complement general practice with six Community Hubs supported by community central to integrate service logistics
- SWIFT enabled access to healthcare information, services and technology that supports self-management and health literacy

HEALTHY COMMUNITIES

Together we can help make healthy options the easy options for everyone and weave healthcare into the fabric of our communities.

- Reduce smoking prevalence to 12% by 2018 and on track to reach 5% by 2025 [to determine a 2020 target]
- Minimize harm from alcohol
- Join up experience and continuity of care for mama, pepi/tamariki – mums, babies and young children – in the First 2000 Days of life
- Implement Healthy Families NZ and its spread across the District in support of the Taamaki Health Families Alliance
- Complement general practice with six Community Hubs supported by community central to integrate service logistics
- SWIFT enabled access to information on population segments that enable targeting of support for communities to be active in their own health

HEALTHY SERVICES

Together we can provide leading services that are well supported to treat those who need us quickly, safely and with compassion.

- Workforce development to attract and retain great people, that are well equipped and supported to deliver kind, safe, effective and excellent care
- Values led people and organisational development
- Advance quality and safety agenda
- Do what we must do – excellent performance in national targets
- Whole of System portfolio of projects and service improvements in key areas that drive acute demand growth eg musculoskeletal, metabolic syndrome, mental health, cardiovascular and respiratory
- Implement community health integration through Locality Leadership Teams, shift of services into Community Hubs and supported by community central
- SWIFT enabled productivity and workforce efficiencies
- Assets and infrastructure that enable whole of system working (e.g. diagnostics, 6 community hubs) using mix of public and private capital investment
- Environmentally sustainable practices

Supporting Messages

CM Health has been working towards being the best healthcare system in Australasia by December 2015, and we're heading in the right direction.

- Ko Awatea's 20,000 days programme saw us give back 23,060 healthy and well days to the people of Counties Manukau.
- We've improved waiting times for cancer treatments with a consistent wait time of less than 4 weeks for our patients.
- We are providing better help for smokers to quit, with over 95% of smokers who are seen in primary care and hospital being proactively offered quit smoking advice.
- We've improved our response to complex and long term conditions, with 6,000 patients now receiving more proactive and coordinated care.

But, our population in Counties Manukau is growing and changing, both youthful and ageing, and our health system demand continues to grow.

- Our population is growing 1-2% each year. By 2020 we expect our population to be more than 561,500 people.
- There is increasing ethnic diversity. By 2020 we estimate there will be 15% Maaori, 22% Pacific, 26% Asian and 36% NZ European and other ethnicities living in Counties Manukau.
- Our older population will increase by approximately 22% with an estimated 70,000 people aged 65 years and over by 2020.
- At the same time we have the largest population of children of any District Health Board and a high proportion of them living in poverty.
- Just over a third of our population live in areas of high socioeconomic deprivation; if the situation continues at current levels this could be as many as 202,150 people in Counties Manukau in 2020.

To improve health for all and to prevent demand due to potentially preventable causes across the system, we need to focus on being Healthy Together.

- We need to work together to decrease our smoking prevalence – smoking affects health at all ages
  – In Counties Manukau 15.9% of people in 2013 were smoking – to work towards our goal of less than 5% we need to support those groups with the highest rates of smoking to be Smokefree.
- We need to work together to decrease our obesity prevalence
  – Currently 40% of adults over 15 years old and about 19% of children are obese.
  – Tackling this requires action and commitment across sectors, families and communities.
- We need to work together to reduce the need for services like renal dialysis
  – Currently over 600 people are treated with renal dialysis each month, and this is expected to increase to over 800 people by 2020.
- We need to work together to improve early access to health services to keep people well
  – Currently growth in Emergency Care presentations to CM Health facilities is higher than population growth, and growth in hospital admissions

We need to work <u>together</u> to support mental health and wellbeing for all our communities and for people to be able to get support when they need it, quickly and easily, in their local community.

Next Steps

We now need your help and advice to bring these missions to life so we can shape and join up all our planning in a practical and clear way. This includes how we work with people, families and whaanau and enable development of services, the workforce, facilities, information, communication systems and all other required facets.

Please share your thoughts and advice by answering the short questions below:

- **Where and how do you see us focusing our resources and actions to:**

  - involve people, families and whaanau as an active part of their healthcare team?

  - help make healthy options the easy options for everyone?

  - provide services that treat people quickly, safely and with compassion?

Waiuku Health Centre.

Tahuna Pa Marae Clinic

Joanne Eustace
RN, MN (Hons)

Waiuku Ethnicity Breakdown

Ethnic Group	Age Group						Total	%
	00-04	05-14	15-24	25-44	45-64	65+		
Maori	234	435	298	447	334	85	1833	15%
Pacific Island	38	52	43	63	43	12	251	2%
European	617	1325	1201	2116	2821	1863	9943	80%
Asian	28	56	37	83	81	20	305	2%
Other	7	24	21	23	26	9	110	1%
Unknown	2	0	0	0	1	2	5	0%
Total	926	1892	1600	2732	3306	1991	12447	100%

Ethnic Group	Percentage in each Age Group by Ethnicity							
	00-04	05-14	15-24	25-44	45-64	65+		
Maori	13%	24%	16%	24%	18%	5%		
Pacific Island	15%	21%	17%	25%	17%	5%		
European	6%	13%	12%	21%	28%	19%		
Asian	9%	18%	12%	27%	27%	7%		
Other	6%	22%	19%	21%	24%	8%		
Unknown	40%	0%	0%	0%	20%	40%		
Total	7%	15%	13%	22%	27%	16%		

Our whare

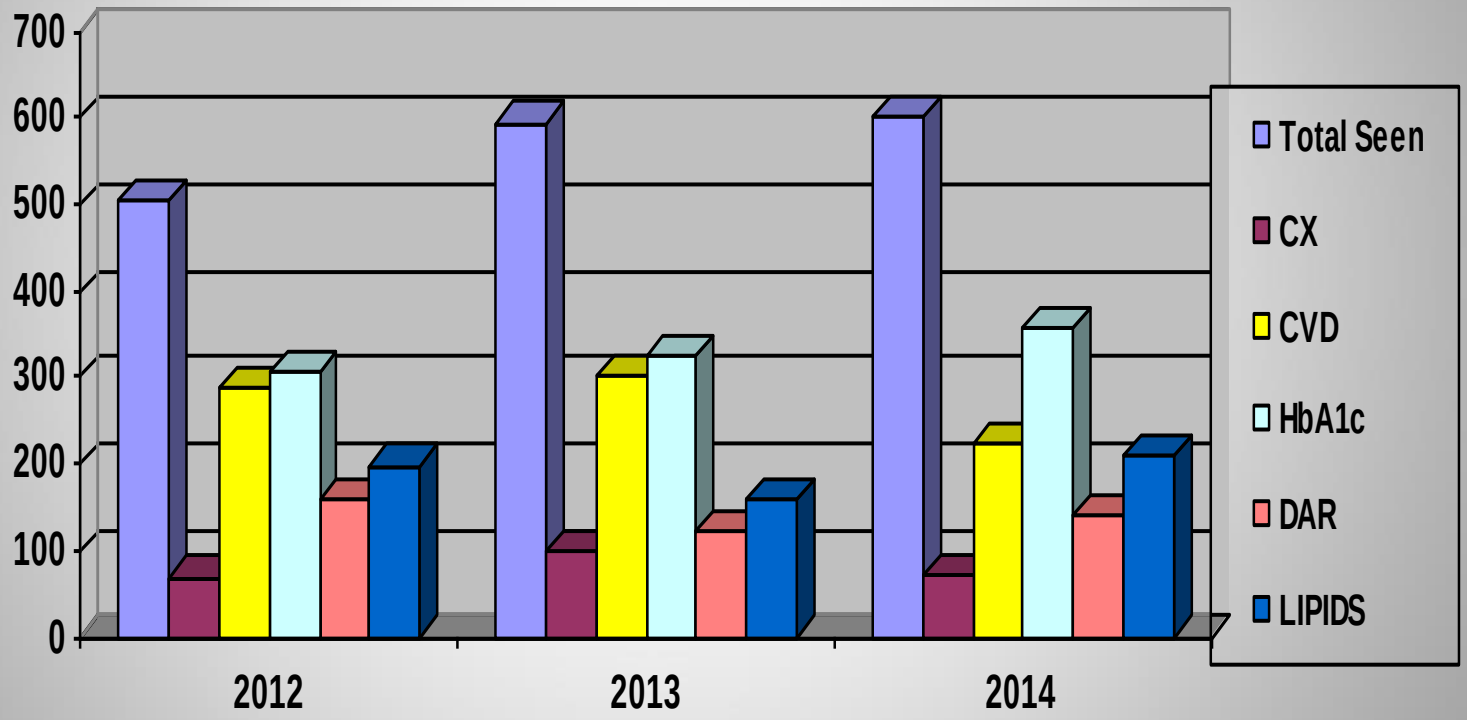
• Information
• Resources
• Support
Mobile Diabetes Awareness Service
diabetes nz
Auckland branch
MLE306
0508 DIABETES (34 22 38)
www.diabetesauckland.org.nz
BreastScreen
AOTEAROA
0800 270 200
BreastScreen
AOTEAROA
a free national breast screening programme for women aged 45 to 69
0800 270 200

Tahuna Pa

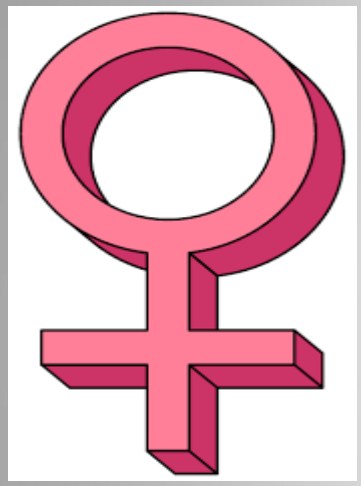
Collaboration

Whakawhanaungatanga

Total attendance and screening



Eligible CVDRAs



Women aged over 45 years =78%

Men aged over 35 years = 87%

A couple of examples

Counties Manukau District Health Board
Director Primary Health & Community Services Report

Recommendation

It is recommended that the Community & Public Health Advisory Committee **receive** the report of the Director Primary Health & Community Services.

Prepared and submitted by: Benedict Hefford, Director Primary Health & Community Services

Glossary of Terms

Acronyms	Description
A&D / AOD	Alcohol and Drug
ACP	Advanced Care Plan
AH+	Alliance Health Plus
ARDS	Auckland Regional Dental Service
ARI	At Risk Individuals
ARPHS	Auckland Regional Public Health Service
ARRC	Aged Related Residential Care
AT&R	Assessment, Treatment and Rehabilitation
AWHHI	Auckland Wide Healthy Housing Initiative
B4SC	Before School Checks
CCM	Chronic Care Management
COPD	Chronic Obstructive Pulmonary Disease
CSW	Community Support Worker
DHS	Director Hospital Services
DNA	Did Not Attend
EOI	Expression of Interest
GAS+	Group A Streptococcal Positive
GP	General Practitioner
hA	healthAlliance
HBSS	Home Based Support Services
HBT	Home Based Community Team
HHC	Home Health Care
HOP	Health of Older People
IDF	Inter District Flows
IFHC	Integrated Family Health Centre
IPIF	Integrated Performance & Incentives Framework
LTCF	Long Term Conditions Facilities
MOH	Ministry of Health
NGO	Non-government organisation
PHN	Public Health Nurse
POAC	Primary Options to Acute Care
PRIMHD	Project for the integration of mental health data
PSAAP	Primary Services Agreement Amendment Protocol
SUDI	Sudden Unexplained Death of Infant
VHIU	Very High Intensive User
VLCA	Very Low Cost Access

Contents

1.	Actions from Previous CPHAC Meetings
2.	National Health and Integrated Performance & Incentives Framework Targets
3.	Primary Health
4.	Child, Youth and Maternity
5.	Mental Health and Addictions
6.	Adult Rehabilitation & Health of Older People
7.	Intersectoral Initiatives
8.	Progress with Systems Integration
9.	Locality Reports
10.	Financial Report

Executive Summary

- We remain in a good position to achieve all of the National Health Targets. Close monitoring of the 8 month immunisation performance is required from PHO's to ensure we remain on track to meet the target of 95% after an expected drop over the summer holidays. The Alliance Leadership Team are working together and are considering a variety of initiatives to meet the challenges of the new IPIF cervical screening target.

- Zero Fees for Under 13s is on track for implementation by PHO's from 1 July 2015 with initial analysis showing the majority of general practices opting in to the scheme. Fully subsidized prescriptions for under 13's from 1 July is also being implemented with an increase in service being built into the Community Pharmacy Services agreement contract extension. Consideration is currently being given to how after-hours free of charge dispensing for under 13's will affect pharmacies.

- Progress with the Rheumatic Fever Prevention plan is rapid with primary and secondary prevention activity augmenting appropriate diagnosis and management of Acute Rheumatic fever and Rheumatic Heart disease. Ministry of Health data recently released shows a 25% reduction of cases of Acute Rheumatic Fever in all ages from 2013 to 2014.
- Approval has been given by the Ministry of Health to proceed with a Community Breastfeeding and First Foods Support programme, which is community based and provides support and advice on breastfeeding, promoting Mother-to-Mother support, and the introduction of healthy first foods. This will be rolled out over 15 months with recruitment beginning in April and the programme commencing in July 2015.
- A targeted Flu vaccine campaign is beginning this month to reach all children who have been admitted to hospital with respiratory conditions, people with chronic illness, pregnant women and people of 65 years. Locally driven posters, pamphlets, paper advertisements and radio advertisements will commence this month, with the vaccine becoming available.
- Mental Health and Addictions have refreshed an interagency suicide prevention group and are formulating a new suicide prevention plan for 2016. They have also commenced a GP initiative at parenting support groups where in addition to their core purpose of building positive parenting techniques, building family relationships and long term positive parenting, the GP's are able to offer free services to meet any medical needs they may have. This is in line with the wider move for integration in Primary Health & Community Services.
- Community Health Service Integration is progressing with the focus this month on completing the draft Case for Change document that outlines the new model of care for community health services. An analytics group has been added to the three main workstreams of Reablement, Restorative and Community Central. These three workstreams are scoping possibilities for a winter rapid response approach that can be used to test systems and processes.

1. Actions from Previous CPHAC Meetings

Action/Description:

Is there a group of older vulnerable people who would benefit from immunisation for Shingles and Whooping Cough?

Current situation

Annual influenza vaccinations are funded for 65 years and over or those adults who have a long term condition or meet other eligibility criteria for a funded annual influenza vaccine. This is provided at no cost to the patient.

Whooping Cough (Pertussis) vaccines are on the immunisation schedule for babies and young children with a booster at 11 years of age. The only adults who receive a funded vaccine for Whooping Cough are women between 28 and 38 weeks of pregnancy. It is recommended but not funded for people in close contact with new-born babies and close family members are often advised to pay for vaccinations to protect their new babies. Young babies are the population most at risk of hospitalisation in the first 3 months of life. In some countries it is recommended but not funded for child care workers to be immunised against Whooping Cough.

Vaccinations currently funded for adults are Tetanus and Diphtheria at age 45 and 65. The vaccine is funded, but the administration of the tetanus and diphtheria is not funded, resulting in costs to the patient. Patients can request to have a Tdap (Tetanus, Diptheria and Whooping Cough). There is a charge for the full cost of the Boostrix vaccine.

Shingles

There are no funded vaccinations for Herpes Zoster (Shingles) which is licensed in New Zealand for use in people over 50 years of age. Vaccination for Shingles (Herpes Zoster) is provided through a single dose of Zostravax. Shingles is a reactivation of the Varicella Zoster virus (Chicken pox) and Zostravax is licensed and recommended for people over the age of 50 years.

The reactivation of the virus provides a constant reintroduction of the virus causing the chicken pox virus in those not exposed before. There is no current data on the burden of disease from Shingles in New Zealand. 30% of the population will develop shingles in their lifetime and it can affect 50% of those living to at least 85 years however relatively few people require hospitalisation.

In 2013 there were less than 280 admissions nationally for those over 65 years. Most people are managed in the community. Locally the numbers of those requiring hospitalisation in 2014 were 35 individuals with an average length of stay of 4.51 days. 13 of these admissions were under the age of 65. The total cost of the 35 admissions was $169,877 with a total of 158 bed days used. It would cost approximately $20 million to vaccinate all 50+ year olds in Counties Manukau.

The number of hospitalisations has decreased from 51 in 2011 to 35 in 2014. This may be due to the increased use of antiviral medications reducing the severity of the infection. Although there are relatively few hospitalisations for shingles it is important to consider the personal and community impact of shingles infection. The post infection complications can affect people's independence; increase the need for primary care visits and use of medications to manage persistent nerve pain. The shingles vaccine reduces the incidence of shingles by 69.8% and reduces burden of disease by 50% with a 66% reduction in post herpetic nerve pain (nerve pain persisting for more than 3 months post shingles infection).

Zostravax for shingles was only licensed in 2006. Finland, Australia and England have looked at population modelling and have indicated that for there will be increased numbers of shingles in the population for the following 40-50 years with introduction of vaccination programme for chicken pox in childhood. This is due to the gap between children vaccinated and those who have had natural infection with chicken pox. It is expected in the longer term as herd immunity of 90% -80% is achieved this number will decrease.

Shingles vaccination is being considered in Germany for 70-79 years age group and has been recommended for those who are 60-79 years in Australia as part of the immunisation programme depending on a government decision. In the UK there is no universal shingles programme for adults but it is recommended for people aged 70 -79 should be introduced depending on the cost of vaccine programme. In Canada it is licensed for those aged 60 and over but is not publicly funded. The Advisory Committee on Immunisation Practice in the US recommends vaccination for people 60 years or older. Efficacy of the vaccine wanes over time studies suggest it remains effective for 7 years.

In New Zealand we have not started to provide a chicken pox programme, however parents can choose to vaccinate their children or adolescents/adults not exposed as children. The vaccine for chicken pox was first licensed in 1995. For our migrant population from tropical regions they may have never been exposed to chicken pox.

In summary no overseas programmes for shingles vaccination of older adults have been funded. It is under consideration in a number of countries due to supply and cost concerns. The data on impact of introduction of vaccination programmes for chicken pox and shingles is still emerging.

Why are some vaccines funded and others not?

PHARMAC is responsible for the managing and purchasing of vaccines. They consider medicine and vaccine funding applications from pharmaceutical suppliers, health professionals, consumer groups and patients. All vaccines are considered for funding once they have been registered and approved by Medsafe. PHARMAC will assess the vaccine, seek clinical input from experts and conduct an economic analysis. Following this process there would be consultation with the health sector on a funding proposal. The MOH remains responsible for the National Immunisation programme.

4.1 National Health and Integrated Performance & Incentives Framework Targets

INDICATOR TABLE

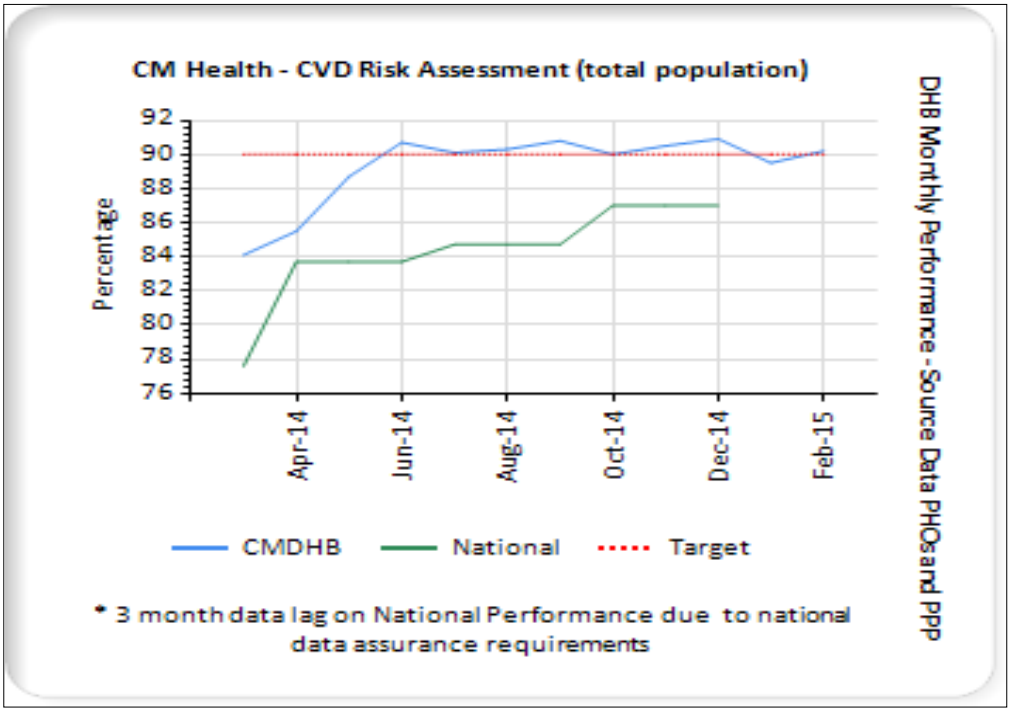
Target	14/15 Target	13/14 Q4	14/15 Q1	14/15 Q2	*February 2015	On Track
More Heart and Diabetes Checks	90%	91.3%	91.1%	91.3%	**90.2%**	**Yes**
Better Help for Smokers to Quit	90%	98.9%	98.0%	95.5%	**90.0%**	**Yes**
Increased immunisations - 8 months	95%	92.0%	95.0%	94.0%	**93.7%**	**Yes**
Increased immunisations - 24 months	95%	93.6%	96.0%	96.0%	**95.2%**	**Yes**
Cervical screening coverage	80%	69.8%	70.0%	71.5%	**N/A**	**Improvement required**

*Note: February results are provisional only, based on calculation from PHO data. Monthly cervical screening data is not available

PROGRESS

Performance against the Integrated Performance & Incentives Framework targets (including National Health Targets) to February 2015 indicates that CM Health is well positioned to achieve the targets for More Heart and Diabetes Checks, Smoking and 8 and 12 months immunisations by June 2015. It is important however that PHOs closely monitor smoking and 8 month immunisations and ensure focused efforts in these areas over the next four months. Significant improvement is required to reach 80% coverage for cervical screening. PHOs and the CM Health are currently implementing a number of activities in support of this target. These are further outlined in the cervical screening progress section of this report.

More Heart and Diabetes Checks



Graph One: CM Health Cardiovascular Disease Risk Assessment Performance to February 2015

*Note that this data is preliminary only, based on calculation from PHO data

	Historical Quarters			*Current Month*
PHO	2014-Q4	2015-Q1	2015-Q2	Feb-15
Alliance Health	87.8	90.5	89.9	88.6
East Health	88.9	90.8	91.1	90.0
NHC	85.0	89.4	88.6	88.5
ProCare	89.5	91.2	91.1	91.6
Total Healthcare	85.1	87.7	88.5	88.0
CMDHB	91.3	91.1	91.3	90.2
National	83.7	84.7	87.0	
Target	90.0	90.0	90.0	90.0

Table Two: More Heart and Diabetes Checks Performance to February 2015

*Note that this data is preliminary only, based on PHO reporting

Progress

- The preliminary result for More Heart and Diabetes Checks for February 2015 is 90.2% for CM Health Total Population (Table Two).
- PHOs received additional funding to maintain and increase the skills of practice nurses in phlebotomy to enhance collection of blood results for Cardio Vascular Disease Risk Assessment (HBA1c and Lipids).
- PHOs analyse the practice data weekly to determine which practices require assistance with the Cardio Vascular Disease Risk Assessment target and practice facilitators then connect with the practice to assist them to improve performance.
- Continuing Medical Education sessions for primary care clinicians on all Integrated Performance & Incentives Framework targets including Cardio Vascular Disease Risk Assessment are planned for March 2015.
- Cell group education sessions are held for all PHOs. Benchmarking of performance is used as a learning opportunity for practices by PHOs.
- The CM Health monthly Integrated Performance & Incentives Framework meetings include a focus on the National Cardio Vascular Disease Risk Assessment target, where PHOs share issues and learning to assist each other to achieve the targets
- PHOs also actively facilitate sharing of successful initiatives with other practices to assist poorer performing practices.
- PHOs continue to use practice advisors to assist practice staff to use the decision support tools and to collect data for Cardio Vascular Disease Risk Assessment.
- Non face-to- face assessments are conducted with the assistance of test safe (laboratory results) data
- Initiatives including after-hours clinics, nurse led clinics, weekend clinics and provision of transport for high needs patients are being offered by general practices.
- Improved data collection with systems enhancements such as ”Dr Info” – one click and appointment scanner functions, queries and recall systems enable more accurate reporting of data and identification of patients who are overdue for an assessment.
- CM Health has two clinical champions who assist PHOs and practices with initiatives to meet Integrated Performance & Incentives Framework targets.
- Exploration of the possibility of offering Cardio Vascular Disease Risk Assessment through pharmacies has begun. This would involve the use of Point of Care testing.
- PHOs frequently link with Non-government organisations e.g. The National Heart Foundation for resources and advice re Cardio Vascular Disease Risk Assessment.

Better Help For Smokers To Quit

	Historical Quarters			*Current Month*
PHO	2014-Q4	2015-Q1	2015-Q2	Feb-15
Alliance Health	91.0	91.0	89.0	91.0
East Health	96.0	100.0	98.0	94.0
NHC	98.0	91.0	89.0	77.0
ProCare	104.0	102.0	99.0	89.0
Total Healthcare	90.0	93.0	93.0	88.0
CMDHB	98.9	98.0	95.5	90.0
National	86.0	88.0	89.0	
Target	90.0	90.0	90.0	90.0

Table three: Smoking Brief Advice and Cessation Support Total Population Performance February 2015
*Note that this data is preliminary only, based on PHO reporting

Progress

Preliminary data shows that CM Health performance to February 2015 for smoking brief advice and cessation is at 90%. There has been a drop in performance over the past 6-8 months. PHOs are aware of this and are working with their practice teams to ensure the 90% target continues to be met. Initiatives to support smoking cessation and brief advice are outlined further below:

- Cessation support is being promoted by PHOs and other key stakeholders, in particular local cessation support services tailored to the CM Health population.
- A Primary Care smoking coordinator position has been filled and she has begun work with the PHOs and the District Health Board.
- PHOs have received additional funding to assist them with call centre functions to offer brief advice and cessation to current smokers.
- Face to face consultations and group cessation sessions are being offered to patients through general practice and PHO support services.
- Practice facilitators and PHO Smokefree Target Champions identify low performing practices and encourage these practices to implement quality processes that will ensure sustainable activity towards the 90% target.
- The Integrated Performance & Incentives Framework clinical champion continues to plan with and support the PHOs and practices with the Smokefree target.
- All PHOs have representatives who attend the monthly Integrated Performance & Incentives Framework meetings where all National Health and Integrated Performance & Incentives Framework targets are discussed. This is a forum where issues and initiatives can be shared amongst PHOs and the DHB with the clinical champions to improve results for the Smokefree target.
- The Smokefree target will be included in the March Continuing Medical Education session which covers all Integrated Performance & Incentives Framework targets.

Immunisations

Childhood Immunisation – 8 months

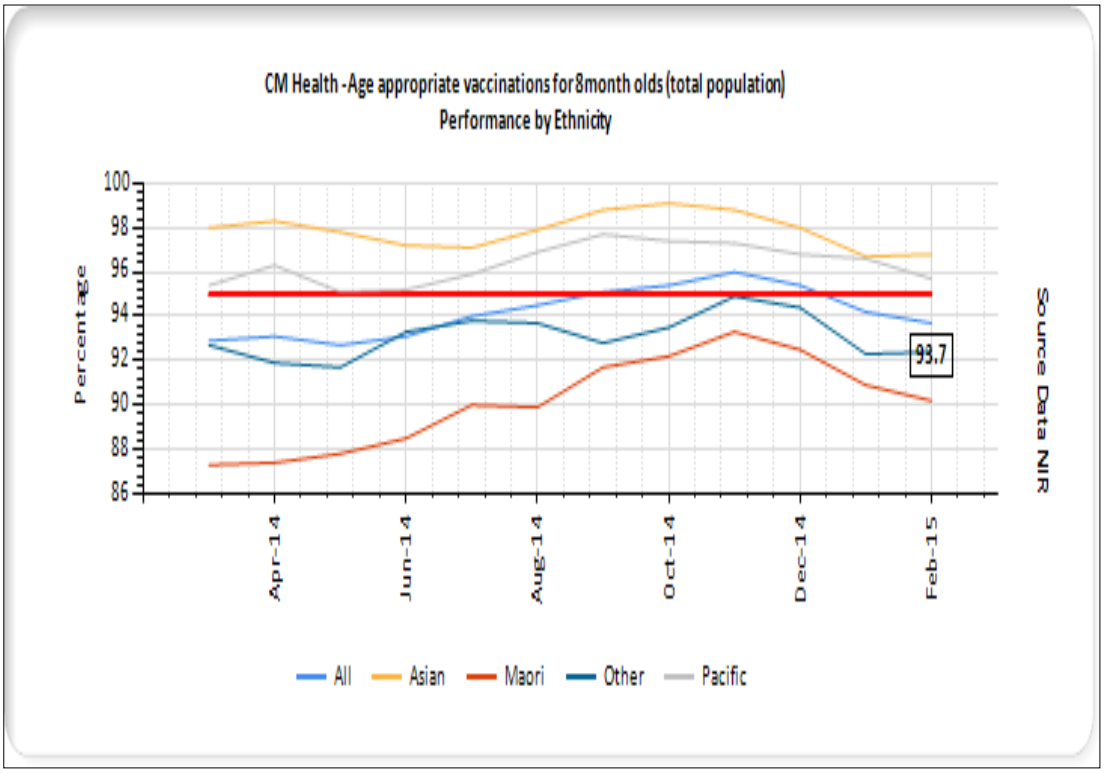
The 8-month immunisation target for 2014/15 requires 95% of all eligible children eight months of age to have completed their scheduled course of immunisation.

The three month period ending in February 2015 is at 93% for 8-month old immunisations. The festivities of the holiday period and the movement of our children during this time have historically seen a drop in coverage over the December to January months, with an anticipated stabilisation by the end of quarter three (March).

Of note, immunisation decline rates are up by 1.5%. The immunisation Nurse Leader is working with these families to ascertain if they have declined outreach immunisation services or the actual vaccination.

Progress

The Immunisation Nurse Leader is working with PHOs to improve the timeliness of immunisation by continually improving the coverage at six months of age and our Outreach Immunisation Service to plan catch up of 10 week old babies who are overdue for their six week immunisation.

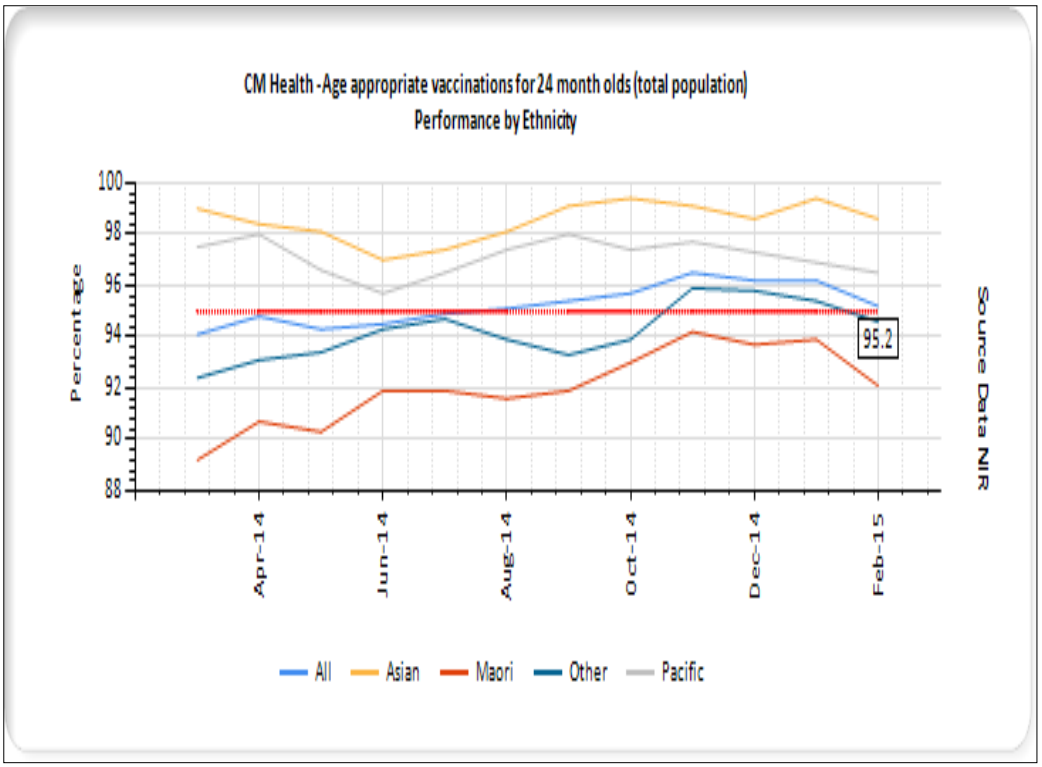


Graph Two: CM Health 8 Month Immunisations Performance Total Population to February 2015

	Historical Quarters			*Current Month*
PHO	2014-Q4	2015-Q1	2015-Q2	Feb-15
Alliance Health	95.0	96.0	96.0	92.3
East Health	95.0	97.0	97.0	94.5
NHC	90.0	95.0	96.0	93.7
ProCare	93.0	94.0	94.0	93.4
Total Healthcare	92.0	96.0	94.0	94.2
CMDHB	92.0	95.0	95.0	93.7
National	92.0	92.0	94.0	
Target	95.0	95.0	95.0	95.0

Table Four: CM Health PHO 8 Month Immunisations Performance Total Population to February 2015
* 3 month data lag on National Performance due to national data assurance requirements

Childhood Immunisation – 24 months



Graph Six: CM Health 24 Month Immunisations Performance: Total Population to Feb 2015

	Historical Quarters			*Current Month*
PHO	2014-Q4	2015-Q1	2015-Q2	Feb-15
Alliance Health		95.0	95.0	93.2
East Health		95.0	96.0	96.6
NHC		95.0	96.0	94.8
ProCare		93.0	94.0	94.6
Total Healthcare		95.0	95.0	96.2
CMDHB	93.6	96.0	96.0	95.2
National	92.0	92.0	94.0	
Target	95.0	95.0	95.0	95.0

Table Five: CM Health PHO 24 Month Immunisations Performance Total Population to February 2015
* 3 month data lag on National Performance due to national data assurance requirements

Cervical Screening

	Total 3 year coverage	**Maori**	**Pacific**	**Asian**	**European/Other**
CMDHB	**71.5%**	**62.0%**	**73.2%**	**61.3%**	**80.3%**
National	**76.5%**	**62.5%**	**72.6%**	**62.2%**	**82.5%**

Table Six CM Health 3 Yearly Cervical Screening Coverage to Dec 2014
Source: National Cervical Screening Programme Register – women aged 25-69 years

Note: Monthly reporting on cervical screening coverage at PHO level is not able to be provided due to the inability to separate monthly PHO performance at DHB level. It is hoped that this will be available from April 2015.

Progress

- The cervical screening target for 2014-15 is 80% coverage, with Counties Manukau Health currently performing at 71.5%
- A proposal was recently approved at the CM Health Alliance Leadership Team that PHOs agree to meet interim targets on a trajectory to meet the 80% target by June 2016. There was also agreement that PHOs develop and submit PHO cervical screening plans with clear actions and milestones to meet targets and to ensure that the approximately 11,000 who need to be screened to reach the target are successfully engaged in screening activities. The PHO plans will align with the CM Health Cervical Screening Action Plan. Additional funding has been agreed to for this activity by CM Health.
- The Maori Health Team have agreed to fund a 1.0 FTE fixed term position for a cervical screening coordinator (12 months) with a focus on unscreened, underscreened and priority women. This position is currently being advertised and it is hoped the coordinator will be in place working closely with the PHOs by late April.

- Discussion is currently taking place, through the PHO and CM Health Cervical Screening Action plans, for the potential to offer vouchers and incentives for women to complete smears.
- Additional volumes for free smears for high needs women have been agreed to by the Ministry of Health for the CM Health district. CM Health has also agreed to commit additional funds for free smears for priority women. This means more of our high needs women can access free smears.
- CM Health and the Metro Auckland Cervical Screening Advisory Group submitted a proposal to the PHO Services Agreement Protocol group who in turn approached the National Screening Unit to request improved cervical screening information for primary care. The National Screening Unit agreed to increase capacity at the National Cervical Screening Programme Register, which means all PHOs can now access six monthly data matches and monthly updates from the National Screening Unit to assist them to identify unscreened and underscreened women.
- The Metro Auckland Cervical Screening Operations group is working on improved referral processes to assist all Independent Service Providers, DHBs and PHOs to work together to reach hard to reach women. A referral pathway has been developed and endorsed.
- The group is also working with PHOs and Independent Service Providers to organise workshops to improve the health literacy and communication skills of staff who have a role in contacting / engaging women to complete cervical smears
- PHO and DHB partners at the CM Health Integrated Performance & Incentives Framework meetings are currently focusing on the following activities to improve cervical screening coverage:
    - Supporting PHOs to register with the National or Regional Cervical Screening Register for data matches: Communications to all PHOs instructing them how to register and what that involves has been sent out.
    - Provision of after hours and outreach smear taking by practice nurses. Currently there are some after hours clinics where women are able to access smears.
    - Cervical smear clinical champions within PHOs who can support practices especially the poorer performing practices
    - Implementation of the 'How To' Guide for Cervical Screening is being supported by the primary care cervical screening coordinator role. RN Jane Grant works directly with practices to support implementation of this.

4.2 Primary Health

OBJECTIVE: To deliver comprehensive in and out of hours primary health care which is 'Better, Sooner, and More Convenient'.

PROGRESS

PHO Services Agreement

All CM Health PHOs have now completed their self assessments against the PHO Services Agreement Minimum Requirements. We have completed an initial review of the assessments and met with each PHO to provide them with feedback and suggestions for improvement. The assessment included the requirement for PHOs to provide evidence of how they currently meet Minimum Requirements such as being part of an Alliance, being not for profit with open accountability and having effective governance, management, clinical, financial, quality and administration systems in place. There is also a requirement to demonstrate how PHO funding streams are used to meet national and local primary care priorities, along with ensuring resources are targeted at reducing health inequalities and improving Maaori health gain. The next step is for PHOs to submit their assessments to the Ministry of Health where they will be reviewed in depth by peer review panels.

Zero Fees for Under 13s

PHOs have now completed the first stage of planning for how the Zero Fees for Under 13s scheme will be implemented in their general practice settings from 1 July 2015. Initial analysis shows that the majority of practices will opt into the scheme (which is voluntary). We are on track for successful implementation by the July deadline.

Regional After Hours Network

A procurement subgroup with PHO and DHB representation is undertaking the development of a procurement process to identify suitable service provider(s). A procurement plan has been drafted and is in the final stages of approval by the members of the subgroup and their relevant organisations. The Register of Interests process has been initiated followed by a Request for Proposal process. This process has been overseen by independent probity advisors with a focus on the process, documentation, and management of conflicts of interests. John Hansen, Chief Legal Advisor, has also had oversight of all tender documents from a CM Health perspective. It is likely that despite best efforts the existing arrangements with After Hours and overnight providers will need to be extended to allow for a robust and thorough process and well managed transition. It is anticipated that the new services will be in place in early 2016.

The procurement process for the GP deputizing service has also been deliberately deferred. This is due to a number of potential respondents to this being involved in the Ministry of Health process for the provision of the National Telephone Advice Lines and it is not appropriate for them to be responding to two significant procurement processes simultaneously.

Primary Care Nursing Update

Over the past month the CM Health Primary Care Nursing team has been actively involved in supporting implementation of priority health initiatives and public health planning. A summary of key activity is provided below:

- All caregivers of 'declined' immunisations for Maaori babies are being phoned to assess any patterns for decliners. A proportion of these have agreed to have immunisations and have been referred to outreach.
- The Influenza Immunisation strategy approved by CPHAC is being implemented and we have identified the children eligible for funded vaccinations following admission for respiratory infection. These lists have been provided to PHOs for recall for immunisation when the vaccine is available. We are working with Midwives to develop awareness of importance of influenza vaccination for pregnant women and distributing Ministry of Health resources.
- Primary Health Care Nursing Service will support the staff vaccination programme at Lambie drive offices as required.
- Both clinical nurse specialists are supporting the Safety in Practice initiative in localities and practices as well as supporting Mangere and Manukau Localites GMs with nursing support.
- Cervical screening is an organisational priority. We are working with Occupational Health Nurses to reinstate screening on site for our staff. This service stopped in November 2014 when the provider withdrew.
- School nurse youth specialists are supporting roll out of Rheumatic Fever in secondary funded schools in collaboration with the National Hauora Coalition Mana Kidz programme. They are auditing standing orders initiated by the school nurses. This is showing some areas for improvement for whanau support workers.
- Very Low Cost Access practice new graduates have now been allocated to PHOs. CM Health was allocated four positions for its PHOs. Procare placed two new graduates locally and Total Health Care will place one new graduate. National Hauora Coalition and Alliance Health Plus graduates have been placed in Auckland practices. We have a total of 17 new graduates who started work in January 2015 including one at the Womens Prison and one in an aged residential care facility.
- The At Risk Individuals Care coordinator training session has been held with another three planned for 2015 for those new to At Risk Individuals programme.

Other current activities related to the primary care nursing workforce in Counties Manukau are highlighted below:

- Two nurses are working towards submitting their Nurse Practitioner portfolios in next few months. One school nurse is aiming to do a prescribing practicum next year and funding and supervision needs to be sourced to support this goal. One Accident & Medical nurse is also requesting prescribing practicum support.
- We are exploring options for Manukau Institute of Technology to commence level 7 papers for primary health care nursing to link with the diabetes course to provide a completed qualification.
- All locality nurse lead positions have now been filled. Locality coordinator positions are being recruited to assist with the front door project.

Pharmacy
Community Pharmacy Services Agreement Extension

The current Community Pharmacy Services Agreement is due to expire on the 30th of June 2015. A new contract has not been able to be secured for the 1st of July and as a consequence it has been

proposed to extend the current contract. This allows for some much needed stability after a period of intense change.

A road show was held on the 10th of March to socialise the terms of the extension. More than 80 pharmacists from across the Auckland metro region attended. The message from pharmacists was a clear vote of no confidence citing increases to funding as being unsustainable. Concerns were raised about the apparent breakdown in process around the negotiations. Warren Flaunty, pharmacist and Waitemata DHB board member has signalled the possibility that individual pharmacists may come to DHBs to negotiate the terms of their contracts on an individual basis.

Free Prescriptions for under 13's

From 1 July 2015 all fully subsidised prescriptions for under 13's will be free of charge as per the terms of the Community Pharmacy Services Agreement. In order to compensate pharmacies for the potential increase in prescription volume an increase in service of 0.24% over 18 months has been built into the proposed July 2015 Community Pharmacy Services Agreement contract extension.

An issue has arisen with prescriptions that would be dispensed after-hours. The Community Pharmacy Services Agreement permits pharmacies to charge an after-hours fee at a rate that they determine. The expectation on DHBs is that 95% of our population should be within 60 minutes of after-hour care and it is assumed that for under 13's this should be free of charge for fully subsidised prescriptions. Pharmacies that are officially recognised as providing after-hours care have been asked to provide a list of their charges to determine if further action is needed. If patients can't access free prescriptions for fully subsidised medicines then it may be necessary to subsidise after-hours dispensing, via a Part P addition to the pharmacy's contract. This will most likely be managed via a Request For Proposal process.

Waste Management

Pharmacists are currently paid, via the service development fee in their contracts, to dispose of medicines and sharps waste. A Request For Proposal is currently being posted and it is hoped to have the service in place and operational by 1 July 2015 to coincide with the extension to the Community Pharmacy Services Agreement as this will allow the amendment to Part P of the Community Pharmacy Services Agreement to be managed concurrently with the Community Pharmacy Services Agreement extension.

Regional Clinical Pathway Programme

In December 2014 the Northern region purchased the HealthPathways Platform for the publishing of regional agreed pathways. This gives access to the clinical content of over 500 pathways that we will localise (correct addresses, contact details) and make available in the coming months. Additional work has commenced to ensure pathways that have already been completed in the old publication system move across to the new format. An evaluation plan is also being completed to measure success.

The Dynamic Pathways tool which is a programme embedded in GP Computer Systems to give real time guidance to clinicians, now has nine pathways (iron deficiency, Diabetes and Atrial Fibrillation added) available to the 86 General Practitioners testing the system. 466 patients have been managed through these pathways, with some patients on more than one pathway.

4.3 Child, Youth and Maternity Services

OBJECTIVE(S)
To integrate maternal and child health services; reduce perinatal mortality; improve care in the First 2,000 Days of life; intervene early to support vulnerable children; reduce Rheumatic Fever by two-thirds to 1.4 cases per 100,000; and improve youth services.

1st 2000 days-Maternity

Early Engagement
Waitemata and Auckland DHB have expressed interest in joining CM Health in a regional media campaign to improve early engagement of newly pregnant women with Lead Maternity Carers. The campaign is looking at different strategies to socialise the importance of early antenatal care. The Maternity Consumer Forum will meet in April to provide feedback on the campaign.

Contraception
A draft service specification has been developed to fund a Clinical Champion within PHO's. The service will include improved linkages with Lead Maternity Carer's, facilitation of early pregnancy care, strengthened provision of contraception and support for newborn enrolments into primary care.

The funded vasectomy service continues with a move toward making vasectomies an option for the partners of pregnant women who are seeking tubal ligations.

1st 2000 days - Improving Infant Nutrition Project
The overarching aims of the Improving Infant Nutrition Project are to:

- Improve nutrition and promote healthy feeding of infants and toddlers (aged 0-2 year olds) through community based initiatives that engage with wider whaanau/family environments using a public health approach; and
- Enhance the way maternity, child health, primary and secondary care health professionals engage and communicate with parents and whaanau/families around infant and toddler nutrition through a workforce development initiative.

In late 2014, a Request for Proposal was undertaken to identify a provider(s) to develop and implement these key priorities; however a suitable provider was not identified. Meetings took place with an internal governance group and the Ministry of Health to discuss options going forward for this work stream and the following options have been explored:

Approach	
Utilise the implementation model that the Waitemata DHB 'Healthy Babies, Healthy Futures' Project is using. Bringing together and contracting a range of community based service providers to form a 'collective' partnership to design and deliver services.	This approach is not recommended given that it took Waitemata DHB a significant amount of time (15-months) to develop and contract this approach. In addition, an Request for Proposal was undertaken in CM Health in late 2014 and suitable providers to develop and implement this work were not identified
Delivery via Healthy Families	The Ministry of Health have advised that the delivery of

New Zealand	the community initiatives through Healthy Families New Zealand is not feasible and outside of the scope of the Healthy Families New Zealand contracts
DHB employing a coordinator to work with the three target communities using the World Vision model	Elements from the World Vision have been incorporated into the service delivery model proposed in this report
Adapted Breast Feeding Community Initiative/La Leche League/B4Baby Model	See below

Proposed Programme: Community Breastfeeding and First Foods Support

The proposed programme is community based and uses a community educator and peer supporter model and community breastfeeding clinic to provide support and advice on breastfeeding and the timely introduction of healthy first foods. The proposed programme was presented to the Ministry of Health on Friday 13th April and we were given approval to proceed with the approach of the model.

Objectives

Primary

1. Increase access to breast feeding and first foods support in the community
2. Increase access to facilitated peer support groups to promote Mother-to-Mother support
3. Increase family support for breastfeeding and age appropriate introduction of healthy first foods
4. Increase access to lactation consultant services in the community

Secondary

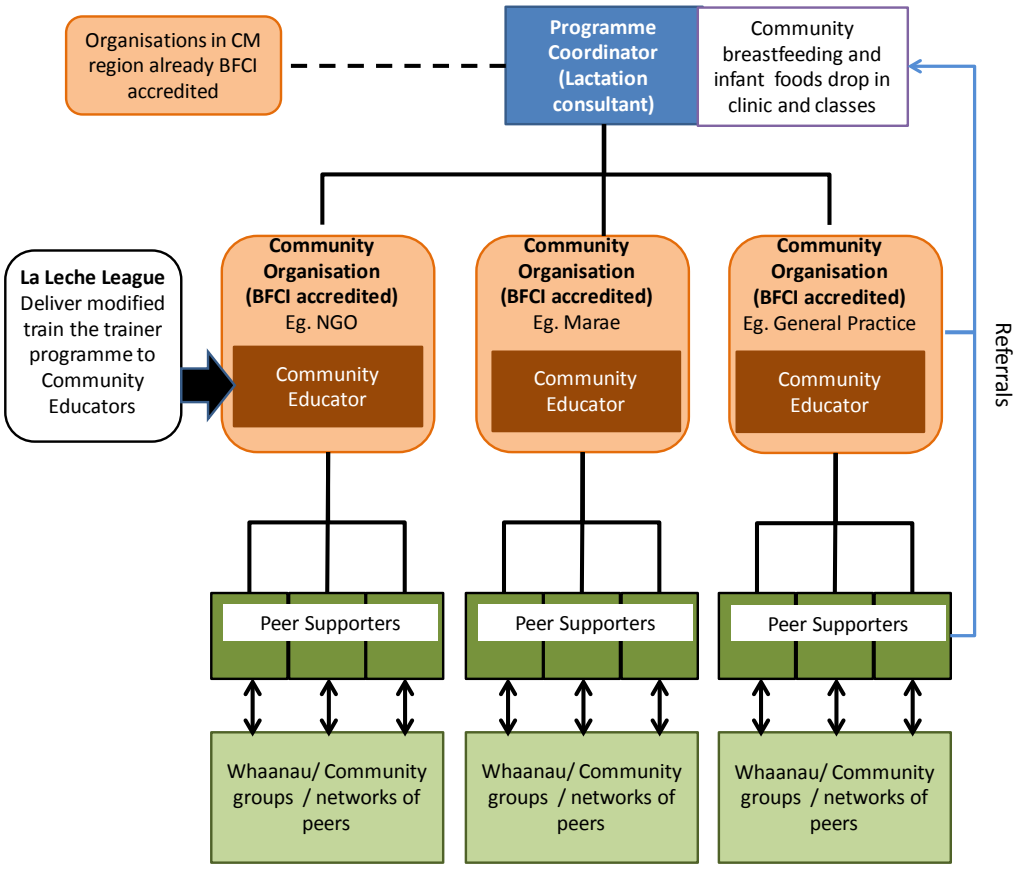
5. Develop and improve practical skills of parents and 0-2 year olds and influential family members to make healthy, affordable and culturally appropriate infant first foods and meals for the whole family.
6. Support families and communities to develop/figure out their own solutions to the identified barriers

Timeline

The Infant Nutrition Community Breastfeeding and First Foods Support Programme would roll out over 15 months, with the Coordinator and other staff being employed in April and May 2015 and the programme commencing July 2015.

It is recommended a pilot is undertaken in the first 15 months in the Manukau locality to prove the programme model and concept before expanding the programme into other localities.

Proposed structure, referral pathways, roles and organisations



	Descriptions	To be completed by
1.	Present to the Manukau Locality Leadership Group	April 2015
2.	Employ Programme Coordinator/Lactation Consultant	End of April 2015
3.	Identify and consult with community organisations	End of April 2015
4.	Programme Coordinator/Lactation Consultant to attend La Leche League NZ training	End of May 2015
5.	Confirm community organisations to be involved	Mid May 2015
6.	Employ Community Educators/contract community organisations	Mid June 2015
7.	Identify and confirm venue(s) for breast feeding drop in clinic	Mid June 2015
8.	Community Educators attend La Leche League NZ training	End of June 2015

1st 2000 days - Healthy Attachment Development and Parenting Skills

The four areas under this work stream include:

- Implementation of universal screening during pregnancy and postpartum for mental health and alcohol and drug issues
- Improve processes for universal screening of infants / children for mental health difficulties
- Improve the co-ordination in the delivery of parenting programmes in CM Health
- Increase skills and confidence of those working in Primary health care to improve recognition and response to maternal mental health, bonding and parenting issues

Progress to date
Education sessions are being offered to Self Employed and DHB Midwives to support the implementation of a universal screening tool for mental health and alcohol and drug issues. The sessions will cover how to ask the predictor screening questions, how to screen for attachment difficulties and how to respond effectively when mental health issues are identified. The sessions will also include referral pathways/processes. Education sessions for Well Child/Tamariki Ora Providers are being developed to improve the quality of the 24 month old check. The training will include assessing bonding and parenting problems in under two's, and how to assess for parental mental health issues. The Werry Centre has developed a resource which is a collation of all parenting programmes on offer within the region. This precedes an accompanying triage/ decision tree document to help primary care professionals decide which parenting programme is the appropriate one to refer parents to.

Sudden Unexpected Death in Infancy

Safe Sleep Education

The 2015 Safe Sleep Education online training for all stakeholders and staff will be launched in April. Both programmes will have assessment and professional accreditation points.

- Ministry of Health website will host the online Sudden Unexpected Death in Infancy e-Toolkit
- Whakawhetu website will host their e-learning Safe Sleep Workshop.

Whakawhetu have scheduled a Sudden Unexpected Death in Infancy Symposium for April and will provide an update on the latest evidence and progress.

Safe sleep devices

The Safe Sleep team continue to provide Pepi-pods to babies and their whaanau. Referrals are received through the midwifery network. A program is being developed to invite Mothers into community health providers to weave their own whahakura as part of their antenatal support.

Sudden Unexpected Death in Infancy Holistic Community Initiative

The Ministry of Health is funding the development of a holistic model of care to reduce Sudden Unexpected Death in Infancy and address risk factors for a limited number of DHBs. The funding is to develop and implement a community based initiative over the next 18 months to engage Maaori mothers and their whaanau in a series of Whaanau Hapu Waananga delivered through community networks in Counties Manukau.

The initiative will integrate the key messages of early antenatal engagement, safe sleep, breast feeding, smoking cessation and link-in support services such as Midwives, Well-child Tamariki ora providers, smoking cessation, breast feeding, mother and infant nutrition support in a supportive Whaanau based environment.

Influenza vaccination campaign

There will be a focussed Flu vaccine campaign targeting all children who have previously been admitted to hospital with respiratory conditions, children and adults with chronic illness, pregnant women and the elderly over 65 years (This will commence in April when the vaccine is available). A localised communications campaign will start in April with posters and pamphlets in primary care, dental clinics, well child providers and midwives clinics, childcare centres, and local papers plus ethnic radio.

Mana Kidz - Rheumatic Fever Prevention Programme

Decreasing the incidence of Acute Rheumatic fever is a Better Public Service Target with the aim of reducing the incidence of Acute Rheumatic fever nationally by two thirds, to 1.4/100,000, by 2017. Reflecting this there is a Ministry of Health expectation, articulated in the Annual Plan, that the rates of hospitalizations for Acute Rheumatic fever/100,000 for all ages will decrease by 10% annually compared to a three year rolling average.

CM Health has a Rheumatic Fever Prevention plan which outlines the activity underway to prevent Acute Rheumatic fever in our population and includes;

- Primordial prevention -addressing housing through referring eligible families to the Auckland Wide Healthy Housing Initiative
- Primary prevention -identification and treatment of Group A streptococcal infection by increasing access to primary health care services both through school based clinic and free Primary care treatment of sore throats
- Secondary prevention -preventing people who have had Acute Rheumatic fever getting further episodes of Acute Rheumatic fever (which in turns leads to worsening of their heart disease) by ensuring they receive monthly prophylaxis on time.

In addition appropriate diagnosis and management of Acute Rheumatic fever and Rheumatic Heart Disease is also important.

The Ministry of Health has recently released the latest official Acute Rheumatic Fever incidence figures based on International Classification of Diseases discharge data. In 2014 there was a 25% reduction in cases of Acute Rheumatic Fever in all ages compared to 2013[1].

Official MoH Acute Rheumatic Fever data for Counties Manukau, all ages, 2008-2014

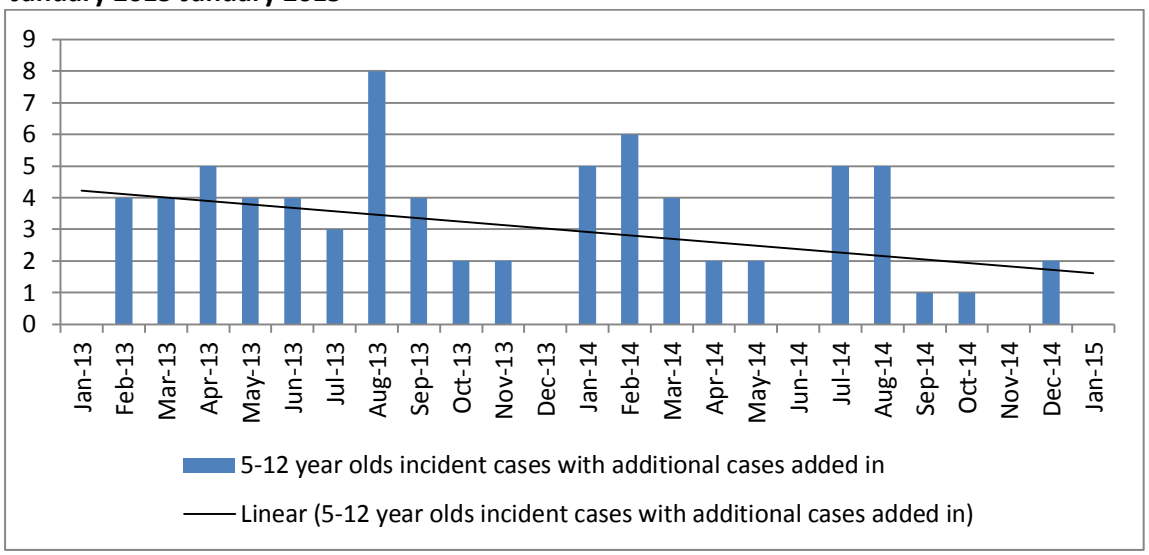
	2008	2009	2010	2011	2012	2013	2014
No. cases	48	59	67	61	72	77	51
Denominator	467370	472860	478950	485570	491550	496290	509060
Rate	10.3	12.5	14.0	12.6	14.6	15.5	10.0

Source: Numerator; Ministry of Health. Acute Rheumatic Fever ICD code I00-I02. Primary diagnosis of Acute Rheumatic Fever. Excludes any admissions where a person has been admitted with any Acute Rheumatic Fever or chronic Rheumatic Heart Disease diagnosis from 1990-2005. Denominator; Population projections based of 2013 census data.

In addition to the National data we are also reviewing discharge data from CM Health facilities. This data provides a facility rather than domicile view but has the advantage of being checked to ensure that the cases are correctly coded as Acute Rheumatic Fever. It is also possible to look at the 5-12 year old age group specifically, which is the age group where the school based service has been targeted.

[1] Note these are small numbers and as such there is variation seen that may be due to chance alone rather than representing a true change in incidence of the disease. More time is needed to see if the reduction continues and is sustained.

Incident cases of Acute Rheumatic Fever discharged from CM Health facilities, 5-12 years January 2013-January 2015



Source: ICD discharge data from CM Health decision support. Primary diagnosis of Acute Rheumatic Fever (ICD code I00-I02). and audited for against case definition.

Oral Health Services

Reduce Arrears (children not seen within 30 days of the recall date)

Unfortunately the Auckland Regional Dental Service rate of arrears has risen to 11.35% against a target of 7%. This equates to some 10,000 children overdue for their recall appointment. This is due to an under-resourced clinical team and insufficient coverage of the growing patient group. Recruitment is underway, which will allow for an additional six FTE to address the growing arrears.

Children Receiving Fissure Sealants & Fluoride Protections

To support the preventative oral health model and reduce incidence of oral disease, 41% of CM Health children receive preventative treatments vs 36% Auckland DHB and 31% Waitemata DHB children.

Adolescent Oral Health Services

The interim result is 72% for 2014 versus target of 80% however the final result is not due until July due to late claims, so the final result is expected to increase.

Oral Health Pilot for Women with Diabetes in Pregnancy

The aim of the pilot is to improve care of pregnant diabetic women to improve health outcomes for both Mother and baby. We are progressing well with 357 women under treatment out of a cohort of 400, with the remaining 43 on a waiting list. Many of the women need a higher volume of complex clinical treatments and this has caused extended treatment plans and impacted on capacity. The pilot evaluation will finish in December 2015 with the report due February 2016.

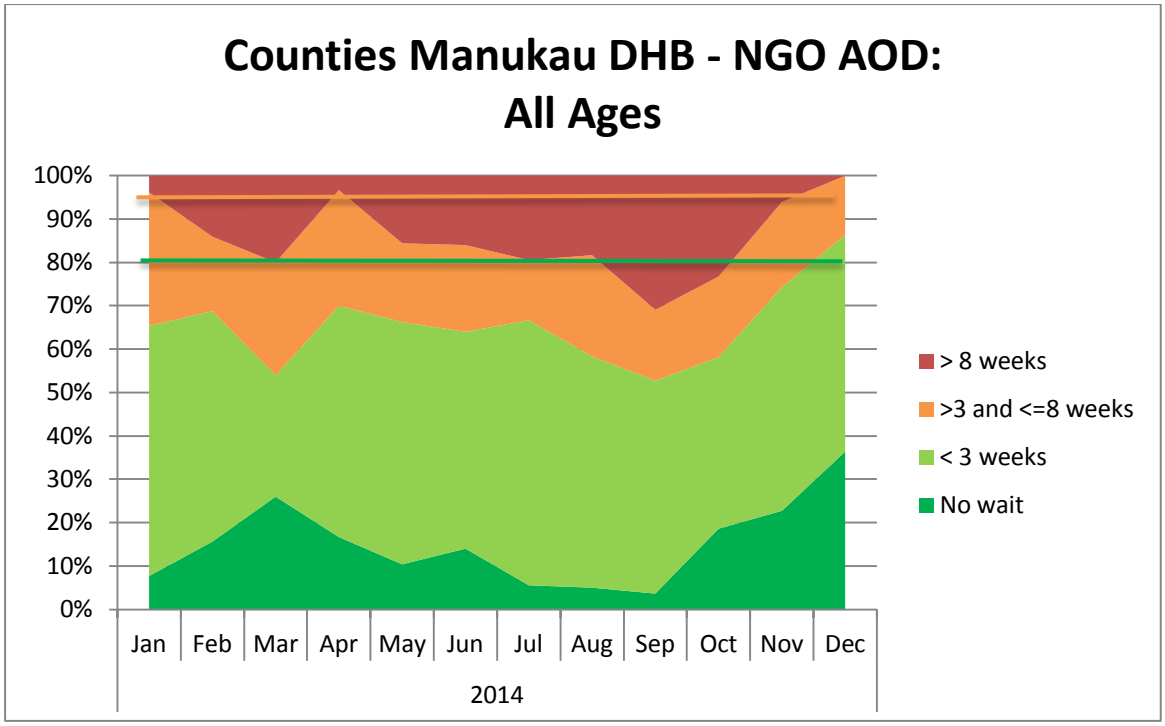
Youth Health

Expressions of Interest have been requested to identify representatives in Counties Manukau who are interested in taking on a leadership role to oversee the implementation of a whole of system model of care for Youth Health and the Prime Minister's Youth Mental Health Initiative. They will prioritise and provide advice on the allocation of youth health funding ensuring the model of care aligns with the health needs of young people aged 12- 24 years living in Counties Manukau district. The revised group will commence in May 2015. In the interim, the existing Advisory Group will complete a comprehensive service stocktake and begin to prioritise service provision within existing financial constraints.

4.4 Mental Health and Addictions

VISION: That the communities of Counties Manukau will support mental health and wellbeing and be able to get support when they need it, quickly and easily, in their local community.

PROGRESS



Graph showing waiting times for NGO AOD services from January 2014 to December 2014 (NGO & DHB services).
Note that there is a 3 month report lag due to national data assurance requirements

All wait times continue to exhibit significant improvement in the most recent months depicted, with all areas above set targets. The nature of addictions means that low to no wait times are important. This is an area that we will continue to monitor closely with our NGO partners.

Whole of Systems

We are embarking on a challenging agenda to improve people's experience of mental health and addictions through an integrated approach across primary, community and secondary partners. To help inform and drive this agenda, we have a created a new Integrated Mental Health and Addictions Leadership Group, with membership of the group reflecting a range of experience and expertise across the sectors. The group will meet on a monthly basis from April with the following purpose and scope:

- to provide leadership and direction for transformational service improvement;
- to use data and an evidenced-based approach to balance the needs of patient care and well-being with sustainable service delivery;
- to identify areas requiring redesign and innovation to achieve locality-based mental health and addiction integration; and

- to ensure oversight and appropriate linkages with wider CM Health Whole of System activity.

Through to December 2015, the focus of the agenda will be on developing a greater understanding of how to best meet the needs of our local communities and identifying options for delivering service improvements and transformational change. The integration strategy and resulting implementation plan will be, in part, informed by a process of co-design with service users, family/whaanau, NGOs, primary care and CM Health Mental Health and Addictions community staff. The co-design workshops will have a locality focus and will be conducted from late April to early June. The detailed implementation plan and timescales for integration will be finalised by December 2015.

Commissioning Framework for Mental Health & Addictions

The Ministry of Health is developing a national commissioning framework to enable implementation of an outcomes-focused approach for Mental Health and Addictions. The framework will cover the full range of publicly funded services, including health promotion, primary, specialist, District Health Board and services provided by non-government organisations. The framework will provide a nationally consistent approach to commissioning that ensures accountability for public funds while allowing more integrated approaches to be developed.

It will include the development of an outcomes framework and associated measures.

Suicide Prevention Planning

A Suicide Prevention Toolkit was released at the end of February. The interagency suicide prevention group is beginning to formulate a new suicide prevention plan for 2016 utilising current statistical data and evidence based practice to ensure the plan has a clear intervention logic. There are five areas of activity that are being explored as part of the plan:

- *Workforce development* – taking a regional approach to develop a cost effective, sustainable training plan across a range of service and professions. This will include the utilisation of current resources and a gap analysis
- *Resilience building and health promotion* – especially in regards to our specific at risk groups such as Maori, Pacific and other vulnerable populations
- *Access to help when needed* – ensuring that people know how to get help when needed – making it ok to ask for help
- *Quality improvement* – with over 50% of suspected suicide victims being known to mental health and addictions services within a year of death, we will look at emerging themes from serious incident reviews of deaths and near misses to enable better service delivery
- *Postvention*
    - Postvention Accountability Framework – Counties Manukau already has an established postvention service, this would build on current gains to further improve postvention supports both immediate and at anniversaries and significant dates
    - Postvention self-care – It is acknowledged that this work is stressful and painful for all those involved. Whilst most professionals have access to individual supports / supervision this would enable opportunity for the group as a whole to ensure that their needs are met.

Parenting Support Groups

These evidence based programmes have been shown to have a positive effect and build on positive parenting technique whilst breaking negative trans-generation parenting habits. They have been

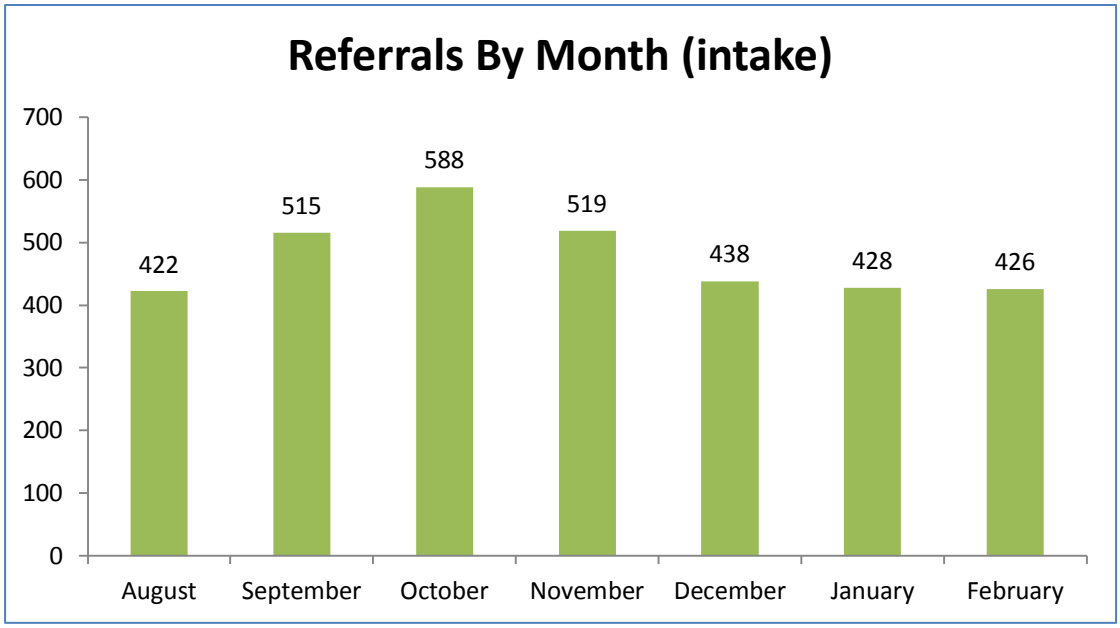
shown to aid the building of family relationships and long term positive parenting inputs which in turn have been indicated to reduce conduct issues and mental health problems. One of the groups recently reported that they have engaged with primary care and currently have two doctors that come weekly to the community house where the programmes are held to offer free services to the families to meet any medical needs that they may have. This service has been of great value to the mothers as a majority have found it difficult to travel to the doctors, having no form of transport. This includes one of the mothers, who had lost the sight in one of her eyes due to an on-going severe eye infection that had not been treated as she couldn't afford a doctor's visit. After meeting with the doctor the infection has been treated and the mother has now been put on the eye transplant programme.

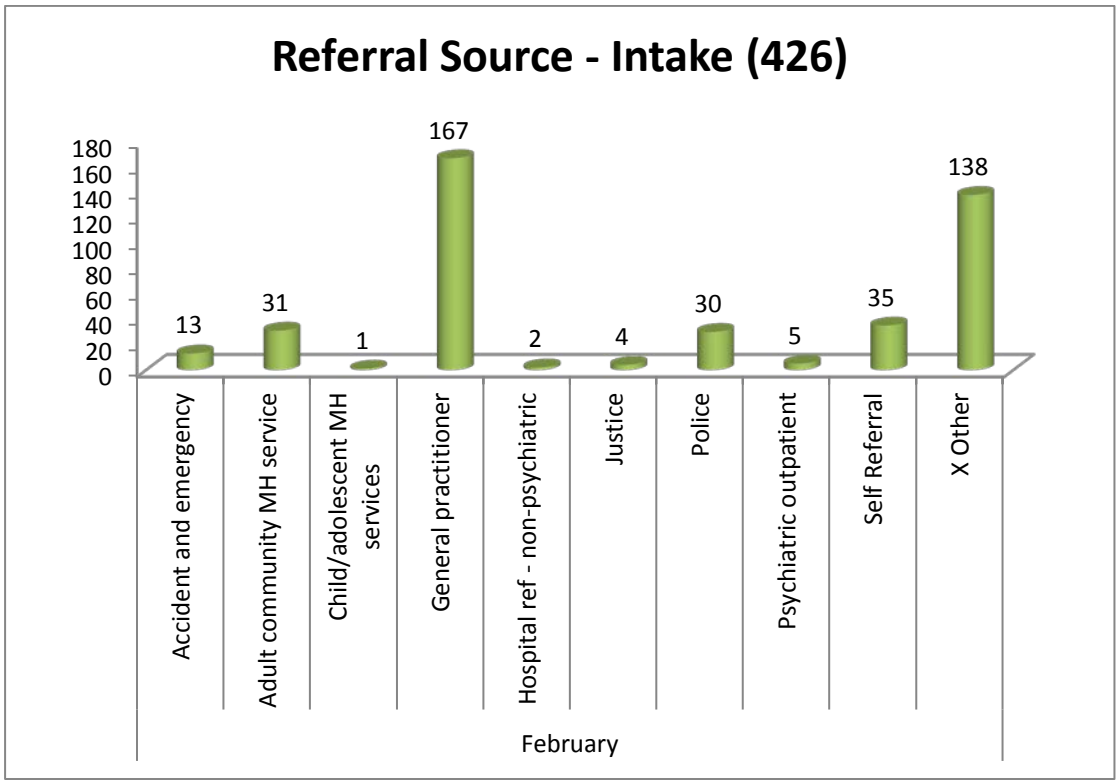
Keyworker Review
The keyworker review project aims to ensure that clinical case management roles are integrated across services and localities in the future.

A proposal for change document is being developed for consultation, including a question and answer opportunity. Human Resources and union guidance has been provided throughout this first phase and will be ongoing through the change process.

Acute Pathway
Intake and Assessment After Hours Consultant Roster: This new initiative which has a consultant psychiatrist rostered to work from 5 -10pm Monday to Friday continues to operate successfully and has now become standard practice. The advantages include being able to conduct mental health assessments with senior medical staff in the evenings and this has led to better quality decision making with fewer admissions to Tiaho Mai solely for assessment purposes.

Intake and Assessment Referral Data: Since the service commenced in August 2014 we have been attempting to refine the process by which we receive reports that indicate demand and response. This is the first month that we have been reasonably confident in some of the data that is being collected and reported against. The following graphs show the total number of referrals to Intake and Acute Assessment since the service reconfiguration, and the referral's source. Ideally we would like to understand the numbers "urgent" versus "non-urgent" and work is continuing to refine the reports.





Navigate Update

Representatives from Navigate, the Mental Health and Addiction NGO Provider group, have requested a 2% increase to all contracts and an extension of contract terms from three to five years. We are currently in negotiations with NGOs, over terms and prices for the new contracts which will take effect from 1 July.

Richmond NZ Trust and Recovery Solutions Group Merger

The Boards of the Trusts of Richmond NZ and Recovery Solutions Group, two large national NGOs have subsequently advised that they are planning a merger of their organisations to be achieved by 1 July 2015. Merging would create a national organisation with a strong presence in all health regions and in 17 District Health Board catchments. It has been conveyed that the new merged organisation will have a new name and brand, a new culture, and most importantly new ways of delivering services.

We will continue to work closely with Richmond and Recovery Solutions throughout the merger process.

4.5 Adult Rehabilitation and Health of Older People

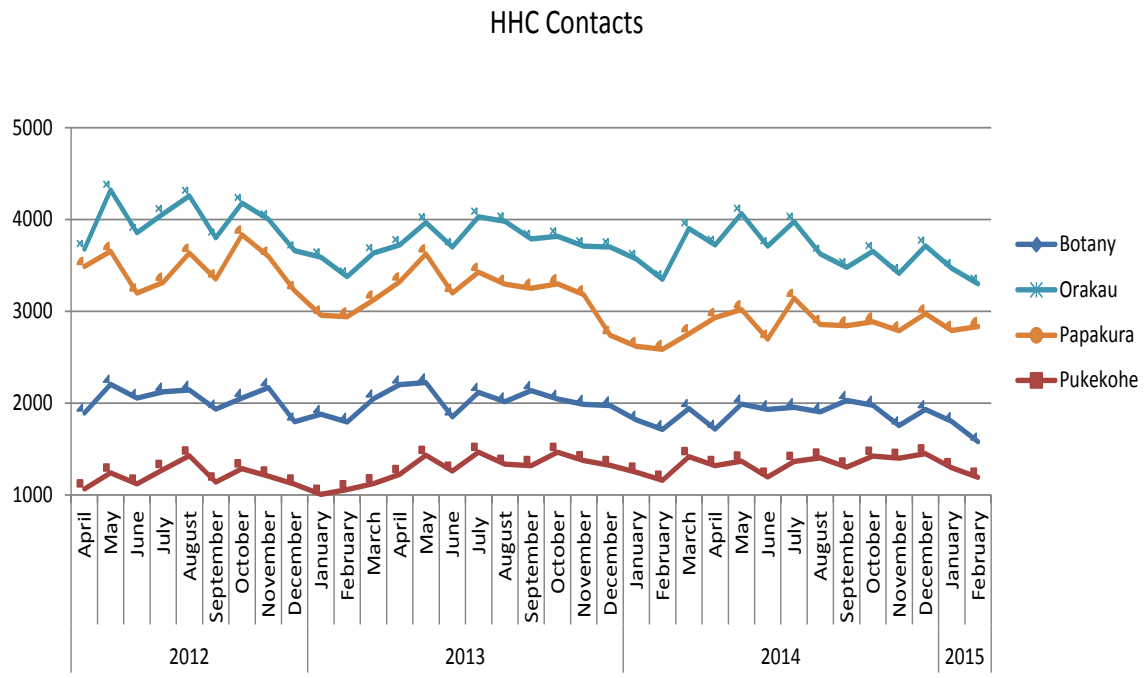
OBJECTIVE: To support older people in their homes and communities with integrated, locality based services that maximise independence through rehabilitation and quality care.

PROGRESS

Home Health Care - Community District Nurses and Allied Health Teams
The Home Health service is available to people in their own home or at a clinic facility at four sites aligned to the four localities. The Home Health teams consist of allied health, district nursing, care assistants and other locality based staff with professional, clinical and cultural skills.

Home Health Care received 1,021 referrals; discharged 1,038 clients and completed 8,907 contacts across all bases for the month of February.

Additional cars to support the Needs Assessment teams in Eastern and Manukau Localities have arrived and are in use.



Community Allied Health - *(delivered from Home Health Care)*
Occupational Therapy and Physiotherapy waitlists in Manukau have not increased. All waitlist numbers in the Eastern Locality have been affected by planned and unplanned leave during January.

	Previous month	Total	Orakau	Manukau	Franklin	Eastern
Waiting list Dietetics	**14**	**19**	4	4	7	4
Contacts Dietetics	**83**	**56**	14	2	21	19
Waiting list Occupational Therapy	**182**	**167**	98	30	1	38
Contacts Occupational Therapy	**247**	**248**	84	61	40	63
Waiting list Physiotherapy	**45**	**42**	3	6	3	30
Contacts Physiotherapy	**233**	**264**	57	77	94	36
Waiting list Continence	**40**	**36**			1	35
Contacts Continence	**84**	**144**			22	122

Waitlist - Acute Allied Health Outpatients Waitlist Activity

Musculoskeletal Outpatients remains an issue with staff leave in February pushing the waitlist higher with the waitlist now at around 460 patients. Referrals to the service continue to steadily increase. Additional resource has been directed into the team to assist in reducing the waitlist within the clinical target levels. The women's health waitlist has increased again with the recent changeover of therapists.

Acute Allied Health Outpatients	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
MSOP	225	298	296	304	314	346	380	407	421	397	431	416	464
Obstetrics/Gynae*	317	297											
Gynae*			253	214	196	168	127	128	130	79	71	49	105
Obstetrics*			35	50	37	29	27	25	37	19	18	11	40
MORRSA (Rheumatology)	59	67	55	64	56	56	53	30	46	41	43	38	38
Physio Hyperventilation Service	97	106	112	103	94	106	107	112	115	112	121	127	127
Cardiac Rehabiliation	17	7	10	17	28	29	24	22	29	28	29	24	17
Pulmonary Rehabilitation	124	64	80	56	49	33	94	99	112	133	168	186	128
OT Rheumatology	26	29	18	15	25	22	18	42	38	37	30	30	22
Total AAH waitlist	865	868	859	823	799	789	830	865	928	846	911	881	941

*reported separately from April 2014

Assessment and Coordination of Care for Older People – (Reported Quarterly in arrears)
At 16 October 2014 100% of facilities were either training or booked for InterRAI assessment training:

- 34 (81%) facilities are trained or actively involved in training
- Eight (19%) facilities are engaged and awaiting confirmation of the training timetable.

Three of the currently untrained facilities have a training plan through national processes (Bupa and Selwyn). Four small stand-alone Rest Homes have not yet commenced training.

Early Supportive Discharge – Supporting Life after Stroke – The Early Supportive Discharge (ESD) remains stable at its current level. The focus for the next three months will be around completing the final elements of the project; the business case for sustainable funding has been submitted.

National and Regional Spinal Strategy

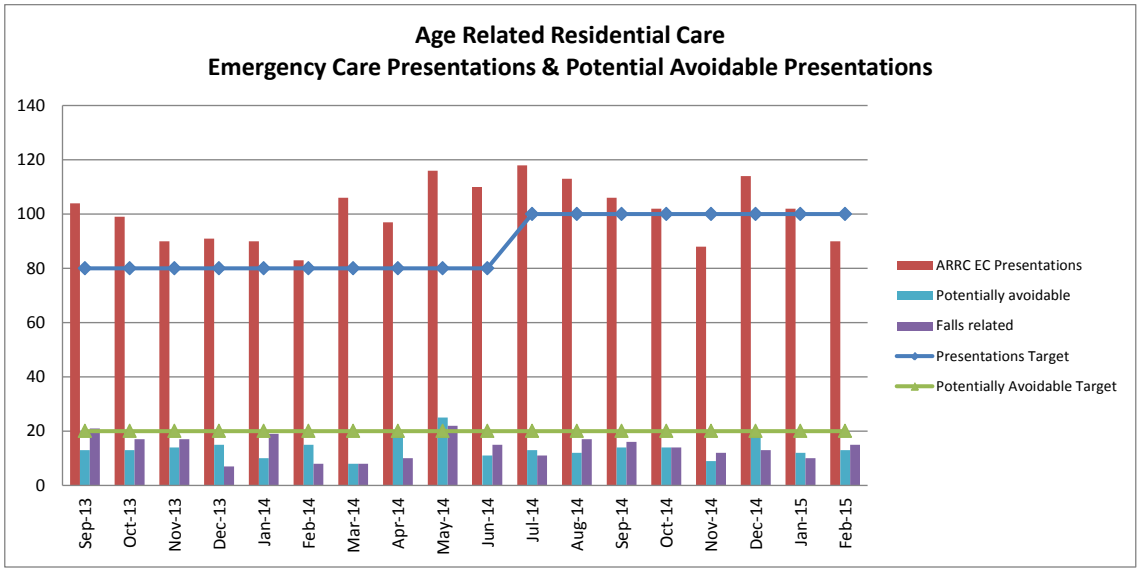
We have had 40 acute patients through the acute spinal service since 1 July 2014 with a continuing high number of complete cervical injuries. Not all patients admitted to acute services go on to receive rehabilitation at the Auckland Regional Spinal Unit. The high numbers of complex cervical cases has put pressure on resources, and a review of the model of care is underway with business cases being developed to accommodate increased demand in both acute and rehabilitation areas. Work continues on whole of system approach to clinical pathways for urology, psychology and tracheostomy.

Community Geriatric Services

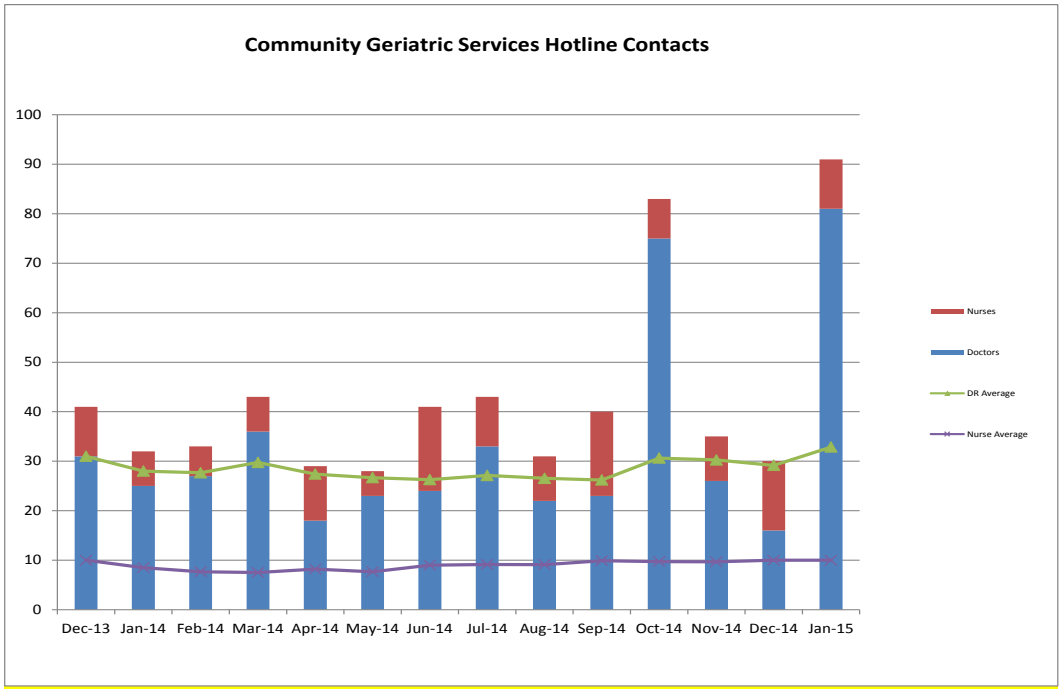
An important component of the Systems Integration/Locality development is to provide additional Geriatrician support to primary care practices and aged residential care. The Community Geriatric Service continued to provide support to three GP practices during the month of January.

Target <100 Emergency Care presentations from residential facilities per month

February 2015 saw 90 Aged Related Residential Care Clients present to Emergency Care. Of these, 15 presentations were falls related and 13 were potentially avoidable admissions.



Hot Line Data for February is not available due to system errors. Community Geriatric Services Hotline Contacts Total: 91 Hotline Calls. Average hotline contact time for the month of January was 2.4 minutes for Doctors and 2.6 minutes for nurses.



Community Specialists Health of Older People Teams (reported quarterly)

Community Specialists Health of Older People Teams continue to provide proactive support to Aged Related Residential Care and primary care by Gerontology Clinical Nurse Specialists and Geriatricians. The monthly Age Related Care education session for facility staff continues to be well attended, with 175 Registered nurses attending education forums during the last six months.

The Assessment, Treatment and Rehabilitation Advanced Core Training education program for Registered Nurses in facilities continues to be promoted by the CM Health Community Geriatric team.

Target: Provide 25 hours Gerontology Clinical Nurse Specialists and Geriatrician support per month to five primary care practices including clinics and education sessions with GPs+

Geriatrician	Number of Primary Care Clinics Visited	Primary Care Hours
Quarter 1	5	31.5 hours
Quarter 2	5	23.5 hours

Target: Provide 26 hours Geriatrician support per month to six Age Related Residential Care Providers for medication review case conferences

Geriatrician	Number of ARRC Providers Visited	ARRC Provider Hours
Quarter 1	6	Average 42 hours per month
Quarter 2	6	Average 54 hours per month

Percentage of Home Based Support Services client interRAI assessments complete by locality - Each of the locality teams continue to roll out interRAI assessments for all clients receiving home based support services.

Between October 2014 and December 2014, 82.8% of patients have had an InterRAI assessment at some point.

Locality	Clients	# w/InterRAI	Percentage
Eastern	1105	864	78.2%
Franklin	683	600	87.8%
Mangere/Otara	611	527	86.3%
Manukau	1546	1275	82.5%
CMDHB	3945	3266	82.8%

Memory Team (Dementia Care Pathway) January 2015 – The Outreach model has been developed into a briefing paper which was presented to the Clinical Advisory Network meeting in Franklin. This gained their support and is to continue to proof of concept with a selected GP Practice. Support has been gained form the Community Geriatric Service and Alzheimer's Auckland to participate in the model. Following discussion with several GP Practices the pilot will start in Waiuku in March / April.

A pathway has been developed to represent and manage patients to the Memory Team.

A number of referrals have been received due to a research study. This inundated the Memory Team and resulted in mostly inappropriate referrals.

Number of referrals (all for cognitive assessment this month)	60	524 cumulative accepted referrals (June 2013)
Number declined (due to out of Memory team catchment area)	26	
Referrals managed by Memory Team	33	55% (target 30%)
Referrals from General Practice	14	42%
Contacts	426	From 50 GP Practices
Caseload	310	
Cases under Alzheimer's Auckland	80	
Number of clinicians	6	
Diagnosis made	285 dementia, 32 no dementia, 78 pending /deferred	

Long Term Support Chronic Health Conditions Update on service mix provided – (Reported Quarterly)

Counties Manukau Health LTS-CHC utilisation as at 30 September 2014

There are 204 clients receiving long term supports for chronic health conditions and who are receiving the following services:

Service	Number of clients
Community Residential Services	
Dementia	4
Hospital and Specialised Continuing Care	22
Rest Home	17
Respite	3
Rehab and Community	-
Carer support	14
Household Management	54
Personal Care	78
Individualised Funding	11
Dementia Day Care	1
Total	**204**

This data is provided quarterly and isn't available for the new quarter as yet

4.6 Intersectoral Initiatives

OBJECTIVE

Target populations/communities with high health, housing, social, employment and education needs to improve the health status and reduce health inequalities.

PROGRESS

Warm Up – Counties Manukau (Retrofitting Home Insulation Project)

Warm Up Counties Manukau is a free home insulation programme that retrofits insulation into the homes of low income families with high health needs. This programme is funded and delivered through a working partnership between the Energy Efficiency Conservation Authority, Autex Industries Limited, The Insulation Company, CM Health and the Middlemore Foundation. We insulate the homes of low-income families with health issues that may be related to housing, creating healthier homes which are more energy efficient, thus ensuring that the home contributes to the health of the family. In addition, we offer a comprehensive health and social assessment for participating families to ensure that they are accessing appropriate health and social services. This approach ensures that we can address both housing and health issues.

Referral Generation

CM Health is responsible for referral generation. Families/households can self-refer or may have the programme suggested to them by their health professional. We target the programme through information accompanying outpatient clinic appointments and by working in partnership with health professionals, government agencies, the non-government sector and the local community.

Project Outcomes for the Warm up – Counties Manukau Project (1 July 2014 to 28 February 2015)

Month	Total Number of Referrals	Total Number of Homes Insulated	Total Number of Home Visits completed post install
July 2014	313	98	48
August 2014	251	107	47
September 2014	169	83	48
October 2014	148	139	27
November 2014	81	143	43
December 2014	64	116	15
January 2015	42	103	21
February 2015	55	70	56
Total number of referrals generated	**1,123**	**859**	**305**

Please note: There is a time delay between referrals being received, completion of the insulation install, and subsequent home visit.

Warm Up-Counties Manukau targets deprivation 9 and 10 areas in order to reach low income families with high health needs.

The home visit is voluntary and separate to the automatic post installation audit which assesses the quality of every installation.

Warm Up-Counties Manukau Self-identified ethnicity by household (total referrals received 1st July 2014 to 28th February 2015):

Ethnic Group	Number of total referrals	Percentage of total referrals	% Population CM
Asian	**116**	**8.1%**	**19%**
European	**384**	**27.2%**	**38%**
Indian	**38**	**2.7%**	**3%**
Maori	**315**	**22.3%**	**16%**
Other	**49**	**3.5%**	**-**
Pacific	**509**	**36.2%**	**23%**
Total	**1,411***	**100%**	**100%**

* Please note: households are able to choose more than one ethnicity per household

Starting In September 2014 the Warm Up-Counties Manukau Team began engaging with local industries based in our community. We have visited 40 local factories and provided them with information on the free home insulation programme. This month we engaged with the following companies/organisations:

- Wiri Timber
- Independent Liquor
- The Laminex Group
- DB Breweries
- Lion Breweries
- Tip Top Bread Factory
- Tip Top Ice Cream Factory
- Delmaine Fine Foods Ltd
- Big Ben Pies
- Tip Top Bread Factory
- Quilton Tissues Factory
- Griffins Factory

The PATHS (Providing Access to Health Solutions) Programme

Providing Access to Health Solutions is an intersectoral programme resulting from a partnership between CM Health, and the Ministry of Social Development that was established in 2004 in an effort to help tackle the growing problem of long-term benefit dependency. The aim of this voluntary programme is to assist people in receipt of certain benefits to return to work, using an intensive individualised case management model aimed at reducing health barriers to employment.

The key objective of the Providing Access to Health Solutions programme is to reduce health barriers to employment by providing an appropriate health intervention, which enables participants to return to employment.

Total Number of Voluntary Participant Enrolled onto the PATHS Programme

Month	Total Number of Participants enrolled
July 2014	15
August 2014	20
September 2014	13
October 2014	19
November 2014	13
December 2014	13
January 2015	16
February 2015	14
Total Number	**123**

Review of Boarding House Pilot Project in South Auckland

A pilot project is currently underway to review/investigate 20 boarding houses in Counties Manukau. Auckland Council is currently undertaking inspections using a multi-disciplinary team made up of representatives from the building control, resource consent and the environmental health teams.

The purpose of the project is to assess the conditions of the boarding houses and to gauge whether current legislation is effective at addressing non-compliance. A cross sectoral project team has been established to oversee the project and to assist address any issues that may arise from the inspections which commenced on the 16th of March 2015.

Mangere Transformation

Alliance Health Plus PHO has developed a proposition for joining up services across sectors to better support families in Mangere. This builds on their existing relationship with CM Health and other public services in the area.

We are supporting Alliance Health Plus to progress the ideas with Central and Local Government as part of the "Better Public Services" agenda.

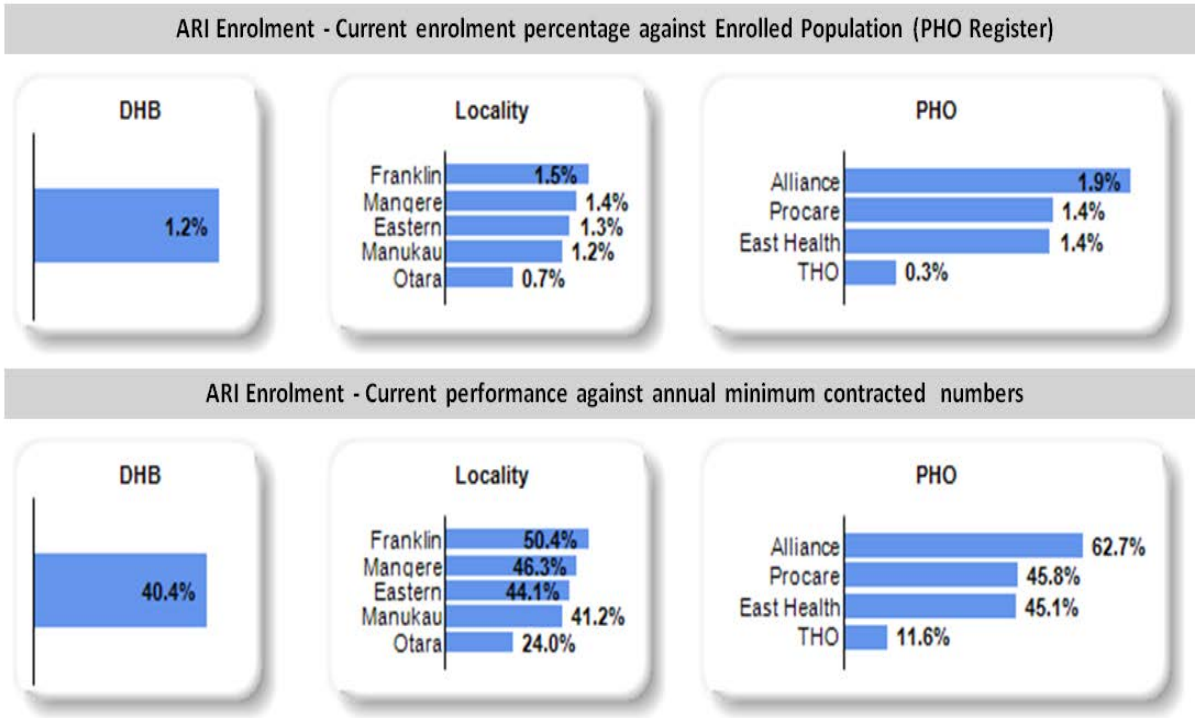
4.7 Progress with Systems Integration

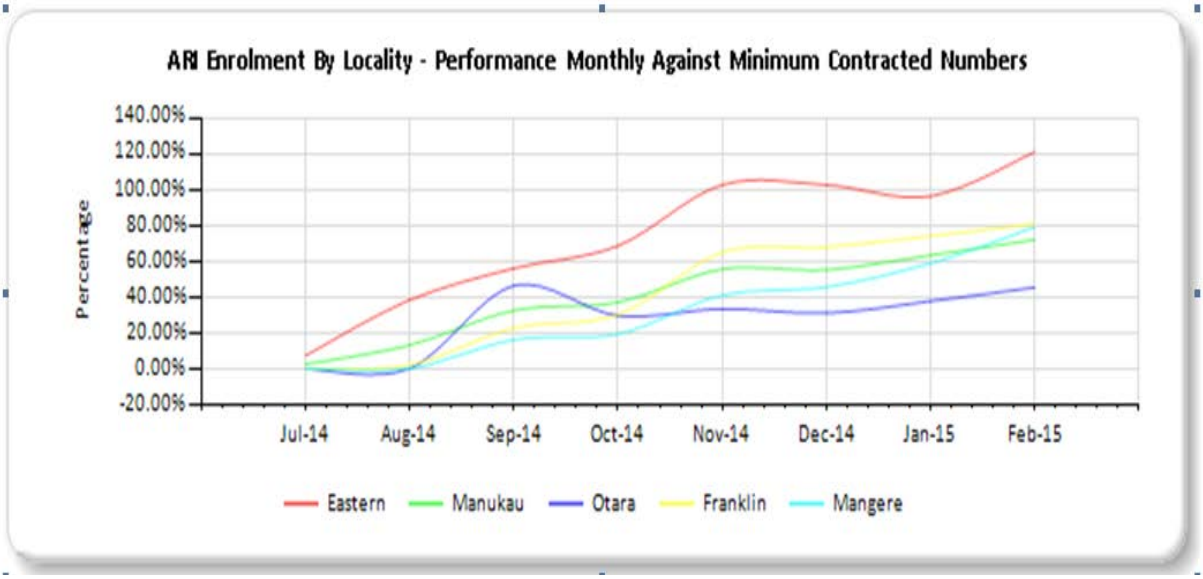
At Risk Individuals

92 practices have transitioned to the At Risk Individuals programme, with the seven remaining practices scheduled to transition in April. Four practices across the district have elected not to proceed with At Risk Individuals due to their inability to implement the programme. All four are small practices which have identified that they do not have sufficient nursing resource and/or IT infrastructure to implement the At Risk Individuals model of care. All four practices did not utilise Chronic Care Management funding therefore, no patients will be faced with the removal of funding without a possible alternate source.

Enrolment figures are increasing rapidly, with 5,083 patients now enrolled within the programme, representing 1.2% of the CMH population (as at 01.03.15). The current trajectory indicates the 3% minimum contracted volumes for year one of implementation is on track.

PHO and locality performance is indicated below:





Work is underway to develop phase two of the programme following engagement with key stakeholders in February. A development plan has been agreed to expand the At Risk Individuals programme to specifically incorporate mental health, child health, complex families, Diabetes Care Improvement Package and palliative care. Detailed design and implementation plans will be developed over the next three months. A district-wide quality, training and roll out plan is being to developed to maintain a quality lens across the programme.

Quality and Safety – *Safety in Practice*

Learning Session three held on the 17th March 2015 had 77 attendees. As per our contractual arrangements with the practices, each practice had at least two people attend with six practices having three people attend and one practice had six representatives attending. The evening's agenda was positively received by attendees with the shared discussion breakouts proving very popular for sharing learning across the practice climate surveys, the primary care trigger tool and the three care bundle audits.

This session celebrated the work that the practices have been doing over the past year and the opportunity was taken by the project's clinical sponsor, Dr Campbell Brebner to invite the group to remain with the collaborative into phase two looking at a new care bundle focus or refining/completing the work that has been done over the year. There will also be capacity for new practices to indicate their interest to enrol in the programme. The evening was primarily facilitated by the project's clinical lead, Dr Beven Telfer whose employment with the project has sadly ended. Recruitment interviews are currently underway for Dr Telfer's replacement.

As reported last month our Safety in Practice Road Shows (March to May) are now underway which sees one of the Improvement Advisors accompanied by the respective DHB Primary Care Advisor to present to PHO Continuing Medical Education evenings and Clinical Board meetings regarding Phase 2 of Safety in Practice. An engagement session is scheduled for 17 June this year and the team are liaising with practices prior to this for expressions of interest for phase two of the programme. Practices from Phase one are also invited to change audits and be involved in Phase two of the programme.

There has been a positive uptake of the primary care trigger tool and the practice climate survey which should see good baseline data develop for the New Zealand general practice context over time.

Community Health Service Integration

The project board continues to meet and has reaffirmed the required workstreams, workgroups and scope for each key area of the work programme. The focus this month has been on completing the first draft of a Case for Change document that outlines the new model of care for community health services. A workplan has been developed to ensure that inputs required to accurately inform the development of the business case are achieved. An analytics group has been added to the three main workstreams to co-ordinate these inputs and analysis.

1. **Reablement Workstream**

   The scope of this workstream remains unchanged and continues to focus on the development of locality community teams to assist people to be as well as they can be at home ("reablement"), particularly during and after an acute deterioration. This includes continuation of work commenced to refocus district nursing, allied health and NASC teams to work effectively within the locality model.

   Progress this month includes resetting the workstream into two key groups. The first group involves clinical leads and project support people to drive the home health care redesign process forward that is inclusive now of all locality teams other than just the Manukau Locality. The first meeting is set for next week.

   The second group will focus on development of the ReaCH services within the locality community teams that include early supported discharge, admission avoidance and the reablement approach across the continuum. This group has a more senior level of representation and includes key clinical roles such as the Director of Integration and Rehabilitation Physician.

   A small subgroup of this workstream is also meeting to understand the wound care component of the current district nursing role and scoping opportunities for routine wound care to be delivered differently. The aim of this is to create capacity for rapid response within the district nursing service.

2. **Restorative Workstream - Re-design and procurement of contracted long term home and community support services under a restorative services model**

   A review and procurement of currently contracted home and community support services is required to align care delivery with the integration and service delivery approach going forward.

   This workstream remains unchanged and continues to meet. The focus this month has been on scoping possibilities for a winter rapid response approach that can be used to test systems and processes to inform the Reablement Workstream and also seeks to utilise a different approach to co-ordination which in turn tests processes for Community Central.

   The Restorative workstream has also focussed on understanding the current state of service delivery from a pathway's perspective for different patient groups and this work informs the next focus area which is writing a Case for Change document to describe the restorative model of care.

3. **Community Central**

   Community Central will be one point of contact and referral for all, enabled by a technology solution that supports a 'first response' request for services, triaging, allocating resources, capacity planning and telehealth capability. This is centrally organised, but locality driven.

An initial workshop has been held with project SWIFT team members and key stakeholders to develop the concept and scope of community central. A workstream group has commenced meetings to drive this work forward.

The first step will be to complete the merging of the intake function for needs assessment for older people and all home health care referrals which will enable efficiencies within the process for patients. It will also release capacity within the team and will move to an approach of one discipline or service response assigned and then a feedback process via MDT's to plan and co-ordinate from there. This will stop patients going onto multiple waitlists.

4.8 Locality Reports

Eastern Locality

1. Acute Demand

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
1.1 Unplanned readmissions (28 days)	6.1%	5.5%	6.4%	5.1%	6.3%	5.4%	5.7%	6.7%
1.2 ASH rate (per 1,000 enrolled patients)	1.4	1.6	1.4	1.3	1.3	1.2	1.3	2.1
1.3 Average bed day usage in last 6 months of life	10.6	7.8	7.5	9.4	13.9	13.9	10.6	12.3

Notes: Numbers for previous months may change as additional mortality data is received for ***1.3*** and as coding is modified for ***1.1*** and ***1.2.*** Aged Residential Care Bed Days in Pukehoke and Franklin Memorial Hospitals are included in the figures for ***1.3*** - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
2.1 Children fully immunised at 8 months (Target = 95%)	95.1%	95.2%	95.2%	95.0%	94.9%	94.8%	94.7%	91.3%
2.2 Children fully immunised at 24 months (Target = 95%)	95.2%	95.0%	95.5%	95.6%	95.5%	95.9%	94.6%	93.9%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	97.0%	95.6%	92.0%	96.7%	92.9%	87.0%	91.6%	91.9%

3. Shared Accountability Services

Item	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Total Feb 2014 to Feb 2015	CMH Total Feb 2014 to Feb 2015
3.1 ED presentations not admitted	221	237	203	224	236	250	2,945	21,229
3.2 Acute medical bed days	1,647	1,305	1,278	1,249	1,267	1,076	16,144	85,966
3.3 Acute casemix-funded non-medical bed days	778	863	868	763	1,097	771	11,077	62,718
3.4 Medical outpatient attendances	1,832	1,744	2,003	1,712	1,718	1,624	24,383	119,851

Note: All SAS volumes for previous months may change as IDF updates are received and coding is modified

4. Other

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
4.1 E-referrals as % of all referrals	12.6%	15.1%	16.4%	16.4%	15.7%	17.2%	15.2%	13.5%
4.2 Medical Outpatient DNA rate	3.5%	2.2%	1.7%	1.0%	2.4%	1.9%	2.5%	8.5%

Note: Numbers for previous months may change as coding is modified for ***4.2***, and additional referrals are included for ***4.1***

Osteoarthritis / falls prevention interventions

The Joint Replacement Alternative Pathway proof of concept has begun. In 0.2 FTE our physiotherapist has seen five patients, with two more to be seen this week. Two patients have completed five weeks and have shown improvement in objective assessments such as strength, balance and walking distance, plus subjective improvements with an increase in daily activities and less discomfort. One patient feels that at this stage he doesn't think he needs his joint replacement. The other patient was accepted on to the waiting list after two weeks in the programme, but feels very pleased with the strength in his knees and ability to walk further. It is expected that his post-operative recovery will be better because of this.

The falls prevention programme and osteoarthritis early intervention groups continue with positive improvements with our 0.5 FTE having, on average, three to four contacts per afternoon

Self management

We are working with Ko Awatea to develop an online foundation course for self management for all health care providers. This will allow a wide range of health care providers to access initial training that will also contribute to improved care planning.

Integrated care Coordinator
Our Integrated Care Coordinator is working closely with the Acute and Post Acute team at Middlemore Hospital, accepting referrals for patients from the Emergency Department or the medical wards that the Acute and Post Acute team believes require more intense follow up in the community to prevent readmission.

As part of our Winter Plan our Integrated Care coordinator is also screening people over 80 years from a pilot practice to determine what they require to keep themselves as well as they can be in the community over winter.

For other practices the proposed Winter Plan will be identification of people previously admitted with COPD or heart failure and feeding back to the general practices that these people may be suitable for pre-emptive action plans to avoid winter admissions.

At Risk Individual programme
There is continued good uptake of the At Risk Individual programme in the Eastern Locality

Dynamic pathways
There are now five general practices in the dynamic pathway pilot programme. Response has been positive since the changes were made in light of the Proof of Concept feedback, although there is still the request that full integration would optimise these pathways.

Botany Community Health Hub
The first workshop with Sapere and the Eastern Locality occurred on 16th March 2015 with the Locality Leadership group and Locality Clinical Advisory Group (28 attendees). There was feedback on the utilisation of CM Health services and the potential to provide some of these in the community.

The next steps are some more intense focus groups with general practitioners and other stakeholders, plus a wider group workshop on 15th April 2015. The opportunities for a futurist Community Health Hub and integrated health services is very exciting.

Home Health Care
It is lovely to receive compliments in stressful times. This is an example of one below that was received, to keep us focused on the importance of our services to patients and their family.

In July 2012 you visited my mother Mrs [X] in her unit at the [Y] Village at [Z] on her discharge from Middlemore Hospital to carry out a Needs Assessment. At the time I was taking care of her but was physically incapable of providing the round-the-clock care that by that time she needed. You very skilfully arranged for her to be admitted to the [Z] Nursing care unit in the same village and within a week she moved into a room with all her own furniture and a lovely view overlooking the garden and [local] Park.

Even though [Mrs X] was reluctant to give up the cottage and gardens that she loved, she realised that she was no longer capable of living independently even with a lot of care brought into her.

Within a few days she was settled and very happy to be in her new home. She has always been a very sociable lady and being continually surrounded by people was just what she needed & I found that she was happier than when I was looking after her because of all the people around her. She would take off with her walker and visit her friends in the village and happily joined in everything that was open to her. When I went back home I spoke to her every day by phone from South Australia and she would always speak of how good the nurses were to her and how she enjoyed all the trips and activities.

However in the past few months age caught up with her and she was more than ready to go, and on the 22nd January she slipped away quickly and very peacefully and her funeral which was on her 100th Birthday started with every one singing Happy Birthday to her. It was just as she had planned. It was happy uplifting, and filled with music and flowers and it was a grand farewell.

[Staff member], I have always felt that the quality of her life (and mine) in these last two and a half years was largely dependent on what you had seen she needed and how you arranged it all so beautifully.
You have my deepest gratitude for all that you have done for [Mrs X] and for me.

With kind regards and best wishes for all good for you.

[Mrs X's] daughter.

Mangere/Otara Locality

1. Acute Demand

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
1.1 Unplanned readmissions (28 days)	8.9%	8.0%	6.5%	7.1%	8.6%	7.6%	7.4%	6.7%
1.2 ASH rate (per 1,000 enrolled patients)	2.7	2.7	2.4	2.2	2.3	2.2	2.5	2.1
1.3 Average bed day usage in last 6 months of life	13.0	14.2	12.4	17.4	11.0	11.3	12.0	12.4

Notes: Numbers for previous months may change as additional mortality data is received for ***1.3*** and as coding is modified for ***1.1*** and ***1.2.*** Aged Residential Care Bed Days in Pukekohe and Franklin Memorial Hospitals are included in the figures for ***1.3*** - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
2.1 Children fully immunised at 8 months (Target = 95%)	95.6%	96.2%	96.1%	95.1%	95.1%	95.2%	94.0%	93.1%
2.2 Children fully immunised at 24 months (Target = 95%)	95.8%	95.9%	96.1%	96.3%	95.9%	96.0%	95.7%	95.1%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	91.2%	91.7%	92.8%	90.5%	82.8%	91.3%	91.5%	91.9%

3. Shared Accountability Services

Item	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Total Feb 2014 to Feb 2015	CMH Total Feb 2014 to Feb 2015
3.1 ED presentations not admitted	608	652	569	690	773	602	8,150	21,001
3.2 Acute medical bed days	2,492	2,307	1,886	1,978	2,002	1,711	26,695	85,937
3.3 Acute casemix-funded non-medical bed days	1,194	1,785	1,411	1,376	1,668	1,367	19,055	62,925
3.4 Medical outpatient attendances	2,900	2,965	2,668	2,476	2,401	2,478	35,150	120,498

Note: All SAS volumes for previous months may change as IDF updates are received and coding is modified

4. Other

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
4.1 E-referrals as % of all referrals	13.8%	16.0%	16.7%	16.6%	17.3%	0.0%	11.3%	14.3%
4.2 Medical Outpatient DNA rate	15.0%	12.1%	16.1%	12.7%	17.3%	14.3%	14.0%	8.5%

Note: Numbers for previous months may change as coding is modified for ***4.2***, and additional referrals are included for ***4.1***

The agreement between CM Health and Alliance Health Plus for Locality support services in Mangere and Otara has now been signed. This provided the mandate for Alliance Health Plus to recruit for the positions of GP Lead - Otara, Nurse Lead – Otara and Allied health Leads for both Mangere and Otara. All four of these positions have now been filled, roles will all be started by 13th April. The Locality Co-coordinator position is also in the final stages of recruitment with start date mid-April.

Home Health Care Team

There is a full clinical team in place representing clinical disciplines working in Otara and Mangere through primary and secondary care based professionals. Community network leads will join the Locality Leadership Team in May. There is ongoing work to integrate social services by developing networks and integrated models of care connected to the Health Care Home. The locality is actively working with diabetes, renal and cardiac services to design and develop ways of working together. Self management support initiatives are a common concern and an active area of work.

At Risk Individual programme

There continues to be ongoing enrolment of adults living with long term conditions into the At Risk Individuals programme. There are nine different multidisciplinary team meetings held each month across practices in Mangere and Otara for At Risk Individuals and other cases for conferencing. There is ongoing review and improvement of the MDT process through PDSA cycles.

Manukau Locality

1. Acute Demand

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
1.1 Unplanned readmissions (28 days)	7.1%	7.1%	5.8%	7.2%	6.6%	6.3%	6.7%	6.7%
1.2 ASH rate (per 1,000 enrolled patients)	2.2	2.3	2.2	2.0	2.2	2.0	2.2	2.1
1.3 Average bed day usage in last 6 months of life	15.8	12.7	12.2	9.5	17.6	11.6	12.0	12.4

Notes: Numbers for previous months may change as additional mortality data is received for ***1.3*** and as coding is modified for ***1.1*** and ***1.2.*** Aged Residential Care Bed Days in Pukehoke and Franklin Memorial Hospitals are included in the figures for ***1.3*** - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
2.1 Children fully immunised at 8 months (Target = 95%)	93.9%	93.5%	94.0%	93.7%	94.6%	93.2%	92.3%	93.1%
2.2 Children fully immunised at 24 months (Target = 95%)	95.0%	95.5%	97.0%	96.1%	96.6%	94.6%	94.7%	95.1%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	94.1%	92.1%	94.5%	90.2%	85.7%	91.9%	92.3%	91.9%

3. Shared Accountability Services

Item	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Total Feb 2014 to Feb 2015	CMH Total Feb 2014 to Feb 2015
3.1 ED presentations not admitted	612	672	583	729	769	598	8,490	21,001
3.2 Acute medical bed days	2,586	2,779	2,439	2,170	2,404	2,213	32,345	85,937
3.3 Acute casemix-funded non-medical bed days	2,180	1,776	1,987	1,785	1,840	1,868	25,073	62,925
3.4 Medical outpatient attendances	3,859	3,847	3,496	3,312	3,092	3,252	47,303	120,498

Note: All SAS volumes for previous months may change as IDF updates are received and coding is modified

4. Other

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
4.1 E-referrals as % of all referrals	18.8%	21.5%	20.3%	20.3%	22.5%	0.0%	15.3%	14.3%
4.2 Medical Outpatient DNA rate	7.4%	8.1%	7.9%	7.4%	9.7%	9.2%	7.8%	8.5%

Note: Numbers for previous months may change as coding is modified for ***4.2***, and additional referrals are included for ***4.1***

Home Health Care Team

The Home Health redesign project is now focusing on strengthening working as an interdisciplinary team and is commencing a review of the current multidisciplinary team meetings which are held fortnightly.

The General Manager has attended the MDT's to understand the complexity of patients discussed and the issues the team faces in meeting the patient and family needs. There is significant opportunity to improve the way patients are managed through the health care system. Two areas stand out that include growing the understanding of the options available in the community for the patient, and adopting a co-ordinator role within the home health care teams that links with the healthcare home.

The home health care team have completed training in the use of eShared care and accessing and interpreting InterRAI assessments which improves opportunity for integrated care. The teams have accompanied locality cluster leads to meet with general practice teams in the locality and the first primary care MDT meeting occurred last week. The team members attending have felt the meetings add value in understanding how best to support the patient and how best to co-ordinate interventions. This work signals a move from well organised multidisciplinary ways of working to an integrated and interdisciplinary approach that will improve patient experience of care and increase capacity within the team.

At Risk Individuals

The At Risk Individuals program continues to progress well and the major achievement for the month is the support from the PHO's to facilitate primary care team meetings with practices to introduce the enhanced care team members. Two meetings have been held so far with a further four scheduled over the next week.

The primary care teams have found the initial meetings beneficial with one practice holding their first MDT the following day. ProCare's At Risk Individuals implementation team have been updated on the direction of travel with the Community Health Services Integration workstream in order to inform the planning for At Risk Individuals phase two and the further development of enhanced primary care teams to include mental health integration and child health community services.

The locality leadership group will work on the locality approach for At Risk Individuals phase two next month. ProCare practices are beginning to operationalize the combined predictive risk tool which will assist in the identification of the most appropriate patient enrolments onto the At Risk Individuals programme.

ProCare is also actively driving the use of the patient portal and has also developed a quality improvement audit tool for practices to trial which seeks to review multiple aspects of the At Risk Individuals programme including how practices are managing the tasks in their workflows, adopting a team approach to At Risk Individuals and also ensuring the ethos of the programme remains at the centre including patient centred care planning as an example.

EXPO and Winter Wellness

The locality is supporting a three day expo in April that has been initiated by a local innovative accident and medical centre. The locality GP lead has developed in partnership with PHO clinical directors a patient wellness flier that offers practical patient centred advice and support on how to stay well in the winter and options for care when unwell. This flier could be used more widely than the expo to spread these key health messages. The expo hosts a wide range of health and social organisations of interest to the community including Quit Bus, Well Women's Trust, budgeting organisations, family planning, and health NGO's such as Asthma Auckland, Gout testing and Counties Manukau Sport. The locality will host a stand that encourages winter wellness and "how to find a GP" as key themes.

Clinical Priorities

The locality clinical team including GP lead, senior medical officers and nurse lead have commenced work on setting clinical priorities for the locality to try to improve outcomes for the patients most at risk. Work has started with the support of Ko Awatea and a Plan/Do/Study/Act approach to research and review 200 patients with HBA1C over 100. This will involve working with the patient's healthcare home in the first instance and ProCare have shared practice data to identify the patient group we are seeking.

The approach will be to facilitate the patient onto the At Risk Individuals program if appropriate and the locality SMO's and locality co-ordinators will support practices to achieve this when needed. This may include home visits by the co-ordinators and clinic reviews by the SMO's. The second meeting to confirm the approach is scheduled this week. These patients will also need strong links to the "At Risk Foot" project and this offers opportunity to test a cohesive approach to assessing for complications from poorly controlled diabetes and ensuring patients are linked into the right services at the right time.

Sapere Master Services Planning Process

The Locality Leadership group agreed a way forward to begin the development of a master services plan. Unlike the other localities Manukau will not benefit from one integrated community health hub and is likely to need at least two centres to meet the population needs. The Manukau locality needs to focus on understanding the population health needs, patterns of service access and to identify key patient groups that are particularly at risk of poor health outcomes.

It is proposed that to progress service integration in the Manukau locality that the focus is on engaging primary care clinicians in the process of identifying local key issues and priority areas, developing the three cluster groups of Primary Care Teams in the Manukau Locality and understanding the local need for services and opportunities within the communities. The approach is to start from the ground up and be mindful of existing projects and provider capacity for change. Our approach needs to compliment the At Risk Individuals programme, SWIFT and community integration work while supporting/enhancing the initiatives in the District. To do this we propose;

- Needs analysis
- Cluster level workshops
- Draft service delivery models

Franklin Locality

1. Acute Demand

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
1.1 Unplanned readmissions (28 days)	6.3%	6.1%	5.1%	7.2%	8.5%	4.9%	6.1%	6.7%
1.2 ASH rate (per 1,000 enrolled patients)	2.5	1.8	1.8	2.0	1.5	1.6	2.0	2.1
1.3 Average bed day usage in last 6 months of life	12.2	16.1	15.8	15.3	29.6	19.0	16.5	12.4

Notes: Numbers for previous months may change as additional mortality data is received for ***1.3*** and as coding is modified for ***1.1*** and ***1.2.*** Aged Residential Care Bed Days in Pukehoke and Franklin Memorial Hospitals are included in the figures for ***1.3*** - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
2.1 Children fully immunised at 8 months (Target = 95%)	91.4%	94.3%	95.0%	91.2%	86.9%	87.8%	88.6%	93.1%
2.2 Children fully immunised at 24 months (Target = 95%)	91.7%	92.2%	95.0%	95.9%	93.8%	92.3%	92.0%	95.1%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	91.9%	100.0%	92.7%	85.9%	84.4%	89.1%	90.5%	91.9%

3. Shared Accountability Services

Item	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Total Feb 2014 to Feb 2015	CMH Total Feb 2014 to Feb 2015
3.1 ED presentations not admitted	98	116	105	145	133	107	1,451	21,001
3.2 Acute medical bed days	1,069	932	806	721	731	712	10,570	85,937
3.3 Acute casemix-funded non-medical bed days	750	629	575	636	558	546	7,835	62,925
3.4 Medical outpatient attendances	1,119	1,229	1,206	957	847	988	13,884	120,498

Note: All SAS volumes for previous months may change as IDF updates are received and coding is modified

4. Other

Indicator	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Locality Avg Feb 2014 to Feb 2015	CMH Avg Feb 2014 to Feb 2015
4.1 E-referrals as % of all referrals	19.4%	23.0%	23.0%	23.1%	21.5%	0.0%	16.8%	14.3%
4.2 Medical Outpatient DNA rate	3.5%	9.7%	5.0%	2.9%	6.2%	5.6%	5.9%	8.5%

Note: Numbers for previous months may change as coding is modified for ***4.2***, and additional referrals are included for ***4.1***

Home Health Care / Community re-design Workshops

Four workshops have been completed with an excellent attendance from all community health care providers across all sectors. Two consumers from the Franklin Health Forum attended each session. Planning is now underway to collate the ideas and translate them into separate work streams with action plans.

Winter Planning for Franklin Locality
A discussion paper has provided detailed analysis of the increase in Emergency Department attendances at Middlemore Hospital last winter from residents of Franklin Locality. A list of possible actions the Locality could take to reduce Emergency Department presentations for next Winter is being discussed by the various Locality groups. An action plan is expected to be drawn up next month.

50,000 Self-Management Campaign- Help You, Help Me
A workshop is planned for late March for local NGO and community providers within Franklin to engage with the project by enrolling their service in to the Healthpoint template.

GP Lead Role
Interviews have been held and an appointment is expected to be made shortly.

At Risk Individuals Implementation
Practices in Franklin continue to progress with the enrolment of patients on to this programme. The project implementation group met again this month and discussed the paper on Winter Planning for Franklin.

Green Prescription plus
The proposed programme was cancelled due to lack of referrals. Discussions are being held with GP Practices to ascertain reasons for the lack of referrals.

4.9 Primary & Community Finance Report

This report highlights net exceptions from agreed budget with a focus on full year variances.

CPHAC Financial Report As at 28 February 2015	Mth Actual $000	Mth Budget $000	Mth Var. $000	YTD Actual $000	YTD Budget $000	YTD Var. $000	FY Actual $000	FY Budget $000	FY Var. $000
Total Revenue	32,490	32,513	(23)	258,884	260,105	(1,221)	391,138	390,158	981
Expenditure									
Pharmaceuticals	8,284	8,337	54	67,874	66,700	(1,175)	101,750	100,050	(1,700)
PHO/GMS/Rural Retention	7,072	6,902	(171)	55,730	55,212	(518)	83,595	82,818	(776)
Primary Care & Service Development	335	318	(17)	2,707	2,541	(166)	4,061	3,812	(249)
Planning & Funding - Governance	187	138	(48)	1,235	1,105	(130)	1,852	1,658	(194)
Primary Care NGOs	828	914	86	7,247	7,315	68	10,870	10,972	102
Chronic Health Conditions Programme (CCM)	817	923	106	6,982	7,386	403	11,108	11,079	(29)
After Hours Regional Service	584	566	(17)	4,888	4,532	(357)	7,332	6,797	(535)
Child, Youth & Mortality	654	588	(66)	5,588	4,703	(885)	7,446	7,055	(391)
Oral Health	465	464	(1)	3,708	3,713	5	5,563	5,570	7
Localities/20k initiatives	373	575	202	4,637	4,602	(35)	7,199	6,902	(296)
LTS - Chronic Health Conditions	259	347	88	2,704	2,773	68	4,056	4,159	103
Immunisations	246	246	(1)	1,963	1,965	2	2,944	2,947	3
Primary Options for Acute Care (POAC)	142	181	40	1,355	1,452	97	2,032	2,178	145
Intersectorial	85	110	25	644	880	236	967	1,320	354
Healthy Lifestyles	142	91	(51)	562	728	166	843	1,091	249
> 65 Home Based Support Services	1,791	1,715	(76)	13,395	13,721	326	20,092	20,582	490
> 65 Aged Residential Care	6,119	6,038	(81)	46,843	48,302	1,459	71,165	72,452	1,288
> 65 Other	316	441	125	2,976	3,530	554	4,464	5,295	831
Mental Health NGOs	3,959	4,194	236	30,786	33,556	2,769	50,321	50,333	12
Other - incl. Budget Savings Target	(676)	(699)	(23)	(5,622)	(5,592)	31	(8,520)	(8,387)	133
Total Expenditure	**31,983**	**32,390**	**407**	**256,203**	**259,123**	**2,920**	**389,139**	**388,686**	**(454)**
Net contribution	507	123	385	2,681	982	1,699	1,999	1,472	527

The eight months of 14/15 Primary and Community budgets as a whole, are on target with a net favourable contribution variance of $1,699k and $527k favourable position as a full year forecast.

Other than the two main variances highlighted below and in prior months, most unfavourable expense variances have corresponding and matching favourable revenue variances. A departure from this is a recent trend, as localities/integration implementation matures, for unbudgeted FTE and contractor costs to arise where previously these costs were budgeted as different expenditure types i.e. via PHO contracts or in the localities contingency budget line.

Community Pharmaceuticals (FY $1.7m unfavourable variance)

40% of the $100m pharmaceuticals budget consists of pharmacy funding relating to drug dispensing and added value services. This expenditure has been under constant change over the last couple of years as we move from a pure volume dispensing arrangement to a hybrid of volume dispensing coupled with greater patient health management. This transition has been a complex programme of 1) ensuring consistent pharmacy income, 2) maintaining access to appropriate drugs and 3) implementing greater managed healthcare for patients with long term conditions.

Under the implementation, managed by the Ministry the total country dispensing cost has been controlled and capped but that has not prevented variation at District Health Board level. CM Health is one District Health Board with forecasted dispensing growth greater than average and greater than our budget. Complexity of the changes have meant forecast detail was not available at budget time and consequently the dispensing budget has been under estimated by $2m or 5%. Changes in co-pays and rebates net the variances down to a $1.7m overspend.

Reasons why CM Health differs from the average District Health Board are complex but relate to the extent how well District Health Board's have managed their pharmacies dispensing activity. District Health Board's with pharmacies with historically excessive repeat dispensings have seen their costs reduce as the incentive for dispensing volume decreases. Consequently, District Health Board's like CM Health with well managed dispensing have had to take an increased share in maintaining the total capped dispensing budget.

Health of Older People (FY $2.9m favourable variance)

These costs include Home Based Support and Aged Residential Care for over 65s. CM Health over 65s population is growing at over 4% pa and Health of Older People budgets have been fixed to this growth. Recent forecasts have revealed growth utilisation of these services are below population growth and on current trends will result in a cost under spend of $2.9m.

Counties Manukau District Health Board
Auckland Region Public Health Service Update

Recommendation

It is recommended that the Community & Public Health Advisory Committee **note** the update below.

Prepared and submitted by: Julia Peters and Jane McEntee

Executive Summary

This briefing is an update since your last report of 9 September 2014, on a range of work currently underway with Auckland Regional Public Health Service (ARPHS):

1. Input to the draft Auckland Unitary Plan
2. Policy submissions made by ARPHS
3. Action on Alcohol - Regional Plan
4. Healthy Eating and Physical Activity in the Auckland region – update on the Healthy Auckland Together project
5. Smokefree Intersectoral Project update
6. Tobacco programme – Controlled Purchase Operations (CPOs)
7. Social and Emergency Housing Stocktake

1. Input to Auckland Unitary plan hearings process

The ARPHS submission on behalf of the three Auckland DHBs on the proposed Auckland Unitary plan highlighted key recommendations and supported other submissions aligned with ARPHS goals, as follows:

- Seeking a ninth issue of regional significance to be added to the strategic objectives in the regional policy statement of the plan for 'health and wellbeing'.
- Emphasis on Mana Whenua engagement, use of Hauora models.
- Strong emphasis on housing quality.
- Priority to active transport; cycling and walking, reducing car dependence.
- Climate change mitigation policies.

ARPHS has been participating in the Unitary Plan hearings process which will be continuing until late 2015. A Medical Officer of Health, with policy support, has been attending mediations and hearings, and putting forward public health perspectives. The table below indicates Unitary Plan activities during February and March, arranged by issue and type of meeting (Pre-Hearing, Mediation or Hearing).

During February ARPHS was involved in the following matters:

- Hazardous Substances – Prehearing
- Contaminated Land – Prehearing
- Natural Hazards and Flooding – Mediation
- Regional Policy Statement – Mediation
- Artworks, Signs and Temporary Activities – Mediation.

ARPHS has been involved in the following matters during March 2015.

- Hazardous Substances – Mediation
- Transport Objectives, Policies, Rules & Others – Prehearing
- Centre Zones, Business Parks, Activities & Controls – Prehearing
- Social Infrastructure – Prehearing
- Water Quality – Prehearing
- Infrastructure – Prehearing
- Artworks, Signs & Temporary Activities – Hearing
- General Coastal Marine Zone and Activities – Hearing
- Air Quality – Hearing.

2. Policy submissions made by ARPHS

ARPHS completed and submitted a range of submissions on public health matters to central government agencies and Auckland Council since your last report in September. These can be viewed on the ARPHS website at http://www.arphs.govt.nz/about/submissions. Topics included:

- Public health concerns relating to resource consent processes, to Auckland Council
- Health claims on formulated sports foods and electrolyte drinks
- Cycling safety
- Alcohol policy and licensing issues
- Local Board Planning
- Legislation including the Health (Protection) Amendment Bill 2014 to the Ministry of Health, and the Food Act 2015 to the Ministry of Primary Industries
- Auckland Council's Long Term Plan (10 year Budget) – this included both written and verbal submissions
- Auckland Transport's Draft Long Term Regional Transport Plan

3. Action on Alcohol – Regional Plan

In consultation with key stakeholders, ARPHS has identified the following strategic priorities for regional action on alcohol:

- Reduce the availability and accessibility of alcohol.
- Build workforce and community capacity to effectively engage in alcohol legislative processes.
- Improve the capacity to monitor and report on alcohol-related harm.
- Increase approval of policies which support alcohol harm reduction.
- Strengthen stakeholder relationships and interagency networks.

The ARPHS alcohol health promotion team has been collaborating with Hapai Te Hauora, CAYAD, Te Ha Oranga, and Alcohol Healthwatch, and met with Local Board Chairs from Manurewa and Papakura Local Boards to clarify statutory and health promotion roles regarding liquor licensing and alcohol harm reduction.

ARPHS has supported the implementation of the regional alcohol action plan (*Action on Alcohol* 2013-2018), as a member of the Executive Planning Group that provides oversight and leadership of the implementation and monitoring of the plan. Priorities for action for the group over the next 12 months include effective implementation of the new alcohol legislation, particularly a robust local alcohol policy.

A submission was made to Auckland Council's consultation document on local alcohol policy (LAP) in July 2014, in collaboration with DHBs, and also presented at the oral hearings. In summary, it was argued that greater restrictions on alcohol availability were needed throughout the LAP to reduce

alcohol-related harms. A survey had previously been undertaken which indicated very strong community support for more restrictive provisions for alcohol licensing.

Council staff are now developing a draft LAP for Council approval. Once approved, it is likely there will be an appeals process, as either health, other government agencies, or industry parties (or a mix of these) are unlikely to be satisfied with the outcome. Reporting in the NZ Herald on 21 March indicated that the draft LAP was supportive of a liveable and healthy Auckland.

4. Healthy Eating and Physical Activity in the Auckland Region

Auckland Regional DHB Healthy Food and Beverage policy and guidelines were developed during 2014 by a working group of DHB and ARPHS representatives, and have now been endorsed by each DHB. The implementation of the policy and guidelines is under way, but will take time as there will be implications for existing catering contracts which will need to be re-negotiated at appropriate times.

Recent achievements in this area include:

- Shared healthy nutrition environments policy agreed across all three Auckland DHBs.
- Establishing a coalition of health providers working towards a common goal to reduce long-term impact of obesity on morbidity, disability and mortality.
- Working and collaborating with Auckland Council on reducing obesity rates across Auckland at both policy and operational levels.
- Development of services for early childhood education settings and workplace health programme 'Heartbeat Challenge'.
- Key public health submissions on policy documents supporting healthy nutrition and physical activity including:
    - The Auckland Unitary Plan
    - Guidelines for Preparing Regional Transport Plans
    - Inquiry into the determinants of health and wellbeing for Māori children
    - Options to reduce sugar sweetened beverage consumption in New Zealand

There are currently 114 active Heartbeat Challenge (HBC) companies, and nine potential companies have been identified for participation in HBC.

Healthy Auckland Together

The Auckland regional obesity prevention project, Healthy Auckland Together (HAT), led by ARPHS, has focused on relationship building and engagement with key stakeholders over the last six months, to inform the overall framework for the programme (see attached, work in progress).

A solid planning infrastructure has been developed, including processes for engagement and collaborative activities. A detailed action plan will be completed by 30 June 2015. Actions for the collaborative development and endorsement of the plan will include:

- Engaging each organisation's chief executive, to secure commitment/full endorsement of Healthy Auckland Together.
- Commencing implementation of the communications plan which includes active media engagement, extending stakeholder interest and support.
- Implementing initiatives for collaborative action within Healthy Auckland Together organisations to improve nutrition and increase physical activity. Collaboration among the HAT organisations, who collectively employ more than 40,000 staff, will also be a lever for
    - demonstrating shared leadership

  - raising the profile of Healthy Auckland Together,
  - generating regional debate on obesity and
  - achieving good public health outcomes, e.g. promoting stair climbing, sharing DHB nutrition policies, or reducing the supply of sugar sweetened beverages in Council and DHB premises.
- Improve collaboration on policy development between Auckland Council and ARPHS to maximise the potential for public health outcomes and other shared goals.

HAT engagement with primary care: ARPHS clinical director Julia Peters discussed the project with Alan Moffit, CD Procare, on 10 March. Julia and Michael Hale also presented on HAT to the Metro Auckland Clinical Governance Forum (PHO CDs and DHB representatives) on 26 March, where strong PHO endorsement was received and the group nominated a representative to be part of the HAT collaborative on their behalf. In CM Health, a summary of the project will be taken to the District Alliance with the aim of 'whole of system' endorsement.

5. Smokefree Update

ARPHS has been working with Cancer Society Auckland, which with Ministry of Health Pathway to Smoke-free 2025 Innovation funding, will be working with communities in the Southern Initiative catchment area on a smoke-free bylaw model that would be appropriate for them. ARPHS and CMDHB are represented on the project's advisory group along with other NGOs.

The Intersectoral Smokefree Project, initiated by CM Health and ARPHS for the region through the Smokefree Innovation Fund, now has a new service name "Smokefree Together 2025" with the by-line "Building Smokefree Partnerships Together". Feedback had been received from Regional Smokefree Forums throughout Auckland, which included a range of stakeholders and community providers, that it was important the project reflects the Smokefree Aotearoa 2025 goal and that it is about partnerships with the non-health organisations involved.

The Smokefree Together 2025 Project Team are now delivering a range smokefree activities in selected non-health settings primarily in Counties Manukau as the initial priority area. These non-health settings include:

- Work & Income NZ (9)
- Department of Corrections – Community Probation Services, Auckland Regional Women's Correction Facility (7)
- Social Services (6)
- Alternative Education (7)
- Tertiary (2)
- Workplaces – The Warehouse, Everest Staff (8).

The level of engagement with these sites has varied, depending on their workload and staff capacity to support the programme. Activities already implemented include;

- Needs Assessment
- Drop-In Clinics (on-site)
- Group Based Treatment
- Quit Bus
- Smokefree promotions (WERO, Stoptober)
- Staff health days
- Linking other Smokefree services to the sites.

6. Tobacco – Controlled Purchase Operations (CPOs)

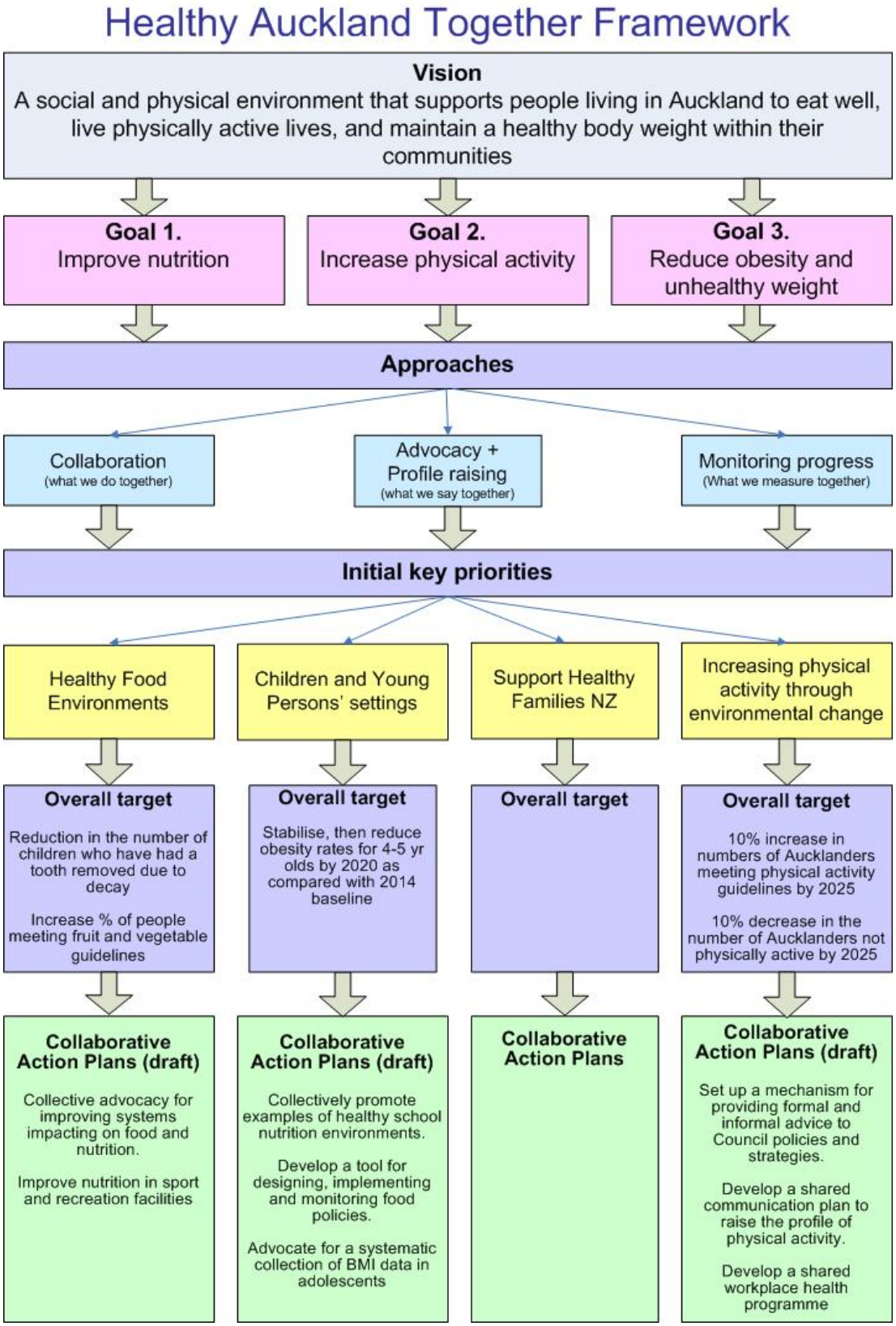
This work is scheduled from March – June to allow for the high pressure of summer special event license applications. In total there are 301 tobacco CPOs planned. Nearly one quarter (24 per cent) of these visits are in the Counties Manukau DHB area (there is currently a bigger focus on ADHB retailers because they have a higher number of retailers and there have been more failures in this district in the past). The majority of tobacco retailers were identified for CPOs on the following basis:

All retailers that fit at least three out of the five criteria below

1. 2km around the retailers that failed CPOs last year
2. 1km around secondary schools
3. 1km around malls
4. 1km around transport hub
5. Areas of high deprivation (Score 8/9/10)

7. Social and Emergency Housing Stock-take

The Ministry of Social Development is leading a stock-take on Social and Emergency Housing initiatives in Auckland. ARPHS and DHB representatives are participating in a social sector agency meeting to inform this stock-take, which is to be completed for Ministers by the end of June 2015.



(Note this is a work in progress)

Counties Manukau District Health Board
Community & Public Health Advisory Committee Meeting – (15 April 2015)

6.0 Resolution to Exclude the Public

Resolution:
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, 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
7.1 Minutes of the CPHAC Meeting with public excluded 4 March 2015	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(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** For the reasons given in the previous meeting.
7.2 Action Items Register Confidential	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(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32 (a)]	**Action Items Register** For the reasons given in the previous meeting.