PART I – Items to be considered in public meeting

AGENDA

9.00 am 1. AGENDA ORDER AND TIMING

2. GOVERNANCE

9.00 am
2.1 Apologies
2.2 Register of Interests
2.2.1 Does any member have an interest they have not previously disclosed?
2.2.2 Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

9.05 am
2.3 Confirmation of Public Minutes of the Community & Public Health Advisory Committee Meeting – 5 December 2019

9.10 am
2.4 Action Items Register

3. BUSINESS CASE

9.30 am
3.1 Owning My Gout (Trevor Lloyd, Diana Phone)

MORNING TEA – 10.00 am to 10.10 am

4. BRIEFING PAPER

10.10 am
4.1 Quarter 1 2018/19 Non-Financial Summary Report (Alanna Soupen, Planning & Reporting Advisor)

5. UPDATE

10.30 am
5.1 Community Hubs Current State (Alan Greenslade, Service Development Manager, Mangere/Otara Locality)

6. DISCUSSION

11.00 am
6.1 2019 CPHAC Workplan (Colleen Brown, Margie Apa, Kate Yang)

7. INFORMATION PAPERS (information only, no discussion)

7.1 Long Term Conditions Model of Care Update - Co-design phase progress and future models of care commissioning options
7.2 Screening Female Prisoners
7.2.1 Women in Prison: Provision of Alternatives to Detention
7.3 CPHAC Committee Visit to Papatoetoe High School Brief 31.1.2019

Next Meeting: Wednesday, 10 April 2019 at Ko Awatea, Room 101 (9am to 12.30pm)
## BOARD MEMBER ATTENDANCE SCHEDULE 2019 – CPHAC

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>27 Feb</th>
<th>Mar</th>
<th>10 Apr</th>
<th>22 May</th>
<th>June</th>
<th>3 Jul</th>
<th>14 Aug</th>
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<th>6 Nov</th>
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<tbody>
<tr>
<td>Colleen Brown (Chair)</td>
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<td>Ashraf Choudhary (Deputy Chair)</td>
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<td>Dianne Glenn</td>
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<td>George Ngatai</td>
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<td>Katrina Bungard</td>
<td>No Meeting</td>
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<td>Apulu Reece Autagavaia</td>
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<td>Dr Lyn Murphy</td>
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<td>John Wong - External Appointee (appointed 13/9/17)</td>
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<td>Member</td>
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</tbody>
</table>
| Colleen Brown (CPHAC Chair)           | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Chair, Rawiri Residents Association  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group  
• District Representative, Neighbourhood Support NZ  
• Board Member, Neighbourhood Support NZ |
| Dr Ashraf Choudhary (CPHAC Deputy Chair)| • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Island Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust |
| Dianne Glenn                          | • Member, NZ Institute of Directors  
• Life Member, Business and Professional Women NZ  
• Life Member, Business and Professional Women Franklin  
• Member, UN Women Aotearoa/NZ  
• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
• Life Member, Ambury Park Centre for Riding Therapy Inc.  
• Member, National Council of Women of New Zealand  
• Justice of the Peace  
• Member, Pacific Women’s Watch (NZ)  
• Member, Auckland Disabled Women’s Group |
| George Ngatai                         | • Director, Transitioning Out Aotearoa  
• Director, The Whanau Ora Community Clinic  
• Chair, Safer Aotearoa Family Violence Prevention Network  
• Huakina Development Trust (Partnership Clinic)  
• Lotteries Community (Auckland)  
• Board Member, Counties Manukau Rugby League Zone  
• Member, NZ Maori Council  
• Member, Tamaki kit e Tonga District Maori Committee |
| Katrina Bungard                                                                 | • Chairperson MECOSS – Manukau East Council of Social Services.  
|                                                                              | • Deputy Chair Howick Local Board  
|                                                                              | • Member of Amputee Society  
|                                                                              | • Member of Parafed Disability Sports  
|                                                                              | • Member of NZ National Party  
| Apulu Reece Autagavaia                                                        | • Member, Pacific Lawyers’ Association  
|                                                                              | • Member, Labour Party  
|                                                                              | • Trustee, Epiphany Pacific Trust  
|                                                                              | • Trustee, The Good The Bad Trust  
|                                                                              | • Member, Otara-Papatoetoe Local Board  
|                                                                              | • Member, District Licensing Committee of Auckland Council  
|                                                                              | • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation  
|                                                                              | • Member, Workforce Development Early Childhood Education Advisory Committee  
| Dr Lyn Murphy                                                                 | • Director and Shareholder, Bizness Synergy Training Ltd  
|                                                                              | • Director and Shareholder, Synergex Holdings Ltd  
|                                                                              | • Trustee, Synergex Trust  
|                                                                              | • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
|                                                                              | • Member, New Zealand Association of Clinical Research (NZACRes)  
|                                                                              | • Senior Lecturer, AUT University School of Interprofessional Health Studies  
|                                                                              | • Member, Public Health Association of New Zealand  
| John Wong                                                                     | • Board member, Asian Family Services (a subsidiary of Problem Gambling Foundation of NZ).  
|                                                                              | • Chair and Trustee, Chinese Positive Ageing Charitable Trust.  
|                                                                              | • Founding member and council member, Asian Network Incorporation (TANI).  
|                                                                              | • Board member, Auckland District Police Asian Advisory Board.  
<p>|                                                                              | • Board member, Chinese Mental Health Consultation Service Trust. |</p>
<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
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<tbody>
<tr>
<td>Apulu Reece Autagavaia</td>
<td>Item 4.1 on the CPHAC agenda – New Government’s health Policies &amp; Priorities</td>
<td>Mr Autagavaia is a member of the District Licensing Committee of Auckland Council</td>
<td>21 February 2018</td>
<td>That Apulu Reece Autagavaia’s specific interest is noted and the Committee agreed 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, if applicable.</td>
</tr>
</tbody>
</table>
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee
Held on Wednesday, 5 December 2018 at 9.00am – 12.30pm
Ko Awatea, Room 105, Middlemore Hospital, 100 Hospital Road, Otahuhu, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Dr Ashraf Choudhary
Dianne Glenn
Apulu Reece Autagavaia
John Wong

ALSO PRESENT

Margie Apa (Chief Executive)
Jenny Parr (Chief Nurse and Director of Patient & Whaanau Experience)
Dr Gary Jackson (Director, Population Health)
Dr Campbell Brebner (Chief Medical Advisor, Primary Care)
Kate Yang (Business Manager, Primary Care)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present at this meeting.

APOLOGIES

Apologies were received from Katrina Bungard and George Ngatai and Vicky Tafau for an early departure.

WELCOME

The meeting commenced at 9.00am with a welcome from the Chair, Ms Brown.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

There were no Disclosures of Interest amendments.
There were no amendments to the Disclosure of Specific Interests.
1. **AGENDA ORDER AND TIMING**

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

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 7 November 2018.**

**Resolution** (Moved: Dianne Glenn /Seconded: Colleen Brown)

That the minutes of the Community and Public Health Advisory Committee meeting held on 7 November 2018 be approved.

**Carried**

2.2 **Action Items Register/Response to Action Items**

Action Items were noted as on track.

Kate Yang is awaiting confirmation from Housing First that they will be able to present on 27 February 2019.

Youth One Stop Shop: Pap School Health Council will meet with CPHAC Board members in early 2019.

South Auckland Prisons: Dianne Glenn is in contact with Corrections. She has received a one page doc that Ms Tafau will include in the next agenda as an information paper.

Ms Tafau to determine who at CM Health is the liaison for Women in Prisons (in terms of screening, etc).

3. **PRESENTATION**

3.1 **Southern Corridor Planning with a focus on Primary & Community Developments**

(Tony Phemister, Portfolio Manager, Regional Planning & Service Delivery, NRA and Kathryn de Luc, General Manager, Specialised Care Funding & Development, CM Health)

CPHAC wanted to ensure that Health was at the planning table and Mr Phemister advised that the MBIE lead is very good at networking and is attempting to get intersectoral links formed. It was noted that a health impact assessment has been submitted as part of this process.

Policy statements are being developed for the three DHBs in terms of who they might wish to partner with including creating meaningful contracts for the community.

CPHAC wanted to understand how best to engage in this space and was advised that it is best to be clear when at the table, what we want to happen. If there is a community of x people, this would be our preferred development, this is the level of service that is required. DDG Auckland is a good lead as a policy contact.

Health Service Planning – conversation is around Community Services/Hubs. Will revisit plans from 2015 and develop more detailed plans taking into account all of the new information to hand. Where services are put and developed needs to take into account where the new Southern Hospital may be built.
Action: update to CPHAC sometime in 2019 (date TBC). The Chair felt that this should be at the Board table too. The Committee was advised that this briefing will get round to all of the committees, including the Board.

To deliver the kind of project needed in the South, needs to consider who owns the piece to determine what services/model of care will look like for 20 to 30 years’ time. Conversations have been started early, in conjunction with Heath/NRA to ensure both sides are taken into consideration.

The Chair thanked both Kathryn and Tony for the information provided.

4. BRIEFING PAPER

4.1 ARPHS Briefing for CM Health (Jane McEntee, GM, ARPHS & Dr Doone Winnard, Clinical Director Population Health, CM Health)

**Ill Traveller**
Medical Officers of Health are responsible for granting or withholding pratique in ill traveller events. On 9 September, ARPHS was notified of a potential ill traveller event where 100 passengers on an international flight from Australia were reported unwell by the airline. There was a high level of concern because the potentially symptomatic passengers were reportedly returning from Saudi Arabia, where a serious infectious disease MERS (Middle East Respiratory Syndrome) is circulating.

Pratique was withheld while St John Ambulance staff screened all the passengers on board the plane to identify unwell passengers and assess whether further medical treatment was required. No passengers were identified as seriously unwell and all passengers were allowed to disembark and leave the airport without further medical treatment. ARPHS worked closely with St John Ambulance and Auckland International Airport to ensure that the event was managed as efficiently as possible, with the entire response completed within two and a half hours. An internal and external debrief has been conducted to review the response. The external debrief included all key stakeholders from Auckland Airport. Recommendations will be developed as part of this process.

**1080 Drop**
On 21 September, the Court made the decision to allow the operation. In its decision document, the Court provided analysis of the material before it, including reviewing the evidence about the HSNO approval. It was favourable in its findings in respect of the proposal and the permit conditions, which reflected well on the ARPHS’ processes. The Court had a clear understating of the evidence presented by ARPHS as to how the risk assessment and permit conditions work to protect the water supply. On 22 September, subsequent to the court decision, Auckland Council proceeded with the 1080 aerial application in the Hunua Ranges. ARPHS has conducted an operational audit in accordance with permit conditions.

**Smokefree**
ARPHS Smokefree Compliance Officers recently ran 96 controlled purchase operations (CPO’s) over the October school holidays. The CPO’s were conducted in:
- Manurewa 27
- Papakura 25
- Otahuhu 25
- Glen Innes 13
- Panmure 3
- Mt Wellington 3
The CPOs resulted in a total of eight sales of tobacco to minors. Of these eight sales, three were in Manurewa, three in Papakura, one in Otahuhu and one in Glenn Innes. Four of the non-compliant retailers were petrol stations and four were dairies, and all eight of these retailers were issued with infringement notices by the Ministry of Health. Following these sales, ARPHS makes a recommendation to the Ministry. Infringements ($500 per individual seller) are issued by the Ministry. ARPHS is considering potential future projects to reduce the availability of tobacco and address non-compliance on a larger scale. An immediate fine is issued. Prosecutions are likely to result from this work.

Prosecutions are also given to those who sell individual cigarettes.

**Marketing to Children**

Representatives of HAT met with McDonalds senior executive members to discuss their policy on marketing to children following HAT’s complaint to the Advertising Standards Authority (ASA). Following the meeting McDonalds NZ has removed the happymeal.co.nz site which included games for children. They have also removed an advertisement in Manurewa that targeted children (“I want a Cheese Burger Daddy”). HAT’s marketing to children project work has been highlighted as successful in changing industry practices. At a University of Otago symposium in September, Simon Kenny, McDonald’s communications manager, publicly acknowledged that HAT has been strongly influential in McDonalds’ reconsidering their advertising approaches.

In collaboration with HAT partners, key messages were developed for a novel and engaging communication tool to raise awareness and stimulate public discourse on the issue of unhealthy food marketing to children. The resulting graphic comic will be disseminated widely through HAT partners and social media channels.

A communications tool has been developed that supports organisations and communities to make complaints to the Advertising Standards Authority (ASA). This tool will accompany the release of a Marketing to Children Snapshot written by Dr Louise Signal of the University of Otago. HAT partially funded the update which will be published by Activity and Nutrition Aotearoa (ANA) and distributed through their networks.

**Food and Drink Policy**

The healthy events work continues in partnership with Auckland Council and Healthy Families Waitakere. A healthy food and drink workshop for Diwali stallholders was held with The Chip Group and Procare and was attended by nine stallholders and two Auckland Tourism, Events and Economic Development (ATEED) event organisers. The stalls at the Festival were audited and prizes awarded to the three healthiest stalls. A $15,000 grant was received from HAT partners, the Health Protection Agency, to develop stall holder information for healthy food and drinks at these Auckland Council events.

HAT attended a meeting with Frucor and ATEED about the possibility of an exclusive beverage supplier contract for ATEED and Auckland Council events. It was agreed that negotiations would align with the healthy food and drink work being done at these events.

HAT has provided public health input for an Auckland Transport vending procurement (100 machines across Auckland) and achieved agreement on vending proposals that align with Auckland Council food and drink guidelines. HAT was pleased with an agreement that there will be 45-50% water in all beverage vending.

HAT staff met with Coca-Cola Oceania and Coca-Cola Amatil NZ about what they are doing to reduce the sugar content of drinks and marketing to children. As a result, the organisations have committed to change the imagery on children’s juice bottles from the current cartoon imagery.
The mumps issue is fizzling out, pertussis is making a comeback and there has been a campylobacter resurgence.

A major review of drinking, waste and storm waters is underway. Major infrastructure requirements are involved. Auckland looks to be in a relatively good position. There will be options for a new regulatory environment.

Syphilis
There has been a Syphilis outbreak which is proving to be serious and complex. Extra nursing has been provided for contact tracing.

As a public health service, ARPHs do not receive any funding for sexual health. If a proper public health response to sexual health promotion and addressing sexual health outbreaks, having a clinical team is not enough which is essential what there is in the Auckland-region.

5. PRESENTATION

5.1 SUDI Workplan Briefing (Christine McIntosh, GP Liaison & Tina Higgs, Youth Health Service Development Manager)

The Report was taken as read.

Action
The Sudi Sleep Calculator tool will swing into action in the New Year, mid-January. Come back to the Committee with a preliminary report on the findings (3 July), including some more information on why the rates for Pacific women increased in the 1990’s.

The Chair thanked the Committee for their work throughout the year and looks forward to 2019.

The meeting concluded at 11.55am.


Colleen Brown
Committee Chair
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/Resolution Register – 5 December 2018**

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<td><strong>Standing Items</strong></td>
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<td>19.8.15</td>
<td>1.15</td>
<td>Locality Updates:</td>
<td>10 April</td>
<td>Penny Magud</td>
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<td>Manukau</td>
<td>22 May</td>
<td>Penny Magud</td>
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<td>Otara/Mangere</td>
<td>14 August</td>
<td>Penny Magud</td>
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<td>Franklin</td>
<td>6 November</td>
<td>Penny Magud</td>
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<td>14.6.17</td>
<td>1.15</td>
<td>ARPHS – six-monthly update.</td>
<td>3 July</td>
<td>Dr Doone Winnard</td>
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<td>29.11.2017</td>
<td>17/18</td>
<td>Population Health Plans (Asian, Pacific &amp; Maaori) – quarterly update</td>
<td>27 February</td>
<td>Marianne Scott/Alanna Soupen</td>
<td>There is no new data from the MoH for the SLMs this year. New data will be available in 2019.</td>
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<tr>
<td>29.11.2017</td>
<td>17/18</td>
<td>17/18 Metro Auckland SLM Improvement Plan – quarterly report.</td>
<td>10 April</td>
<td>Kate Dowson</td>
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<td>29.11.2017</td>
<td>17/18</td>
<td>Every $ Counts – Project team to present an update on this project.</td>
<td>22 May 2019</td>
<td>Sarah Sharpe</td>
<td>Deferred in agreement with the Chair (Colleen Brown)</td>
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<td>18.10.2017</td>
<td>3.4</td>
<td>3.4</td>
<td>Healthy Weight Action Plan for Children: Update</td>
<td>10 April</td>
<td>Carmel Ellis</td>
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<td>6.9.2017</td>
<td>3.1</td>
<td>Owning my Gout – the project team were asked to return in 6 months’ time to update the Committee on their progress, particularly how they have got on working with A/WDHB as they have the balance of the 31,000 Gout sufferers</td>
<td>27 February</td>
<td>Diana Phone, Rebecca Lawn, Trevor Lloyd</td>
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<td>21.2.2018</td>
<td>3.1</td>
<td>Green Prescriptions in Counties Manukau - The CPHAC committee would like Ms van Paauwe to return in the latter half of year to provide an update on progress.</td>
<td>TBC</td>
<td>Matt Hannant</td>
<td>Green Prescription is currently undergoing a re-procurement process and will update once this process has concluded.</td>
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<td>23.5.18</td>
<td>3.1</td>
<td>Mental Health &amp; Addictions Update: with regard to homelessness for MH&amp;A whaanau, Housing First to be invited to present to CPHAC.</td>
<td>TBC</td>
<td>Kate Yang</td>
<td>Julie Neilson (Housing First) has tendered her apologies for 27.2.19 as she has been called to a meeting with the Prime Minister. This presentation will</td>
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Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

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<th>COMMENTS/UPDATES</th>
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<tr>
<td>4.7.2018</td>
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<td>Youth One Stop Shop: Provide basic information/data around the youth in this community and what services they are accessing and how they are accessing them. Oranga Tamariki – provide information around how many youth are in vulnerable situations that may lead to them being adults that are unaware around how to navigate health services. Community Meeting - Youth: Invite youth from the Youth Councils across Manukau to participate in a meeting and ask for feedback around their concerns and their needs.</td>
<td>To be organised in early 2019.</td>
<td>TBC</td>
<td>be rescheduled for later in the year. A visit to Papatoetoe High School was held on 31 January 2019.</td>
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<td>4.7.2018</td>
<td>5.1</td>
<td>Mangere/Otara Community Hubs: Mr Greenslade to return to CPHAC with a community hub update.</td>
<td>10 April</td>
<td>Kate Yang</td>
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<td>19.9.2018</td>
<td>Board</td>
<td>MoH Letter – Strengthening the DHB Healthy Food &amp; Drink Policy - Doone Winnard and Stella Welsh are looking at what the DHB is currently doing and what this letter means and will report back via HAC and CPHAC.</td>
<td>10 April</td>
<td>Doone Winnard/ Stella Welsh</td>
<td>Doone Winnard and Gloria Johnson are still finalising this piece of work.</td>
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<td>26.9.2018</td>
<td>3.1</td>
<td>Healthy Families New Zealand: Update to CPHAC in 6 months’ time.</td>
<td>10 April</td>
<td>Carmel Ellis</td>
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<tr>
<td>26.9.2018</td>
<td>5.1</td>
<td>Maaori Immunisations: The paper that has been submitted to ELT to be made available to CPHAC.</td>
<td>TBC</td>
<td>Colleen Brown</td>
<td>CPHAC to confirm with Ms Apa at the meeting on 5 December if this paper is ready for release to Board Sub-committees.</td>
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<tr>
<td>7.11.2018</td>
<td>2.4</td>
<td>Women in Prisons: Report back on health services that are provided to all Prisons in South Auckland – breast screening, cervical, prostate, bowel, vision &amp; hearing.</td>
<td>TBC</td>
<td>TBC</td>
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<td>7.11.2018</td>
<td>2.4</td>
<td>Youth Leaders: The Chair would like to meet with at least three to four Youth leaders, prior to a more extensive meeting in 2019. Ms Yang will investigate the possibility of convening a meeting prior to Christmas for The Chair to attend.</td>
<td>2019</td>
<td>Kate Yang</td>
<td>A visit to Papatoetoe High School was held on 31 January 2019.</td>
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<tr>
<td>7.11.2018</td>
<td>2.4</td>
<td>South Asian Community Meeting</td>
<td>22 May</td>
<td>Kate Yang &amp; Dr</td>
<td>Meeting has been scheduled for</td>
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<td>7.11.2018</td>
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<td>Diana Phone</td>
<td>Rebecca Lawn</td>
<td>Trevor Lloyd</td>
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<td>Senior Responsible Owner/Project Executive</td>
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Purpose

This business case seeks approval for $83,100 per annum for 250 patients to be part of the Owning My Gout (OMG) service, following on from a highly successful pilot of 120 patients over the past 17 months.

Owning My Gout (OMG) is a pharmacist-led service consisting of:

1. Serum urate testing and monitoring
2. Medicines optimisation
3. Patient education and self-management support

Patients remain in the service until they have achieved and remain below target for 3 consecutive months after which care is transferred back to the general practice. The main outcome measure for this pilot was clinically desired serum urate results. During the pilot, 69% of patients have achieved clinically desired urate levels which are better than anticipated as these are usually the harder to engage population.

The implementation cost of the programme, comprising of 0.5 FTE Project support of $40,000, will be met by the Pharmacy Contract Service Development fund.

It is recommended Counties Manukau District Health Board approve further implementation of the Owning My Gout service.
Strategic Case

Gout is a form of chronic arthritis that causes painful inflammation and swelling, limits function and impacts on the ability to work and spend time with whaanau. Too often, gout management is focused on controlling the patient’s symptoms during acute exacerbations [2] while the risk of irreversible joint damage and other negative health outcomes continue to grow.

Current initiatives in Counties Manukau Health (CMH) for gout management include education programmes for Health Practitioners, Enhanced Primary Care, Planned Proactive Care and Maaori & Pacific Community Education programmes. However, these initiatives are discrete with no common interface for the patient.

Despite these initiatives and the availability of best practice guidelines, there is large variability in gout management in primary care. [16] This variability can result in unnecessary pain and financial burden on healthcare resources.

Barriers to effective management of gout are multifactorial and include not adhering to best practice guidelines, delaying initiation of preventative therapy, suboptimal monitoring, health literacy, patient non-adherence and lack of knowledge of the disease and cognitive biases towards its causes. [15, 18] Furthermore, recent research has identified that the model of care for chronic arthritis management including gout in New Zealand (NZ) is fragmented due to the lack of collaboration among health care providers. [7]

Owning My Gout (OMG) service addresses some of these barriers to make gout management in Primary Care more collaborative, patient-centred and accessible for patients. The strategic drivers are a collaborative model of care and building provider capability.
# Alignment with Strategy

<table>
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<tr>
<th>Local Context</th>
<th>National Context</th>
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<tr>
<td>Counties Manukau Health’s Healthy Together strategy</td>
<td>New Zealand Health Strategy 2020 and Pharmacy Action Plan 2020</td>
</tr>
<tr>
<td>• <strong>Integration</strong> of care – OMG links with Planned Proactive Care and the Localities strategy, and fosters collaborative relationships between primary and secondary care as well as between primary care providers</td>
<td>• <strong>People powered</strong> - supporting gout patients to understand and manage their care and make choices and have a say in the design of the service.</td>
</tr>
<tr>
<td>• OMG delivers <strong>patient and whaanau centred care</strong> through engagement in self-management programmes</td>
<td>• <strong>Closer to Home</strong> - providing the service closer to home (in the local pharmacy) in an integrated way with a view to manage other co-morbidities (metabolic syndrome) as well.</td>
</tr>
<tr>
<td>• OMG <strong>reduces patient barriers</strong> to access care, education and support.</td>
<td>• <strong>Value and high performance</strong> - improving service delivery in line with best practice guidelines to get better outcomes, equity of outcomes and experience of care and value for resources.</td>
</tr>
<tr>
<td>• <strong>Quality improvement and innovation</strong> - OMG recognises the need to do something different when managing people with long term conditions such as gout, to reduce demand on both primary and secondary healthcare services.</td>
<td>• <strong>One team</strong> - a service model in which the patients will be working with their GPs, nurses and Community pharmacists to manage gout.</td>
</tr>
<tr>
<td>• This <strong>collaborative service model</strong> can be applied to other chronic conditions management programmes within CMH (e.g., heart failure, diabetes)</td>
<td>• <strong>Smart system</strong> - Using an integrated care platform (Whanau Tahi Shared Care) to share data and enable communication across the different interfaces</td>
</tr>
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</table>
The need for Investment

Local Context

Counties Manukau is referred to as the “gout capital of the world”. In 2012, there were 19,000 people aged over 15 living in CMH catchment area with a diagnosis of gout. [4] In 2014, this prevalence had increased to over 24,000 people (7.6% of the DHB population). [4] The true number of people living with gout is likely to be higher and this prevalence is projected to increase.

On average there are 360 admissions per year to Middlemore due to gout as the primary or secondary diagnosis with total estimated cost of admissions at $1,152,000 per year. This is based on one bed day costing $800 and an average length of stay of four days.

The total per annum financial cost for patients is estimated to be $18,000 per person in 2018. [7] This includes financial costs such as GP visits, medical specialists, hospital costs, pharmaceutical costs, laboratory and diagnostic imaging as well as loss of wellbeing costs such as reduced employment, absenteeism and efficiency losses. Chronic gout can have a substantial impact on an individual’s ability to work. This may include a reduced chance of participating in employment, a greater number of sick leave days than average due to the condition, and/or a diminished capacity to be productive at work. As such, arthritis may incur a range of productivity costs not only to the individual but also to employers and the government. [7]

Access and Equity
Management of Gout

Acute gout impacts a person well beyond pain to include issues such as dependency and familial impact, isolation and work disability. However gout can effectively be ‘cured’ by:

1. Commencing serum urate-lowering medications (e.g. allopurinol) at first presentation of gout to reduce serum urate levels below target (<0.36 mmol/L). This helps reduce the risk of further gout attacks and long term complications
2. Monitoring serum urate monthly until target has been reached and then checking 3-6 monthly together with renal function tests.

Effective treatment is dependent on both the patient and prescribing health practitioner; both need significant levels of knowledge about gout. This knowledge is built over a period of time and requires intensive input. Once patients and health practitioners have gained this knowledge patients are more likely to adhere to taking urate-lowering medications long term and health practitioners are more likely to appropriately treat and manage patients to prevent further gout attacks.

Just like diabetes, well controlled gout is crucial as it not only means that gout flares are less likely, it may also help reduce the risk of adverse renal and cardiovascular outcomes. For example, a meta-analysis found that, compared to patients who were not taking a urate-lowering medicine (or were taking a placebo), patients with hyperuricaemia and chronic kidney disease who were taking a urate-lowering medicine:

- Reduced their risk of cardiovascular events or renal failure by more than half
- Had slower rates of decline in renal function
- Reduced their proteinuria

A recent study also found that patients with gout and diabetes who were taking urate-lowering treatment had significantly lower risk of myocardial infarction or stroke.

Current State of unmet needs

However, evidence shows that there are variations in the way gout is managed in Primary Care despite the availability of evidence-based guidelines.

*Management of Gout in a South Auckland Practice* (2014) highlights some of the unmet needs in managing gout in Primary Care. This study found that gout is often sub-optimally managed, and urate levels are often only tested in General Practice when a patient presents with an acute
attack of gout. This is not best practice and will not give a true reflection of the patient’s condition. The limited time that is available in consultations in primary care and the intermittent nature of gout flares also make it difficult for health professionals to focus on the long-term management of gout [11].

Numerous international and New Zealand studies show that urate-lowering treatment is often delayed by prescribers, well beyond the point when it is indicated. Six out of eight of the most robust studies in a systematic literature review found that less than 50% of patients with gout were taking urate-lowering treatment. [2, 13] A qualitative study of a small sample size of Maaori patients with gout found that urate-lowering treatment was not prescribed until, on average, eighteen years after the appearance of symptoms. [11] In the United Kingdom, a study of more than 52,000 patients with gout found that after one year after diagnosis, only 17% had a prescription for a urate-lowering medicine, at five years this had risen to 30%, and after ten years only 41% of patients had a prescription for a urate-lowering medicine. [12]

Once urate-lowering medicines are started, monitoring is also often sub-optimal, meaning that many patients will still have serum urate concentrations above recommended levels for treating gout. A systematic review found that in one study, only one-quarter of patients received a serum urate test in the first six months of urate-lowering treatment, and in another study, only one-third of patients had been tested after the first year of urate-lowering treatment. [2,13]

**Addressing the unmet needs- OMG model of care**

The OMG service model addresses some of these unmet and equity needs as it is a one-stop shop to make gout management in Primary Care more accessible, collaborative and patient centred. This service includes:

- Testing urate levels in pharmacy monthly using a point of care testing meter, making monitoring urate levels more accessible to patients. This is also a walk-in service (patients don’t need to make an appointment with the pharmacy) and does not involve a consultation charge for the patient
- Using a standing order, titrating allopurinol doses to optimise therapy
- Providing tailored education & self-management support to patients using the Stop Gout booklet to address health literacy needs
- Use of electronic tool (Whanau Tahi Shared Care) to enable communication and integration between care team members.
Current and Future State Comparison

Current State

- Multi-disciplinary approach
  - GP driven gout management

Future State

- Multi-disciplinary approach
  - Patients working with GP, nurses and pharmacist to manage gout

- Patient centred care
  - Patients have variable input in their care and decision making

- Adherence to best practice guideline
  - Education & self-management support for patients using Stop Gout booklet Health Literacy Framework. Nurses set goals of treatment with patients on Shared Care Plan to determine what is important to them.

  - Evidence of delayed initiation of urate-lowering therapy and sub-optimal serum urate monitoring

  - Timely initiation of urate lowering therapy and monthly monitoring of serum urate until patient at target

Communication between care team members

- Communication between care team members
  - GP and Pharmacy patient management systems not integrated

  - Using an integrated care platform (Whanau Tahi Shared Care) to capture and share data and enable communication across the different interfaces.
The Pilot

A pilot study of 120 patients in six pharmacies has been conducted over seventeen months. Although Owning My Gout is in its early stages, we have had some promising results so far.

Rationale: The pilot minimised implementation risks by starting small. Repeated, small scale tests of change ideas using the PLAN-DO-STUDY-ACT model were carried out at one test pharmacy, prior to scaling up and implementing changes that worked well across the remaining 5 practices. Any issues that were identified through testing were able to be dealt with quickly with members of the project team easily contactable at any time.

Serum Urate Results

**Graph 1:** Average Serum urate level by visit number for all patients enrolled in the OMG service

Graph 1 above shows the average serum urate (SU) levels of all patients (n=120) enrolled in the service. At the start, their average SU is around the 0.5 mmol/L mark. Over the course of the service, we have been able to reduce their SU levels below the 0.36 mmol/L target (p value <0.0001). A paired t-test looking at the first record and last record for each patient was also done and the two tailed P-value was less than 0.0001. This difference is also considered to be statistically significant.
**Patient Reported Outcome Measures**

The validated Gout Assessment Questionnaire (GAQ 2.0) was used to measure gout specific patient reported outcomes [6]. The questionnaire has 24 questions that collects information about gout impact, medication side effects, unmet gout treatment need, well-being during attack, and gout concern during attack. Each item is scored on a 5-point Likert scale.

A total of 22 participants completed the questionnaire. From the graph we can see that the OMG service has had a positive impact on the outcomes assessment with average scores per question increasing from 2.5 to 3.2.

![Average Gout Assessment Questionnaire score for patients at start and at 1 year of OMG service (n=22)](image)

**Graph 3:** Average Gout Assessment Questionnaire score for patients at start and at 1 year of OMG service

This questionnaire attempts to measure the impact of gout from the perspective of the patient and to comprehensively describe the experience of having gout. The responses are used by nurses and pharmacists to formulate treatment goals and tailor education to the patients needs. This is a self-reported questionnaire which most patients preferred to take home and complete hence the post-response rate was very low (20% of the total cohort). The results are also subject to response bias from the patients.

**Acute GP visits pre- and while on OMG service**

A sample of 21 patients on the OMG service were randomly selected to determine number of acute visits to the GP prior to enrolling on the OMG service and whilst on the OMG service.

The following graph shows that the number of GP visits for acute gout decreased from an average of 2.9 visits to 1.2 visits.
Increasing accessibility and addressing the disparity gap

Gout management in New Zealand needs to change because Māori and Pacific peoples, in particular, are not receiving the medicines they need to manage their health effectively. [4] Research suggests that disparities between how gout is managed in Māori and non-Māori are ingrained in the current model of care, with no reduction in the disparity between 2006/7 and 2012/13. [19]

Māori and Pacific peoples have at least twice the gout prevalence of European/Other and Asian populations. [4] Māori and Pacific people are more represented in quintile 5, have lower health literacy compared with non-Māori non-Pacific, have documented access issues to Primary Care and are less likely to be engaged with traditional models of care. 70% of patients enrolled in OMG are Māori or Pacific patients. This shows that OMG is able to engage with Māori and Pacific people hence addressing the service’s objective of providing accessible care to patients and addressing the disparity gap.

In addition, gout is over three times more prevalent in men than in women. [4] Gout also affects young people of working age, with patients as young as 19 years enrolled in the OMG service. Gout related health outcomes among men also continue to be substantially worse than among women. By providing accessible, evidence-based care early in the disease process, OMG can lead to a greater chance of reducing long term complications, a less intensive treatment regimen, and reduced cost to the public health system.
Economic Case

Option 1- Do minimum (i.e remain with current model of gout management in Primary Care)

Not investing at the level requested would mean that the quality of care of gout patients in primary care reverts to the state prior to the use of the OMG service. This would mean that the previous statistics of 24,000 people affected by gout in the Counties Manukau region [4] may continue to grow. As mentioned previously, the estimated cost incurred by the DHB of admission due to gout is around $1,152,000 NZD per year which may also continue to grow with growing number of unmanaged gout patients in primary care. The OMG service also focuses on health literacy and self-management support which are essential given the complexity of managing the disease, particularly in the Maori and Pacific population. Another risk with this option is that the intellectual capacity to drive improvement and innovation by effectively and collaboratively managing a long term condition in primary care that has been developed over the last 24 months could be lost without continued funding. This model of care has the potential to be used to manage other long term conditions such as diabetes, mental health and heart disease.

Option 2- Continue with OMG pilot level support. This includes continued funding for the current 120 patients in Counties Pharmacies at $27.70/patient/month.

Option 3- Expand the service. This includes resourcing for 250 patients to be managed in the OMG service in Counties Manukau at $27.70/patient/month.
## SWOT Analysis of Option 3

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<th>Weaknesses</th>
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<td>• Collaborative model of care</td>
<td>• Funding is required for pharmacies to deliver the service</td>
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<tr>
<td>• Patient centred model of care with focus on providing tailored education and self-management support</td>
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</tr>
<tr>
<td>• Increase accessibility of care for hard to engage population (men, Maori, Pacific)</td>
<td></td>
</tr>
<tr>
<td>Meets Counties Manukau Health’s and Pharmacy Action Plans strategic aims</td>
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<th>Opportunities</th>
<th>Threats</th>
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<td>• Improve patient care through improved concordance with evidence-based gout guidelines</td>
<td>• Pharmacists not delivering service in accordance with the requirements of the Service Specification and the Service contract</td>
</tr>
<tr>
<td>• Improve patient self-management through tailored education and support</td>
<td>• Lack of effective collaboration between GP, nurses and community pharmacists which is essential for the delivery of the service</td>
</tr>
<tr>
<td>• Reduce GP and nurse work hours through optimised care and shifting workload from GP clinics to community pharmacy</td>
<td></td>
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<tr>
<td>• Increase health literacy across system - health care professionals and patients</td>
<td></td>
</tr>
<tr>
<td>• Enable pharmacists and nurses to work at the top of practice scope</td>
<td></td>
</tr>
<tr>
<td>• Reduce readmissions and cost of healthcare delivery by providing accessible and timely interventions in primary care</td>
<td></td>
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<tr>
<td>• Increase integration within primary care (General Practice and Community Pharmacy)</td>
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**Problems**

- Siloed and fragmented care – lack of visibility and transparency of patient care across primary care providers (GP and pharmacists)
- Variability in gout management – not adhering to Best Practice guidelines e.g. delaying initiation treatment, sub-optimal monitoring
- Lack of coordination of care & lack of focus on health literacy, access to Primary Care issues and low engagement with traditional model of care
- Clinical risks associated with sub-optimally managed gout

**Objective**

- Collaborative model of care and communication via e-Shared Care plan
- Monitoring and dose optimisation via Standing Order and Lasso Medication Plan
- Focus on providing tailored education and self-management support
- Improved patient health outcomes

**Solution**

- **Benefits**
  - Improved efficiency - patients receive care (monitoring, dose optimisation and education) in a timely fashion at point of care, in line with Best Practice guidelines
  - Improved visibility and transparency of care between all care team members
  - Improved patient experience
  - Reduced Clinical Risk from sub-optimally managed gout

- **Changers**
  - Standing Order agreement between GP and pharmacists to ensure care is in line with Best Practice guidelines
  - Pharmacy will be a one-stop shop where patients can get 1) Serum urate monitoring 2) dose optimisation 3) tailored education using Stop Gout booklet

- **Enablers**
  - Activated Clinicians
  - Activated patients
  - Collaborative model of care
  - Use of Whanau Tahi e-Shared Care platform to enable communication between care team members
  - Electronic-Shared Care platform

**Benefits**

- Improved efficiency - patients receive care (monitoring, dose optimisation and education) in a timely fashion at point of care, in line with Best Practice guidelines
- Improved visibility and transparency of care between all care team members
- Improved patient experience
- Reduced Clinical Risk from sub-optimally managed gout
Financial Case

Monthly operating costs are estimated to be at $27.70/patient/month based upon the following:

<table>
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<tr>
<th></th>
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<th>Option 2: Continue with OMG pilot level support</th>
<th>Option 3: Expand the service</th>
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<tr>
<td>Monetary Benefits ¹</td>
<td>Nil</td>
<td>$76,800</td>
<td>160,000</td>
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<td>Costs</td>
<td>Nil</td>
<td>120 patients at $27.70/patient/month: $39,888</td>
<td>250 patients at $27.70/patient/month: $83,100</td>
</tr>
<tr>
<td>Net Benefit</td>
<td>Nil</td>
<td>$36,912</td>
<td>$76,900</td>
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¹ Based 20% of enrolled patients avoiding admission once serum urate is stabilised below target of 0.36mmol/L. Costed at $800 per day for an average of 4 days.
Risks, Assumptions, Issues and Dependencies (RAID)

Potential Risks

The permanent implementation of this collaborative gout management service in primary care will provide a sustainable low cost approach to improving the quality of health care delivered to gout patients in the CMH region. The level of risk attributed to investing in Option 3 is low given that the development phase of the service is complete and the effectiveness of the service model has been proven. Establishing the full financial impact of the investment is complex given that there are both tangible and intangible benefits of quality improvement initiatives like OMG.

The risks of the investment are mainly associated with the uptake of the service and the engagement of community pharmacists with GPS and nurses. However, as this service has been running for approximately 17 months with the initial implementation phase completed, there is a high degree of confidence in the ability to continue to engage the interdisciplinary team, spread and sustain the service to the remaining target areas.

The risks of not carrying out this intervention include:

- Suboptimal management of gout in primary care, resulting in reduced quality of life and poorer health outcomes for our people.
- Increased presentations to hospital by patient with acute gout flare adding pressure to already stretched resources
- Wasted resources through poor medicines management
- Missed opportunity for integration of care through collaboration between GP’s, community pharmacists and secondary care providers

Critical Success Factors

The development, refinement and implementation for the OMG service has required funding for the pharmacists to provide the service and a 0.5 FTE pharmacist Clinical Lead. The ongoing spread, delivery and sustainability of the service require permanent funding for this resource. The 0.5 FTE funding for the Clinical Lead will be met by the Pharmacy Contract Service Development fund. This resource has been the critical factor
for the success of the OMG project and attempting to provide this service without the required resource would not be feasible. This is because OMG requires timely planning and action and regular stakeholder engagement (GPs, nurses and community pharmacists) to deliver the service effectively and efficiently.
Management Case

Contract management and quality control

The Pharmacy Portfolio Manager at CMH will oversee the delivery and management of the OMG service.

The OMG service will be provided in accordance with the requirements listed in the Service Specification and the Service contract between CMH and the service provider. The Services will only be provided by a trained Community Pharmacy Gout Management accredited Pharmacist. The service provider will be responsible for accreditation of staff, maintaining a quality assurance programme and ensuring that all requirements of the Service Specification and contracts are met.

The Pharmacy must be licensed by the licensing authority that is authorised to carry out licensing functions pursuant to the Medicines Act 1981 and registered with the Ministry of Health. A strong professional relationship must also be in place between the Medical Practitioner and Pharmacy/Pharmacist providing the Services. The Pharmacy must also have the appropriate secure IT connection to allow secure electronic communication with the Service User’s Medical Practitioner.

Pharmacist training is currently carried out on-site (at the Practice and Pharmacy) by the Clinical Lead. The project team is working with the Pharmaceutical Society of NZ to develop e-training and accreditation modules for the service so there is consistence in service delivery as the service grows and is adapted by other DHBs.

Performance measurement

Performance of the OMG service will be measured by monthly data collected on the following:

- Patients serum urate
- Number of patients achieving serum urate target (<0.36mmol/L)
- Time (in months) to reach target

Pharmacists will also provide 3 monthly reports on:

- Patients gender, age and ethnicity
- Number of acute gout attacks
- Hospitalisation due to gout attacks
- Patients lost to follow-up
Implementation Strategy

Spread of the OMG service across other practices and pharmacies within CMH will be managed by the Clinical Lead and Pharmacy Portfolio Manager. Pharmacies will submit an Expression of Interest to provide the service. Pharmacies will be prioritised based on prevalence of gout patients in their practice, ability to fulfil all service requirement criteria and their collaborative relationship with the Primary Care team.

The portfolio manager and Clinical lead will be supported by a Project Manager and Improvement Advisor from Ko Awatea as well as an Advisory Group (rheumatologist, hospital pharmacist, GP, nurses, community pharmacists and consumer representatives).

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<td>Service expansion (250 patients in CMH)</td>
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Future Opportunities

- Referrals from secondary care (rheumatology department and ED from within Middlemore hospital) directly to Owning My Gout pharmacies for serum urate monitoring and dose titration, using the e-referrals pathway.

- This gout management model is also flexible and adaptable and has the potential to be spread regionally and nationally.

- This collaborative service model can also be applied to other chronic conditions management programmes within Counties Manukau Health (e.g. heart failure, diabetes), ensuring better use of clinicians unique skills to share workload in this rapidly growing and demanding health system.

Next Steps

This business case seeks formal endorsement from CPHAC ahead of submission for approval from the CMH Board to progress the expansion of the OMG service within CMH.
References


Appendix 1- Project Scope and Deliverables

OMG is centred on collaboration between GP’s, practice nurses and community pharmacists.

Community pharmacy manage the titration of gout prevention medicine, allopurinol, according to a standing order and aided by urate measurements obtained via point of care testing (refer Appendix 3). The pharmacy also provides medicines education and counselling using the Stop Gout booklet. Once patients are at their target urate level for 3 months on the optimal allopurinol doses, they are moved to 3 monthly POC testing then returned to the care of their GP for ongoing gout management. The members of the multidisciplinary team all contribute to the patients care plan and communicate via the e-shared care record of the patient (refer Appendix 2- Owning My Gout Process Map).

To be eligible to receive Community Pharmacy Gout Management Services, Service Users must:

a) Be referred by a Medical Practitioner who delegates point-of-care serum urate testing, dose adjustments and associated patient counselling to a community pharmacy service;

b) For dose escalation of allopurinol in the following patients;

c) Diagnosed with gout

d) Prescribed allopurinol and a gout flare prevention medication by a GP

e) Over 16 years of age

f) Serum urate level ≥ 0.36mmol/L, or ≥ 0.30mmol/L if patient has tophaceous gout

g) No contraindication to allopurinol (i.e. does not meet the exclusion criteria outlined below)

h) The GP has provided written consent for their patient to be managed as part of the Community Pharmacy Gout Management Service

i) The GP initiating allopurinol will sign off treatment as per standing order

j) Patient has provided written informed consent to being managed as part of the Community Pharmacy Gout Management Service.

In order to be a qualified provider for Community Pharmacy Gout Management Services:

i. The Pharmacists undertaking this Community Pharmacy Gout Management Service have a current Annual Practicing Certificate without restrictions; and

ii. At least two pharmacists per site have completed the Owning My Gout training requirement (outlined in the Standing Order- Competency/Training requirements).
Appendix 2 - OMG Service Process Map

GP signs the Standing Order for Allopurinol Dose Escalation, prior to commencing services.

GP identifies eligible patients - Patient > 16 years, diagnosed with gout (please refer to Standing Order for inclusion and exclusion criteria. Patient must use the allocated pharmacy; other pharmacies will not be able to dispense the prescription).

Doctor signs consent form
Patient is given
- Allopurinol + prophylaxis (colchicine or naproxen) prescription - “LASSO Medication Plan” 3 months’ supply (must include serum urate target and eGFR)
- Lab form - serum creatinine/eGFR must be obtained within 3 months of date of an allopurinol prescription to allow for dose escalation according to the standing order.

Patient is referred to nurse
- Patient is provided verbal and written information regarding the project.
- Patient signs consent form
- Nurse will register the patient in the ARI service (unless already registered).
- Go through the Partners in Health Scale (if not done prior) and Gout Impact Section of the GAQ2.0 questionnaire with the patient.
- Go through the “STOP GOUT” booklet with the patient.
- Enter lab results (serum urate and eGFR) in Shared Care
- Notify Pharmacy

Pharmacy dispenses prescription - 1 month supply at a time
- Patient education
- Records serum urate, dose of medications and all other relevant details in the patients Shared Care
- Arrange appointment in 1 month’s time for POC testing

Monthly appointments at pharmacy
- Patient returns to the pharmacy every month to get his/her urate levels tested (finger-prick blood test).
- Based on the patient’s urate levels and eGFR, the pharmacist will then escalate the dose of allopurinol as per the standing order
- Dispense monthly supply of allopurinol and prophylaxis
- Patient education
- If required, the patient will be referred back to the GP.

GP review every 3 months
- GP will sign off treatments as per standing order
- New allopurinol + prophylaxis prescription + lab form is provided.
Appendix 3- Best Practice Dosing Guidelines

Lasso Medication Plan

1. **Prophylaxis** (for at least first three months of stable allopurinol therapy, may need longer if tophi)
   
   a) Colchicine 0.5mg daily
   
   b) If does not tolerate colchicine, NSAID prophylaxis (only if eGFR>60, no PUD or other contraindications to NSAID therapy): naproxen 250mg daily plus omeprazole 20mg daily.

2. **Allopurinol dosing: baseline visit**
   
   a) If not taking allopurinol, allopurinol initiation
      
      - If eGFR>90, allopurinol 150mg daily for 1 month, then 300mg daily
      - If eGFR 60-90, allopurinol 100mg daily for 1 month, then 200mg daily for 1 month, then 300mg daily
      - If eGFR 45-60, allopurinol 50mg daily for 1 month, then 100mg daily for 1 month, then 200mg daily
      - If eGFR 30-45, allopurinol 50mg daily for 1 month, then 100mg daily for 1 month, then 150mg daily
   
   b) If on allopurinol but SU ≥0.36mmol/L (360umol/L), allopurinol dose escalation until at target (maximum dose 900mg daily)
      
      - If eGFR ≥60, increase allopurinol by 100mg
      - If eGFR<60, increase allopurinol by 50mg

3. **Allopurinol dosing: monthly follow-up visits**
   
   a) Once at initiation dose, if SU ≥0.36mmol/L (360umol/L), allopurinol dose escalation until at target (maximum dose 900mg daily)
      
      - If eGFR ≥60, increase allopurinol by 100mg
      - If eGFR<60, increase allopurinol by 50mg
   
   b) No change to dose if SU<0.36mmol/L
Appendix 4- Feedback from Health Professionals

“We had to see people frequently, test their uric acid levels and adjust their medications until they got control, as well as doing the education and trying to get buy-in from the patient. It was time-consuming for us and inconvenient for our patients,”

“I have really appreciated the gout project- it removes a significant work load from the GP’s to manage gout. The education is high quality and knowing there is a system to get the uric acid level measured regularly and at point of care is excellent. We really want this project to be permanent”

Dr Lily Fraser, GP and clinical director at Turuki Health Care

“We can see the difference it’s made for patients. They’re delighted that they’re not getting flare-ups and it’s more convenient for them because there’s no wait time, so they’re more engaged in learning about their condition and the medication they should be on,”

Sana Khalil, pharmacist

“This project can be rewarding especially when patients are having positive outcomes and are motivated with taking their tablets and coming in each month but also comes with its challenges. We find it rewarding to be part of the clinical team - helping the patients achieve good outcomes for their gout condition.

Having patients that appreciate our time and effort by this service to them. We have 4 pharmacists that have done the training for this project - which is good because it means anyone of us could serve the patients when they are needing to do a finger prick test etc and correct or verify prescription/dosage with prescribing doctor as needed. We are also able to do the finger prick test without many problems.”

Jasmine Yap, Pharmacist at Turuki Pharmacy
Appendix 5- Feedback from Patient

“I’d been getting pain and aches in my feet and knuckles. I was really struggling – I’m an engineer so I have to wear safety boots and do a lot of physical work, but I couldn’t put my boots on or walk and my sore knuckles were affecting me. Gout is really painful. I couldn’t even lie down on my bed to sleep.

The GP said I have gout and started me on the programme.

Seeing the nurse was really helpful, because I didn’t know much about gout. The nurse explained it to me and we discussed the changes I needed in my diet and lifestyle to stop the gout coming back.

I see a pharmacist every month and they do the prick test, explain to me the [serum urate] level and supply me more tablets. They’re very friendly and helpful and ring to remind me about coming in for my test.

I’ve been three times now and I’ve noticed a big difference. Since I started taking the tablets I’m great. I’ve almost reached the target, and I can put on my boots and do my work with no problems and no pain.”

Mr Jeganathan Sithamparanthan, Owning My Gout patient, Turuki Health Care
Recommendation

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

Note that this Quarter 1 2018/19 Summary Report was approved for forwarding to the Community and Public Health Advisory Committee by ELT on 11 December 2018.

Note the results for Quarter 1 progress against draft planned 2018/19 actions and performance expectations, including commentary on challenges and resolution plans for those measures where performance was low.

Note that due to Ministry of Health quarterly reporting delays, ELT received the Quarter 1 2018/19 Summary Report toward the end of Quarter 2. As Quarter 2 has now concluded, indicative Quarter 2 updates have been added to this Quarter 1 2018/19 Summary Report. Quarter 2 data has been added with additional commentary provided for those measures where performance continued to be low or dropped in Quarter 2, where this information is currently available. Information for some measures is not yet available and full Quarter 2 performance information will be provided in the Quarter 2 2018/19 Summary Report, after the completion of the Quarter 2 reporting cycle in February.

Note that as the 2018/19 Annual Plan has yet to be approved by the Ministry of Health, for Quarter 1 the Ministry did not rate DHBs’ achievement against Annual Plan targets. For Quarter 1 descriptive assessments have instead been assigned by the Ministry, of either Satisfactory (S) or Not enough information/performance concerns (N). Performance against targets has therefore been provided by the Planning team for reference only and do not represent Ministry ratings of performance.

Review the identified issues and associated actions for Quarter 1 2018/19.

Note the appended Northern Region Health Plan Quarter 1 2018/19 summary report provided by the Northern Regional Alliance (Appendix 2).

Prepared and submitted by Alanna Soupen, Planning and Reporting Advisor on behalf of Margie Apa, Chief Executive Officer

Glossary

B4SC  B4 School Check
CT   Computed Tomography
CVDRA  Cardiovascular Risk Assessment
DMFT  Decayed, Missing and Filled Teeth (index)
ED   Emergency Department
FCT  Faster Cancer Treatment
MRI  Magnetic Resonance Imaging
NCHIP  National Child Health Information Platform
NIR  National Immunisation Register
OIS  Outreach Immunisation Service
PHO  Primary Health Organisation
Q   Quarter (3 month period)
WCTO  Well Child Tamariki Ora
Purpose
To provide a summary picture of how we are progressing against our planned commitments outlined in the 2018/19 CM Health Annual Plan.

Significant Achievements
- **On track to achieve the electives discharge target:** Against the year to date total planned volumes of 5,278 ESD, actual delivery at Quarter 1 2018/19 was 5,391. There was a positive variance of 113 or 102.1% of planned.

- **Achievement of the 90% Better Help for Smokers to Quit Maternity target:** The target was achieved for wahine Maaori and for the total population. In addition there have also been improvements in the acceptance of cessation support and smoking prevalence. Between Q4 2017/18 and Q1 2018/19, the percentage of women who accepted cessation support increased from 57% to 65% for Maaori women and from 55% to 71% for the total population. During this period there was also a drop-in smoking prevalence, from 53% to 46% for Maaori and from 22% to 20% for the total population.

  A key success has been trialing of an opt-out system for the smokefree maternal incentives programme by DHB community midwives (30 midwives), which began in May 2018. This has resulted in a doubling of referrals and a doubling in the number of women that engaged with the system, both in total and for Maaori women. All midwives including independent midwives are now being encouraged to refer all of their women to the programme.

- **Raising Healthy Kids target achieved for all ethnic groups:** 100% of our Maaori, Pacific and Asian tamariki identified as obese during the Before School Check were offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

Key Issues
Not all targets have been met due to differing factors:

- **62-day faster cancer treatment target** – Although performance against this target was high throughout 2017/17, performance has dropped 4% since Q4 2017/18. For the Q1 period 1.04.18 – 30.09.18 CMH has 89% performance against the 90% target with technical changes applied (93% at Q4 2017/18). Overall performance without application of the changes is 76% for the same time period.

  Breach data is collated for all patients that do not meet the 62 or 31 day timeframes and the pathway is broken down to provide narrative details that inform service change and pathway improvement. Clinical consideration remains a reason for the majority of breaches and all breaches are investigated to ensure breach reasons are accurately captured and recorded appropriately. Factors associated with capacity delays include: reduced coordination and tracker monitoring of patients from the start of the pathway because of staff vacancy and a relaxing of effort to achieve the 62 day target.

- **Emergency Department (ED) 6-hour target** – Performance has dropped 7% since Q4 2017/18. Patient volume and bed demand mean the hospital has been unable to reach the six-hour target achieving 84% for September against the target of 95% (91% at Q4 2017/18). This is due to a variety of factors including, high consistent surge presentation rates and consistently high hospital occupancy particularly in General Medicine. Steps we are taking to improve our performance included hospital wide flow project that seeks to understand constraints in the system as a whole.

- **Mental health targets:**
  - **PP7: Improving mental health services using transition planning and employment:** In Q1 84% of clients were recorded as having a discharge plan (target 95%) and only 15% were recorded as having a discharge plan of an acceptable standard (target 95%). These results represent a first effort at new PP7 reporting. The direction from the MoH has been to develop our own audit tool for the quality component of PP7. We have approached this in a developmental approach and the
poor Q1 performance reflects this. Q2 results are significantly improved and we are confident this will continue.

- **PP8: DHBs report alcohol and drug service waiting times and waiting lists for 0-19 year olds:** CMDHB continues to be below target for the within three weeks waiting time target for 0-19 year olds accessing mental health provider arm services (70% seen within three weeks; target 80%). Performance for this measure is likely to be linked to rising demand; the number of unique CMDHB domiciled clients aged 0-19 seen during the year ended 31 March 2018 was 6664, an increase from the 6335 unique clients seen in the corresponding period last year. The Whole of System / integrated Locality approach including the development of School Based Mental Health service and the alignment of NGO/ Primary Care at intake are amongst plans to assist with sustainable progress against this target.

**Appendices**
1. CM Health 2018/19 Quarter 1 Non-Financial Summary Report
2. Northern Regional Health Plan Quarter 1 Summary Report (detailed report available on request)
Appendix 1: 2018/19 Quarter 1 Summary Progress Report

Note: As the 2018/19 Annual Plan has yet to be approved by the Ministry of Health, the Ministry has not rated DHBs’ achievement against Annual Plan targets this quarter. For Quarter 1 descriptive assessments have instead been assigned by the Ministry, of either Satisfactory (S) or Not enough information/performance concerns (N). Performance against targets has therefore been provided by the Planning team for reference only and do not represent Ministry ratings of performance.

Results by ethnic group have been provided where this data is available. The Planning team continues to work with services, providers and the Ministry of Health to strengthen our reporting by ethnicity.

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<th>Dashboard Key</th>
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<td>Green = Target met</td>
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<td>Faster Cancer Treatment</td>
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| Elective Surgery | Volume of elective surgery will increase by at least 4000 discharges per year | Quarterly              |                | S                 | 102% | NR    | NR      | NR    | NR    | Q2 performance update:  
  - Delays to radiation oncology due to demand exceeding capacity. Regional reporting is being developed to ensure visibility of the issues and actions undertaken to resolve.  
  - Care coordination and tracking of patients. Tumour stream pathways are in place to enable a patient to move well through the system, however this still requires consistent and sustained navigation and coordination to ensure the system operates in a timely manner. Where care coordinators or cancer tracker personnel are unavailable this can result in patient delays. |
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<th>Shorter stays in ED departments</th>
<th>Percentage of patients admitted, discharged, or transferred from an ED within six hours</th>
<th>Quarterly</th>
<th>95%</th>
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<th>84%</th>
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<td>Patient volume and bed demand mean the hospital has been unable to reach the six-hour target achieving 84% for September against the target of 95%. This is due to a variety of factors including, high consistent surge presentation rates and consistently high hospital occupancy particularly in General Medicine. Steps we are taking to improve our performance included hospital wide flow project that seeks to understand constraints in the system as a whole.</td>
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<td>Q2 performance update:</td>
<td>In Quarter 3 we will continue to work on priority actions as part of the organisation project ‘Every Hour Counts.’ Capacity and resource to address presentations continue to be barriers to achieve performance.</td>
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<th>Immunisation</th>
<th>Percentage of eight-month olds who have had their primary course of immunisation on time</th>
<th>Quarterly</th>
<th>95%</th>
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<th>93%</th>
<th>85%</th>
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<td>Immunisation coverage at eight months is 93% for the total population and 85% for pepe Maori. We not achieve the 95% target in total or for Maaori.</td>
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<td>The focus on achieving equity for Maaori has become more purposeful in that referrals have been marked to be easily identifiable by the Outreach Immunisation Service (OIS) team, which attempts to connect prioritised whaanau. Maori babies are being monitored and referred to OIS by seven to eight weeks if the general practice are not engaged with the whanau.</td>
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<td>The Immunisation Nurse Leader along with the OIS and the NIR Team have also fostered a closer working relationship with the Maaori Child Health team at CM health. This will support wider collaboration with community-based Maaori health services as a way to better understand their role, as well as develop our understanding of how we may strengthen immunisation promotion and engagement with whanau.</td>
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<td>Q2 performance update:</td>
<td>There has been a notable decrease in the Maaori coverage and we are not achieving equity for Maaori babies. Key challenges included:</td>
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• The social dynamic of families on the move and the multiple visits required before an appointment is kept or engagement. This will be looked at when we introduce the incentive program in February.
• The mobility of families during the holiday season resulted in the Outreach immunisation team immunise less babies.
• Families declining OIS appointments due to other commitments or not wanting upset children over the holiday season including not being home during the past month impacted the immunisation coverage.

Maaori babies who have missed the opportunity of an OIS visit will continued to be offered the service as well as an invitation to the Saturday clinic. Immunisation Nurse Leader to collaborate with other stakeholders and Maaori service providers in the community to establish a case review type forum where families can be supported through existing relationships with Well child providers etc.

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<th>Smoking (primary)</th>
<th>Percentage of enrolled patients who smoke and were seen by a health practitioner in general practice and were offered brief advice and support to quit smoking</th>
<th>Quarterly</th>
<th>S</th>
<th>89%</th>
<th>88%</th>
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<td>90%</td>
<td>Q2</td>
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<td>91%</td>
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In Q1 CM Health did not achieve the target for the total population or for Maaori. The target was achieved for Pacific, Asian and European/Others.

We are concerned to note that performance for Maaori is not as high as other ethnicities and did not reach the target (whereas performance was at 91.3% for Maaori at the end of Q4). We believe that the activities in the Metro Auckland SLM Improvement Plan, many of which are particularly focused on engaging with Maaori, will help increase performance.

**Q2 performance update:**
Preliminary PHO results indicate that for Q2, CM Health has (just) not met 90% target with performance at 89.2%. We believe that, as in previous years, performance will increase before the end of the financial year. This quarter is always challenging with many different priorities competing for practice time/attention.
Performance for Māori continues to be lower but is higher than it has been in previous months so we are hopefully seeing the impact of the activities in the Metro Auckland SLM Improvement Plan, many of which are particularly focussed on engaging with Māori.

| Smoking (maternity) | Percentage of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered advice and support to quit smoking | Quarterly | 90% | S | 92% | Q2 indicative result: 95% | 93% | Q2 indicative result: 96% | NR | NR | NR | CM Health has continued to achieve the 90% maternity Better Help for Smokers to Quit target in Q1, for wahine Māori and for the total population.

In addition to maintenance of the brief advice and support target, there have also been improvements in the acceptance of cessation support and smoking prevalence. Between Q4 2017/18 and Q1 2018/19, the percentage of women who accepted cessation support increased from 57% to 65% for Māori women and from 55% to 71% for the total population. During this period there was also a drop in smoking prevalence, from 53% to 46% for Māori and from 22% to 20% for the total population.

A key success has been trialling of an opt-out system for the smokefree maternal incentives programme by DHB community midwives (30 midwives), which began in May 2018. This has resulted in a doubling of referrals and a doubling in the number of women that engaged with the system, both in total and for Māori women. All midwives including independent midwives are now being encouraged to refer all of their women to the programme.
### Raising Healthy Kids

Percentage of children identified as obese the Before School Check who are referred to a health professional for a clinical assessment and family based nutrition, activity and lifestyle interventions

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<th>Quarterly</th>
<th>95%</th>
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- Q2 indicative result: 100%
- Q2 data not yet available for this measure

### Mental Health and Addictions

PP7: Improving mental health services using transition (discharge) planning and employment 18/19

<table>
<thead>
<tr>
<th>Percentage of clients with transition (discharge) plan</th>
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- Q2 data not yet available for this measure

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<th>Percentage of clients with a wellness plan</th>
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- Q2 data not yet available for this measure

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<th>Percentage with a transition plan of acceptable standard</th>
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</tbody>
</table>

- Q2 data not yet available for this measure

This quarter CMH included Adult Community Mental Health Services as well as CAMHS in the audit of transition and wellness plans. This resulted in twice as many files audited in this period.

The percentage of clients in the service for a year or more with a wellness plan of acceptable standard has improved slightly. The transition plan audit found that 58% of the 40 discharges audited met all our quality criteria for the discharge letter and 30% met all our quality criteria for the wellness plan. While overall this resulted in a small proportion meeting all the criteria we identified that refinement of our audit tool and sample selection is required to have confidence in providing valid and reliable data.

This quarter’s data reflects a continuation of the developmental phase of the new PP7 reporting activity. The Q1 results represent a first effort at new PP7 reporting. The direction from the MoH has been to develop our own audit tool for the quality component of PP7. We have approached this in a developmental approach and the poor
<table>
<thead>
<tr>
<th>Mental Health and Addictions</th>
<th>Percentage of files audited that have a wellness plan of acceptable standard</th>
<th>48%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 performance reflects this. Q2 results are significantly improved and we are confident this will continue. We will ensure we add commentary to future reporting where we do not achieved the target performance measures. Planning work for this measure is underway in the Adult Inpatient service. Reporting will commence in Q2 2018/19.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mental Health and Addictions (PP8):**

<table>
<thead>
<tr>
<th>DHBs report alcohol and drug service waiting times and waiting lists for 0-19 year olds (Provider Arm)</th>
<th>Quarterly</th>
<th>80%</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3 weeks</td>
<td>Quarterly</td>
<td>70%</td>
<td>NR</td>
</tr>
<tr>
<td>Q2 indicative result: 71%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;8 weeks</td>
<td>Quarterly</td>
<td>95%</td>
<td>NR</td>
</tr>
<tr>
<td>Q2 indicative result: 94%</td>
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</tbody>
</table>

Though the 0-19 age group (70.2%) is below target, it is higher than the national percentage (69.0%). Also, it is worthy of note that the corresponding percentage for the 12-19 age group is above the target at 84.0%.

Performance for this measure is likely to be linked to rising demand; the number of unique CMDHB domiciled clients aged 0-19 seen during the year ended 31 March 2018 was 6664, an increase from the 6335 unique clients seen in the corresponding period last year. This represents a significant increase of 5.2%.

This increase has meant delays for some but overall far more young people are accessing specialist mental health services and 94.1% are being seen within the 8 week timeframe. Referrals are triaged and those with the highest need are prioritised and those needing urgent intervention are seen within 48 hours.

The Whole of System / integrated Locality approach including the development of School Based Mental Health service and the alignment of NGO/ Primary Care at intake are amongst plans to further assist with sustainable progress against this target.
<table>
<thead>
<tr>
<th>Mental Health and Addictions</th>
<th>PP8: Alcohol and drug service waiting times and waiting lists for 0-19 year olds (Provider Arm &amp; NGO)</th>
<th>&lt;3 weeks</th>
<th>Quarterly</th>
<th>80%</th>
<th>98%</th>
<th>98%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&lt;8 weeks</td>
<td>Quarterly</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

CMDHB NGO’s are trending well above targets in most areas, however we have noticed in the data some potential areas for improvement. All our providers are aware of the importance of capturing individuals seeking AOD support responsively to capture the individuals whilst they are seeking support but are currently working with some providers on ensuring that the data integrity is precise.

<table>
<thead>
<tr>
<th>Mental Health and Addictions</th>
<th>PP 25: Prime Minister’s youth mental health project</th>
<th>Quarterly</th>
<th>N/A</th>
<th>S</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP 26: Rising to the Challenge: The Mental Health and Addiction Service Development Plan</td>
<td>Focus Area 1: Primary Mental health</td>
<td>Quarterly</td>
<td>N/A</td>
<td>S</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

CMH Health has submitted many reports demonstrating that the number of youth accessing services has remained low, especially Māori and Pacific youth. The implementation of the Wellness Support model of care (removing the age criteria that existed in CCM for Depression) has already started to address this. In addition through the Wellness Support model youth specific resources are being promoted i.e ‘Aunty Dee’ online wellbeing tool (created by Le Va) and the 1737, 24 hour phone line for those feeling anxious or overwhelmed.
<table>
<thead>
<tr>
<th>Focus Area:</th>
<th>Quarterly</th>
<th>N/A</th>
<th>S</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA1: Primary Mental Health</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Focus Area 2: District Suicide Prevention and Postvention</td>
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<tr>
<td>Counties Manukau Mental Health and Addictions services delivered 10 Mental Health First Aid workshops in Q1. We continue a range of activities focussed around mental health/suicide literacy education, community engagement and mental health promotion.</td>
<td></td>
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<tr>
<td>Focus Area 3: Improving Crisis Response Services</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Data on After Hours and Warm line services has been available since September 2017. The average call handle time is 7.5 minutes, this is shorter for wrong numbers, hang ups and prank calls, but obviously much longer for individuals need triage and support services. For service utilisation by gender, there was a peak for males aged 30 to 34, but the females aged 40 to 60 are the higher users. The service is continuing to work towards PRIMHD compliance and a dashboard for reporting. Quality standards have improved considerably since the service was initiated.</td>
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<tr>
<td>Focus Area 4: Improve outcomes for children</td>
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<tr>
<td>The SPHC documentation Audit identified a number of inconsistencies in the recording of information regarding parental status of service users. Work is underway to ensure consistent application across the reconfigured services. The toolkit of SPHC resources is being regularly updated with new resources that are becoming available. Sharing this information with staff and their clients is impacted by the current reconfiguration causing turnover of SPHC Champions. The reconfigured services and teams have been tasked with identifying their new SPHC Champions and we aim to align this work with the new KPI focus on Family/Whaanau engagement.</td>
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</tbody>
</table>
### Focus Area 5: Improving employment and physical health needs of people with low prevalence conditions

#### Quarterly

<table>
<thead>
<tr>
<th></th>
<th>S</th>
<th>S</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

- The reconfiguration of the MH teams has been a key focus throughout Q1. The reconfiguration included restructuring staff from 3 services into 4 services, renaming teams and transitioning caseloads. These changes have been reflected in and updated into our Clinical notes systems during Q1.

- A priority for Q2 is for the newly configured leadership to review and refresh the key activities to identify whether employment support services available to secondary services are meeting high and complex service user needs.

### PP36: Reduce the rate of Maori under the Mental Health Act: section 29 community treatment orders

<table>
<thead>
<tr>
<th></th>
<th>Quarterly</th>
<th>Reduction of 10% or greater from baseline by Q4</th>
<th>S</th>
<th>96 per 100,000 population</th>
<th>362 per 100,000 population</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

- The number of Maori in Counties Manukau under section 29 of the Mental Health Act has decreased from 336 to 321 over the 2017-2018 year. The rate of Māori on a CTO decreased from 387 to 362 per 100,000 of the Māori population during the same period, while the rate of non-Maori under section 29 remains fairly steady at 96 per 100,000 non-Maori population.

**Q2 performance update:**

- The number of Maori in Counties Manukau under section 29 of the Mental Health Act has remained constant at 321 over the last two quarters of the 2017-2018 year. The rate of Māori on a CTO increased from 362 to 366 per 100,000 of the Māori population during the same period, due to a decrease in the Māori population. The rate of non-Maori under section 29 remains fairly steady at 93 per 100,000 non-Maori population.

- We anticipate that as we continue to develop and implement the Rapua Whaioranga team and embed a kaupapa Māori integrated model of care, the rate of Maori requiring a CTO will continue to decrease through culturally appropriate earlier interventions.
<table>
<thead>
<tr>
<th>OP1: Mental health output delivery against plan</th>
<th>Quarterly</th>
<th>N/A</th>
<th>S</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP20: Improved management for acute heart service</td>
<td>Quarterly</td>
<td>&gt;70%</td>
<td>S</td>
<td>69%</td>
<td>74%</td>
<td>55%</td>
<td>67%</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>Indicator 1: Percentage of patients undergoing coronary angiogram who have door to cath within 3 days</td>
<td>Quarterly</td>
<td>&gt;95% (within 30 days of discharge)</td>
<td>98%</td>
<td>94%</td>
<td>98%</td>
<td>95.2%</td>
<td>95.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator 2: Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection</td>
<td>Quarterly</td>
<td>≥ 99% (within 3 months of discharge)</td>
<td>99%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator 3: Percentage of ACS patients who undergo coronary angiogram and have pre-discharge assessment of LVEF</td>
<td>Quarterly</td>
<td>≥85%</td>
<td>93%</td>
<td>95%</td>
<td>97%</td>
<td>94%</td>
<td>91%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A result which reflects the demand pressures on the single Cath Lab, particularly in the acute/in-patient setting. Some extended days have been worked beginning September, although this is hampered by vacancies within the MRT and Nursing teams. The extended days should allow the additional scheduling of elective patients.

A worsening trend to do with changes in staff and pressure on OP clinics causing delayed follow up. Additional SMO FTE has been employed and this will assist shorten OP follow up wait times.
### Long-term conditions

**Percentage of ACS patients who undergo coronary angiogram and who are prescribed, at discharge secondary prevention medication**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Indicator</th>
<th>Result 1</th>
<th>Result 2</th>
<th>Result 3</th>
<th>Result 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly</td>
<td>&gt;85%</td>
<td>▶️ 83%</td>
<td>▶️ 94%</td>
<td>▶️ 83%</td>
<td>▶️ 81%</td>
</tr>
<tr>
<td>Q2</td>
<td></td>
<td>▶️ 85%</td>
<td>▶️ 89%</td>
<td>▶️ 71%</td>
<td>▶️ 82%</td>
</tr>
<tr>
<td>Q2</td>
<td></td>
<td>▶️ 85%</td>
<td>▶️ 89%</td>
<td>▶️ 71%</td>
<td>▶️ 82%</td>
</tr>
<tr>
<td>Q2</td>
<td></td>
<td>▶️ 85%</td>
<td>▶️ 89%</td>
<td>▶️ 71%</td>
<td>▶️ 82%</td>
</tr>
</tbody>
</table>

**Quarterly performance update:**

- **Q2 indicative result:** ▶️ 85%
- **Q2 indicative result:** ▶️ 89%
- **Q2 indicative result:** ▶️ 71%
- **Q2 indicative result:** ▶️ 82%

**Quarterly indicative result:** ▶️ 85%

**Quarterly indicative result:** ▶️ 89%

**Quarterly indicative result:** ▶️ 71%

**Quarterly indicative result:** ▶️ 82%

### PP20 Improved management for cardiovascular health

**Percentage of the eligible adult population who have had their cardiovascular disease risk assessment (CVDRA) in the last five years**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Indicator</th>
<th>Result 1</th>
<th>Result 2</th>
<th>Result 3</th>
<th>Result 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly</td>
<td>90%</td>
<td>▶️ 92%</td>
<td>▶️ 89%</td>
<td>▶️ 91%</td>
<td>▶️ 92%</td>
</tr>
<tr>
<td>Q2</td>
<td></td>
<td>▶️ 91%</td>
<td>▶️ 88%</td>
<td>▶️ 91%</td>
<td>▶️ 91%</td>
</tr>
<tr>
<td>Q2</td>
<td></td>
<td>▶️ 91%</td>
<td>▶️ 88%</td>
<td>▶️ 91%</td>
<td>▶️ 91%</td>
</tr>
<tr>
<td>Q2</td>
<td></td>
<td>▶️ 91%</td>
<td>▶️ 88%</td>
<td>▶️ 91%</td>
<td>▶️ 91%</td>
</tr>
</tbody>
</table>

**Quarterly indicative result:** ▶️ 91%

**Quarterly indicative result:** ▶️ 89%

**Quarterly indicative result:** ▶️ 91%

**Quarterly indicative result:** ▶️ 91%

**Quarterly indicative result:** ▶️ 92%

**CVDRA data for incomplete quarter demonstrates the district has been able to exceed the 90% target at the end of the quarterly period. The overall performance demonstrates that this activity remains embedded in general practice teams despite its removal as a national Health Target.**

To build on this, focus is shifting towards risk factor management for high CVD risk populations (and interventions which promote behaviour change), as part of the SLM and other local work.

For Māori men aged 35-44 years (indicator 2), there has been a slight decrease in performance by 0.3%. There are on-going differences in performance between Māori and other ethnicities. We have been focussing on potential strategies within the community, as well as in primary care. This also supports the focus of the System level measures for metro Auckland.

**Q2 performance update:**

Provisional data has not yet been made available by the MOH. CVDRA data for incomplete quarter demonstrates the district has been able to exceed the 90% target at the end of the quarterly period.

Performance for Māori men aged 35-44 years (indicator 2) cannot be provided due to limitations with the PHO enrolment register.

---

**Long-term conditions**

**Percentage of eligible Māori men in the PHO aged 35-44 years who have had a CVDRA in the last five years**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Indicator</th>
<th>Result 1</th>
<th>Result 2</th>
<th>Result 3</th>
<th>Result 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly</td>
<td>90%</td>
<td>▶️ 74%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Quarterly indicative result:** ▶️ 74%

**Performance for Māori men aged 35-44 years (indicator 2) cannot be provided due to limitations with the PHO enrolment register.**
Therefore, we are awaiting MOH figures to evaluate performance. Based on Q4 17-18 results, there has been a slight decrease in performance for indicator 2 of 0.3% in the last quarter. This may be attributed to the non-renewal of the More Heart and Diabetes Checks funding with PHOs and no funded activity taking place. However, the change in performance is unlikely to be statistically significant.

**PP20**

**Improved management for stroke services**

<table>
<thead>
<tr>
<th>Percentage of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway</th>
<th>Quarterly</th>
<th>80%</th>
<th>S</th>
<th>76%</th>
<th>83%</th>
<th>82%</th>
<th>NR</th>
<th>NR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 confirmed result:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The proportion of patients admitted to the acute stroke ward has a 12 month average of 83.9%. However in July (quarter 1) CMH did not quite meet the target – on further investigation there were 5 patients who died before being able to get to acute stroke ward. Charge Nurse Manager, Clinical Nurse Specialists and Stroke SMO’s continue to develop a strong relationship with the emergency department and Clinical Nurse Specialist (CNS) cover has also been over 6 days per week since late February.

**Q2 performance update:**

On review of patients that were not admitted during this quarter there was a larger number of patients who rapidly improved, died or who were quickly discharged. During July a higher number of patients died (5) and were not admitted to ASU. Also in August the acute stroke ward was significantly affected by SMO and CNS leave which was considerably higher than normal.

Recent review of current quarter revealed some patients who had clinical diagnoses made by medical teams (not always supported by brain imaging) who were not referred to stroke team. If referred, assessed and determined not to have had a stroke (and documented) these patients would not be included in this dominator. Team to regularly review this KPI and cases that are not admitted. In November (most recent month) this target was met (84%) also the 12 month average
<table>
<thead>
<tr>
<th>Percentage of potentially eligible stroke patients thrombolysed 24/7</th>
<th>Quarterly</th>
<th>10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 confirmed result: 19%</td>
<td>Q2 confirmed result: 19%</td>
<td>Q2 confirmed result: 23%</td>
</tr>
<tr>
<td><strong>13%</strong></td>
<td><strong>26%</strong></td>
<td><strong>NR</strong></td>
</tr>
<tr>
<td>Q2 confirmed result: 13%</td>
<td>Q2 confirmed result: 26%</td>
<td>Q2 confirmed result: 12%</td>
</tr>
<tr>
<td><strong>13%</strong></td>
<td><strong>26%</strong></td>
<td><strong>NR</strong></td>
</tr>
<tr>
<td><strong>CM Health</strong>’s achievement in this indicator has been steady with CM Health’s 12 month average at 15%. The Northern Regional Network continues to work towards a regional approach to afterhours stroke care and phase 2 of the hyper-acute pathway which included CM Health began on 3rd September 2018.</td>
<td></td>
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</tbody>
</table>

**Long-term conditions**

<table>
<thead>
<tr>
<th>Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services within 7 days of acute admission</th>
<th>Quarterly</th>
<th>80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 confirmed result: 68%</td>
<td>Q2 confirmed result: 100%</td>
<td>Q2 confirmed result: 86%</td>
</tr>
<tr>
<td><strong>55%</strong> (17/31 patients)</td>
<td><strong>100%</strong> (1/1 patient)</td>
<td><strong>60%</strong> (6/10 patients)</td>
</tr>
<tr>
<td><strong>68%</strong> (17/31 patients)</td>
<td><strong>100%</strong> (1/1 patient)</td>
<td><strong>86%</strong> (6/10 patients)</td>
</tr>
<tr>
<td><strong>It remains a challenge to admit acute stroke patients who are transferred to inpatient rehabilitation within 7 days. There has been general incremental improvement since February and the 12 month average now sits at 60.1%. Recent analysis has shown increased complexity (since 2016 there has been an increasing proportion of B70A in acute stroke unit and higher proportion transferred to rehab ward). Communication between acute and rehabilitation clinical leadership regarding patients potentially requiring rehabilitation continues. CMH now has an agreement with a private provider to provide residential rehabilitation for those patients requiring an extended rehabilitation stay (60 - 90 days). On the 24th September short term rehab began on the acute stroke ward aimed at patients who are likely to discharge home or to CSR within 7-10 days.</strong></td>
<td></td>
<td></td>
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</tbody>
</table>
rehabilitation for those patients requiring an extended rehabilitation stay (60 - 90 days). On the 24th September short term rehab began on the acute stroke ward aimed at patients who are likely to discharge home or to CSR within 7-10 days. Short term rehab on the acute stroke ward may bring a slight improvement in this target - however patient numbers for short term rehab have been small.

<table>
<thead>
<tr>
<th>Healthy Aging</th>
<th>PP23: Implementing the Healthy Ageing Strategy</th>
<th>Quarterly</th>
<th>N/A</th>
<th>S</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>CMDHB is currently exploring different frailty assessment tools to be used in the Emergency Department to identify frail elderly patients and improve care pathways for these patients both in and out of hospital. This work will complement the current work of the Geriatrician and CNS in the ED as part of the ED Front Door Project, and aligns with action 5a outlined in the Healthy Ageing Strategy; Reduce unnecessary acute admissions. This position has since been approved for further funding. Baseline data is currently in the process of being collected and analysed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP21: Influenza immunisation age 65+</td>
<td>Annually</td>
<td>75%</td>
<td>S</td>
<td>● 55% Measure not reported in Q2.</td>
<td>● 48%</td>
<td>● 68%</td>
<td>● 57%</td>
<td>● 54%</td>
<td>For the reporting period ending 30 September 2018, CMDHB has made substantial improvement in performance against this target with an 8.3% improvement in the total eligible population. However, performance for the total population of 54.5% is less than the 75% target. There has been significant increase in performance for the Pacific population. We suspect this is due to improved data capture by a single PHO that has a large portion of the population as enrolled service users. This will be confirmed with further analysis of data when available. There is sustained improvement across high needs populations; whilst not achieving the target, CMDHB performance is within range of the national average.</td>
<td></td>
</tr>
<tr>
<td>Child Health</td>
<td>PP21: Immunisation coverage at 2 and 5 years of age</td>
<td>Quarterly</td>
<td>95%</td>
<td>S</td>
<td>● 93% Q2 indicative result: 92%</td>
<td>● 89% Q2 indicative result: 86%</td>
<td>● 94% Q2 indicative result: 92%</td>
<td>● 98% Q2 indicative result: 97%</td>
<td>● 91% Q2 indicative result: 93%</td>
<td>Please refer to the section on immunisation under the previous health targets.</td>
</tr>
<tr>
<td>Measure</td>
<td>Frequency</td>
<td>Status</td>
<td>Q2 Indicative Result</td>
<td>Q4 Indicative Result</td>
<td></td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>PP27: Supporting Child Wellbeing</td>
<td>Quarterly</td>
<td>N/A</td>
<td>90%</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP37: Improving breastfeeding rates</td>
<td>Six-monthly</td>
<td>70%</td>
<td>52%</td>
<td>46%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFA B4 School Check</td>
<td>Quarterly</td>
<td>90%</td>
<td>29%</td>
<td>31%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFA Well Child / Tamariki Ora Services</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving wait times for PP29a: Coronary angiography – within 3</td>
<td>Quarterly</td>
<td>95%</td>
<td>98.1%</td>
<td>NR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

We will continue to increase access to breastfeeding information and support for Māori women through targeted community-based service provision. This is undertaken via two community-based services, TeRito Ora (DBH service) and B4Baby (contracted out to Turuki Healthcare).

The DHB continue to engage with universal providers such as Plunket to ensure there is continuous engagement and alignment in efforts to target priority populations in the CMH region. With upcoming contract renewals, specific community breastfeeding services contracted and provided by CMH are collaborating with one another and liaising with other local providers to develop respective service specifications that ensure seamless service provision and targeted approaches for Māori, Pacific and high deprivation whānaua.
<table>
<thead>
<tr>
<th>diagnostic services</th>
<th>months (90 days)</th>
<th>All PP29 measures are on a delayed timetable – Q2 data not yet available.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP29b: CT – within than 6 weeks (42 days)</td>
<td>Quarterly</td>
<td>95%</td>
</tr>
<tr>
<td>PP29c: MRI – within 6 weeks (42 days)</td>
<td>Quarterly</td>
<td>90%</td>
</tr>
<tr>
<td>We have contracted 1.FTE of MRI technician starting 7th January and additionally we will be commencing a training programme similar to other NZ DHB’s where a person from another sector of the healthcare workforce will be employed in the unit to assist with patient care positioning assisting in and out of the MRI room itself so this will free up the MRI technicians more.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We have opened our new MRI unit with 2 new co-located machines and this adds 50% capacity to our screening availability and will help reduce waiting lists which are monitored regularly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We are working hard towards recruiting further MRI technicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP29d: Urgent diagnostic – within two weeks (14 days)</td>
<td>Quarterly</td>
<td>90%</td>
</tr>
<tr>
<td>PP29e: Diagnostic – within six weeks (42 days)</td>
<td>Quarterly</td>
<td>70%</td>
</tr>
<tr>
<td>PP29f: Surveillance - within twelve weeks (84 days) beyond the planned date</td>
<td>Quarterly</td>
<td>70%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>PP31: Better help for smokers to quit in public hospitals</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Q2 indicative result: 97%</td>
<td>Q2 indicative result: 97%</td>
<td>Q2 indicative result: 97%</td>
</tr>
<tr>
<td>Improving data quality</td>
<td>OS10: Improving Focus area 1 - NHI</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>
## Focus area 2 - National Collections

### Average length of stay (ALOS)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Acute</th>
<th>Electives</th>
</tr>
</thead>
<tbody>
<tr>
<td>OS3</td>
<td>2.5</td>
<td>1.47</td>
</tr>
</tbody>
</table>

**Electives**
- Significant contributors to increased LOS were the Other Medicine speciality of Acute Care of Older Person, and Other Specialities of Neonates and Antenatal Maternity from outlier LOS.
- Early in the 17/18 FY the surgical based services experienced high acute volumes causing delays in getting to surgery and thus prolonging LOS, especially in Orthopaedics.
- Although the spikes have flattened out the legacy remains at present and when combined with the increasing complexity and acuity of cases adding time to LOS and a shortage of anaesthetists with resultant list cancellations an impact on both the acute and elective LOS is seen.

**Acute**
- Significant contributors to increased LOS were the Other Medicine speciality of Acute Care of Older Person, and Other Specialities of Neonates and Antenatal Maternity from outlier LOS.
- Early in the 17/18 FY the surgical based services experienced high acute volumes causing delays in getting to surgery and thus prolonging LOS, especially in Orthopaedics.
- Although the spikes have flattened out the legacy remains at present and when combined with the increasing complexity and acuity of cases adding time to LOS and a shortage of anaesthetists with resultant list cancellations an impact on both the acute and elective LOS is seen.

### Actions to address:

- **Electives**
  - Q1 July- Sept 17 performance had a LOS per case of between 2-5 hours more than the other quarters of the FY which was at the height of the acute volumes and access issues which impacted elective performance. The Orthopaedic service was particularly impacted with this. The Spinal Rehab Unit and Orthopaedics have had some exceptional outlier cases increasing the elective LOS eg Ortho knee replacement at 54 days. The short notice cancellation of elective lists to accommodate acute volumes and anaesthetist shortfalls has increased elective LOS whilst lists are reconfigured.

- **Acute**
  - Significant contributors to increased LOS were the Other Medicine speciality of Acute Care of Older Person, and Other Specialities of Neonates and Antenatal Maternity from outlier LOS. Early in the 17/18 FY the surgical based services experienced high acute volumes causing delays in getting to surgery and thus prolonging LOS, especially in Orthopaedics.

  - Although the spikes have flattened out the legacy remains at present and when combined with the increasing complexity and acuity of cases adding time to LOS and a shortage of anaesthetists with resultant list cancellations an impact on both the acute and elective LOS is seen.
### SI2: Delivery of Regional Service Plans

- Increased medical beds for the winter period to alleviate pressure on Acute Care of Older Person
- Acute Flow project in Medicine looking at ED performance, increasing day stay and management of long stay patients combined with a review of models of care
- Continuing recruitment of Anaesthetists
- Business Case for additional theatres being developed
- Constant review of theatre operations

<table>
<thead>
<tr>
<th>SI2: Delivery of Regional Service Plans</th>
<th>Quarterly</th>
<th>N/A</th>
<th>S</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

### SI3 Ensuring delivery of Service Coverage

The cardiac surgery and angioplasty results for the 17/18 year are within the parameters set. We note the improvement in the angioplasty rate with a year on year decline in cardiac surgery rate. Cardiac surgery is performed by ADHB on CMDHB patients and the impact of acute complex surgery and transplant surgery on the elective cardiac surgery capacity has been noted by ADHB and CMDHB previously.

<table>
<thead>
<tr>
<th>SI3: Ensuring delivery of Service Coverage</th>
<th>Quarterly</th>
<th>N/A</th>
<th>S</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

### SI4: Standardised intervention rates

- **Angiography**
  - Quarterly 34.70 S
  - Q2 result: 29.24
  - Q2 result: 29.63
  - NR | NR | NR | NR

- **Angioplasty**
  - 12.50
  - Q2 result: 12.23
  - Q2 result: 12.74
  - NR | NR | NR | NR

- **Cardiac Surgery**
  - 6.50
  - Q2 result: 5.82
  - Q2 result: 5.55
  - NR | NR | NR | NR

- **Major Joints**
  - 21.00
  - Q2 result: 24.69
  - Q2 result: 24.06
  - NR | NR | NR | NR

- **Cataracts**
  - 27.00
  - Q2 result: 41.14
  - Q2 result: 42.38
  - NR | NR | NR | NR

### HS Supporting delivery of the New Zealand Health Strategy

<table>
<thead>
<tr>
<th>HS Supporting delivery of the New Zealand Health Strategy</th>
<th>Quarterly</th>
<th>N/A</th>
<th>S</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>
Appendix 2: Northern Regional Health Plan Quarter 1 2018/19 Summary Report

Summary of Key Achievements

**Child Health** - The National Child Health Information Platform (NCHIP) Business Case has been reviewed in terms of its content and approach. High level design work has been completed with the identification of 54 enhancements to the current NCHIP solution. Activity is underway to increase awareness of the regional skin infection prevention messages during spring and summer months. The Northern Region Neonatal Units have drafted an action plan that will support achievement of the Vision and Principles for Neonatal System Improvement. The regional electronic tool to record children’s growth measurements, (called Sysmex) went live in Auckland on the 1st of October.

**Cancer** - A Service framework for Head and Neck has been developed and is due to be presented in October to the Northern Region Integrated Cancer Services Program Board.

**Stroke** - Phase 1 implementation of the Centralised Stroke Hyperacute After Hours Model of Care and Percutaneous Stroke Intervention went well. Forty-one patients received PSI treatment in the quarter ended 30 June 2018. Phase 2 implementation of the ‘Centralised Stroke Hyperacute After Hours Model of Care and Percutaneous Stroke Intervention’ went live on the 3 September 2018.

**Cardiovascular Disease** - An ECHO productivity audit, which includes sonography output, has been completed for WDHB and is underway for the other three DHBs. This supports: continuing to improve access to Echo; addressing issues in the Echo workforce; and development of the heart failure dynamic care pathway. Both Northland and CMDHB’s new and additional cath-lab projects now sit with the specific DHB to progress; regional considerations having been explored and agreed. Regional discussion continues regarding the potential regional impact of these two additional cath labs, on both workforce and waitlists, via the GM’s operational group.

**Primary and Community Care Deep Dive** - The Terms of Reference, Scope, and steering group membership has been confirmed for the Primary and Community Care Deep Dive with the first Project Steering Group Meeting taking place on the 15th October.

**Public and Population Deep Dive** - The Terms of Reference, scope, and steering group membership have been confirmed for the Public and Population Health Deep Dive. The Project Steering Group has been established and has met 3 times.

**Mental Health & Addictions** - Detailed analysis of 4 groups that utilised significant inpatient bed-days between 2008 and 2017 has been completed. This work will inform model of care development to define a rehabilitative continuum of care that better meets the needs of these service users.

**Workforce** - An Auckland metro MRT working group has been established to address general scope MRTs and the MRI workforce. Q1 work has identified a range of issues and problems relating to these workforce areas. An action plan to address these issues has been agreed and implementation of the plan has commenced. A draft report on Palliative Care workforce development initiatives is currently out with stakeholders for feedback. The report details the current state of Palliative Care workforce development initiatives happening across the sector at both district and regional level. The report also outlines future needs and plans. Key Palliative Care stakeholders in our Region have been engaged with during this quarter in support of this work.

**Hepatitis C** - Liver Health seminars have been delivered to 30-40 WINGS Rehab Centre residents with a focus on HCV and treatment. Plans are in place for similar seminars to like-minded services including: Higher Ground; Odyssey House; and Salvation Army Bridge program). Seminar key messages include diagnosis, treatment, risk reduction, and overall liver health.

**Capital Plan** - The Northern Region has received indicative Capital Investment Committee (CIC) funding approval totalling $620m for projects commencing in 2018/19. Final approval is reliant on approval of business cases to be delivered during Q3. The Capital Investment Programme is making progress in each of its three work-streams, and is on track to deliver the outputs indicated for Q2 and Q3.

**Information Systems Strategic Plan (ISSP)** - At both the Informatics Governance Group and Regional Executive Forum in September and Regional Governance Group on 4th October the ISSP briefing paper and consolidated pack was presented and endorsed. This was supported by the three key pillar documents: ISSP vs2.0; ISSP Roadmap vs1.0; and ISSP Programme Charter & Execution Plan v1.0. Following the endorsement, this consolidated pack will be submitted to the 5 Boards for approval from 29th October to 12th December, 2018.
**Recommendation**

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

**Note** the progress and work to mitigate transitional risks and develop the transition plan, including the recommendation to establish a transition contract.

**Note** the Executive Leadership Team and Audit Risk and Finance Committee has endorsed establishing a three month transition contract.

**Note** that a paper has been submitted to the Board regarding a transition contract including the following items:

- Service line 1 – support for palliative care patients receiving non-specialist services and $40,000 of associated funding for Quarter 4
  
  *And/or*
  
- Service line 2 – support for Q5, Maori, Pacific people requiring home visits such as those with limited mobility, carer responsibilities, experiencing acute deterioration and $65,000 of associated funding for Quarter 4.
  
  *And/or*
  
- Service line 3 – support for specific patients identified in the top 5% of the district wide Combined Predictive Risk analysis who are currently enrolled in planned proactive care and are, Maori, Pacific people, Q5 and $270,000 of associated funding for Quarter 4.
  
  *And/or*
  
- Service line 4 – support for podiatry and dietetic services for Q5, Maori, Pacific people and people with CSC who have a diabetes diagnosis and meet the clinical guidelines with $90,000 of associated funding for Quarter 4.
  
  *And/or*
  
- Service line 5 – enabling insulin initiation and titration for Q5, Maori, Pacific people and people with CSC who have a diabetes diagnosis and $15,000 of associated funding for Quarter 4.
  
  *And/or*
  
- Service line 6 – continuing to fund self-management infrastructure including IT, patient resources, surveys and licenses and $9,250 of associated funding for Quarter 4.
  
  *And/or*
  
- Service line 7 – continuation of the health coach pilot with the pilot practices who have trained peer and professional health coaches and $21,000 of associated funding for Quarter 4.

**Note** that the maximum amount of funding available in Quarter 4 is $510,250.

**Receive** the attached paper providing an update regarding the on-going work to co-design and implement models of care for people with complex long term conditions.

**Note** the updated timeline for concluding the co-design work and associated transition period.

**Prepared and submitted by:** Rochelle Bastion, Programme Manager Primary Care, Matt Hannant General Manager Primary Care, Funding and Development on behalf of Dr Campbell Brebner, Chief Medical Advisor, Primary Care.
Purpose

1. Outline the risks and mitigation strategies for specific population groups with the cessation of the four LTC contracts, including those in the new target population.
2. Provide an update on the co-design of new models of care for Maaori, Pacific people and people domiciled in Quintile 5 with two or more long term conditions.
3. Provide an update on the delivery timeline, the key outputs over the next 6 months and progress with data validation.

Background

In June 2018, the Board determined that current contracts supporting long term condition management, quality improvement and model of care development in primary care would not be renewed, and directed management to undertake a co-design process to determine a future approach. Since the last update to the ALT, there has been progress made in the following activities:

- The co-design ‘engage and capture’ phase
- On-going validation of data from currently operational innovative models of care in the region
- Exploration of options for future commissioning future models of care

The District Health Board has been planning and supporting providers for the exit of current contracts and the transition phase. The purpose of the transition planning is to ensure a managed process that is safe and mitigates, to the extent possible, any clinical and quality risks that arise as a result of the termination of the current contracts.

Transition planning process

The activity undertaken to date and in support of the development of the transition plan is as follows:

- Transition was discussed with Primary Health Organisations at 15 November 18 Alliance Leadership Team meeting.
- Bilateral meetings were held between the District Health Board and all the Primary Health Organisations to understand specific transition risks and mitigations as well as identification of the most vulnerable population groups.
- Discussion with PHOs at 20 December 18 ALT meeting with detailed financial information requested.
- A summary of the individual Primary Healthcare Organisation’s feedback can be found in Appendix 3.
- Development of joint communications for practices and patients
- Analysis of current utilisation data
- Development of a risk register (Appendix 1)
- Risk assessment (Appendix 2)
- Analysis of those patients identified through the ‘combined predictive risk’ algorithm who are currently enrolled on PPC who may be vulnerable as a result of the transition
- Data requests from PHOs on clinical risk, workforce considerations, sustainability risks, funding information and plans for Flexible Funding Pool (FFP)
- Briefing the Ministry of Health verbally and through written submissions.

Transition plan

A risk analysis was undertaken using the information and data from Primary Health Organisations, the activity data the District Health Board receives, and feedback received from other stakeholders including General Practice and secondary care colleagues. The full risk analysis that details the risks, mitigations, and impact can be found in Appendix 2.

---

1 As defined by NZDep
From this a plan for transitional arrangements was developed across four areas:

1. Impact on vulnerable patients
2. Impact on access for pathway care
3. Workforce considerations
4. Relationships with Primary Care/trust and confidence in the District Health Board

The table below provides summarises this information and the recommended mitigation strategies.

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Target Population</th>
<th>Risks</th>
<th>Mitigation</th>
<th>Funding Allocation Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact on vulnerable patients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients requiring palliative care services</td>
<td>Currently enrolled PPC patients requiring palliative care services including home visits, extended GP consultations and advance care planning. These are intensive and costly services for patients and their family/whanau</td>
<td>Limited provision within capitation to support palliative care patients in Primary Care the impact for these patients and DHB services is likely to be high due to the intensive support required for people with a palliative diagnosis</td>
<td>Reprioritisation of PHO Flexible Funding Pool (FFP) and a top up of additional DHB investment via a transitional contract. Based on PHO data the estimated additional cost is $40,000 per quarter</td>
<td>Allocated out according to previous PPC spend</td>
</tr>
<tr>
<td>Patients requiring home visiting services including those with significant complexity and/or engagement issues who are high risk</td>
<td>Maaori, Pacific People and Quintile 5 people as well as those with a Community Service Card</td>
<td>Home visits are a costly service for patients and required for those people who require intensive monitoring</td>
<td>Reprioritisation of PHO Flexible Funding Pool (FFP) and a top up of additional DHB investment via a transitional contract. Based on PHO data the estimated additional cost is $65,000 per quarter</td>
<td>Allocated out according to previous PPC spend</td>
</tr>
<tr>
<td>Patients at risk of hospitalisation identified through the Combined Predictive Risk tool require advanced support</td>
<td>Patients within the top 5% of the district wide Combined Predictive Risk analysis who are currently enrolled on PPC and who are Maaori, Pacific People or living in Quintile 5, ~2,700 people. Those patients who score highly on the CPR tool have a high risk of hospitalisation. PPC has been a key enabler for primary care to proactively work with identified patients who may otherwise end up with an unplanned admission</td>
<td></td>
<td>Reprioritisation of PHO Flexible Funding Pool (FFP) and a top up of additional DHB investment via a transitional contract. Contract would be fee for service, targeting named individuals within specific practices and paid in arrears. Based on PHO data the estimated additional cost is up to $270,000 per quarter</td>
<td>$100 per patient as utilised in current funding and patients identified through the district wide CPR</td>
</tr>
<tr>
<td>Reduced accessibility for people for whom cost is a barrier</td>
<td>Those people who are eligible for a CSC and / or Q5</td>
<td>Patients attend ED instead of visiting their general practice team</td>
<td>Implementation of the Government’s Community Service Card and under 14s policy Over 50% of the practices within CMDHB are VLCA</td>
<td></td>
</tr>
</tbody>
</table>

**Impact on access for pathway care**
<table>
<thead>
<tr>
<th>Podiatry and Dietetic services for people with diabetes who meet the clinical guidelines</th>
<th>Maaori, Pacific and Q5 people as well as those with a CSC who have diabetes and meet the guidelines and/or referral criteria</th>
<th>Patients with a moderate or high risk foot need to be seen by a podiatrist in order to develop a customised management and treatment plan according to patient’s needs. This is a key step to preventing amputations.</th>
<th>Reprioritisation of PHO Flexible Funding Pool (FFP) and a top up of additional DHB investment via a transitional contract. Based on PHO data the estimated additional cost is $90,000 per quarter</th>
<th>Based on the number of Maaori, Pacific and Q5 people enrolled within each PHO who have diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with diabetes requiring insulin initiation and titration</td>
<td>Maaori, Pacific and Q5 people as well as those with a CSC who have diabetes</td>
<td>Insulin initiation requires patient education about blood glucose monitoring and how to understand and use the results to support dose titration. Risks include hypoglycaemia resulting in a hospital admission. Insulin should be considered for patients with poorly controlled diabetes, which is over 8,000 people within Counties</td>
<td>Reprioritisation of PHO Flexible Funding Pool (FFP) and a top up of additional DHB investment via a transitional contract. Based on PHO data the estimated additional cost is $15,000 per quarter</td>
<td>Based on the number of Maaori, Pacific and Q5 people enrolled within each PHO who have diabetes and an HbA1c &gt;75</td>
</tr>
<tr>
<td>Self-Management Support Infrastructure</td>
<td>All patients with a long term condition and their family/whaanau are welcome to attend</td>
<td>Structured education is a critical component of care. People with long term conditions should have access to self-management support which is relevant to the ethnicity they identify with however the risks are low</td>
<td>$9,250 per quarter</td>
<td>No allocation, direct DHB cost</td>
</tr>
</tbody>
</table>

**Workforce considerations**

| Continuation of the health coach pilot | Practices actively involved in the health coach pilot who have trained peer and professional health coaches | Loss of momentum for testing an integrated model of self-management support through the involvement of peer and clinical health coaches to support patients with complex long term conditions | $21,000 of additional investment. Four of the PHOs currently have a underspend within the health coach programme budget under the 9 month PC contract | Allocated out to the health coach pilot practices via the PHOs |

**Relationships with Primary Care/trust and confidence in the District Health Board**

<table>
<thead>
<tr>
<th>Implementation of a transition contract</th>
<th>High needs patients</th>
<th>Practices deciding not to engage in future DHB programmes due to uncertainty around the continuation of support and resource.</th>
<th>Development of a three month transition contract with each PHO</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuation of Enhancing Primary Care</td>
<td>Practices actively involved in the Enhancing Primary Care Collaborative</td>
<td>Loss of momentum for testing module three and four which focus on workforce development and extended care team development</td>
<td>Work with PHOs on mechanisms to support practices, continue engagement, explore future funding options.</td>
<td></td>
</tr>
</tbody>
</table>

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Counties Manukau District Health Board– Community & Public Health Advisory Committee 27 February 2019 069
Communication

PHOs, Practices, Patients and other stakeholders

Negative media attention, frustrated patients as they are either asked to fund their care or offered a stepped down option

Frequent communications with key stakeholders. On-going engagement with consumers and providers through the co-design process. Media communications have been developed.

Transition Contract

The proposal is to establish a new three month transition contract for ‘enhanced Primary Care services for people with Long Term Conditions and vulnerable patients’ which targets the population groups identified through the transition planning process. This enables key services and support to continue as well as on-going support for strategic projects including the Integrated Health Coaching Model of Care.

The total funding required for this contract for the three month period is up to $510,250. Appendix 4 describes the full year budget funding for the four current contracts.

The benefits of establishing this transition contract are as follows:

- On the basis of the analysis, approximately halves the associated risk from 186 to 82.
- Increases the probability that vulnerable patients will continue to access key services for their long term conditions
- Enables on-going engagement and relationship management with key stakeholders while the co-design process continues

The proposed duration is three months whilst we complete the co-design phase and begin testing new models of care.

The total funding outlined in this paper is a maximum value and during the process of establishing the transition contracts further work will be undertaken to identify appropriate funding sources. This will include discussions around the prioritisation of Primary Health Organisations’ Financial Year 2018/19 Flexible Funding Pool. There are practical limitations in applying 2018/19 Flexible Funding Pool as budgets were set last year, but where this is possible it will be prioritised, as will ensuring the District Health Board has adequate visibility on local funding decisions prior to funding transition services.

Furthermore the establishment of the contract is predicated on assurances and evidence that Primary Health Organisations are investing their Flexible Funding Pool budgets (Care plus and/or Services to Improve Access funding) to patients with Long Term Conditions in Q4.

In parallel the District Health Board is working with Primary Health Organisations about how funding allocated through the Flexible Funding Pool component of capitation is invested for Financial Year 2019/20 to ensure shared prioritisation, decision making and what provisions can be made to support patients identified through this transition process. This is part of the District Health Board’s work to improve transparency and joint decision making for Flexible Funding Pool.

There is a possibility that the current suite of contracts will be underspent as some Primary Health Organisations are projecting an underspend with the PPC, diabetes allied health and self-management nine month contracts which can be utilised as part of the transitional contact.

The contracts would be paid as a fee for service in arrears. Contracts will be developed based on each Primary Health Organisations’ enrolled populations, patient need and Flexible Funding Pool financial
position. Flexibility would be enabled between the different service lines to minimise the management complexity. Primary Health Organisations will be required to provide detailed patient level interventions reporting as they have been as per the terms of the current Agreement.

Co-design Update

The co-design phase has been instrumental in providing significant insight as to the experiences of health service delivery for our population with long term conditions and from the providers that support them. Through this ‘engage and capture’ period, the team have gathered invaluable information which will be key to the design and implementation of the new models of care.

This initial period of engagement focused on providers as this was able to be organised quickly – see summary in Appendix 6. The feedback received during this initial process (and subsequently with providers) is consistent, indicating that all the themes from this provider group have been captured.

The subsequent focus has been on deeper consumer engagement. This has resulted in several months of engagement and planning with Mana Whenua i Tamaki Makaurau, the outcome of which is two Marae based Hui for up to 100 Whaanau. The first of these Hui will be at Te Awamarahi Marae Port Waikato on Wednesday 13 February with up to 50 Maori Whaanau and the second Hui is planned to occur at Manurewa Marae in the first week of March 2019.

The facilitation of these Hui will be a partnership between Mana Whenua facilitators, the Counties Manukau Maaori Health and Primary and Community Teams and the agreed methodology that the sessions will follow has been supported by Ko Awatea expert guidance as well as information capture techniques that align to ‘walking in your shoes’ format.

In addition, there have been two facilitated sessions with Asian people and supporting family members in January 2019. Both of these sessions were well attended and it has been acknowledged by Ko Awatea colleagues that this is the first time that Counties Manukau Health has been able to convene focus groups with Asian People to hear their experiences of health care delivery. These sessions have been supported by Counties Manukau Asian Health Gain Advisor and the Ko Awatea team. Theming from these two sessions is in progress and has provided valuable insight to the way in which Asian people value their health and seek support from their general practice Doctor. Emerging high level themes include the following:

- Being together
- Priority of health and wellbeing
- Timeliness of receiving care
- Social support networks

From an initial examination there is a reasonable level of consistency between this consumer data and the initial themes captured last year.

A follow up session with the Pacific People’s Health Advisory Group to build on their initial feedback and test new models of care ideas and seek their feedback is planned for Wednesday 20th February.

Further engagement with Counties Manukau Health’s secondary care teams is occurring throughout February. A meeting has been held with Whitiorya (Diabetes specialty team) on 8th February 2019 to gain their feedback/insight on models of care. There is a meeting scheduled with the Counties Manukau Health Complex Case Manager team on 28th February 2019 and also in planning is a workshop to hear the experiences and model of care suggestions of the Clinical Nurse Specialists that specialise in the management of long term conditions.

2 ©April Strategy LLP 2015
The summation of this rich data set including the amalgamation of the consumer and provider view, will be incorporated into a Discovery Phase report which will be presented to the Board in April 2019, see Figure 1 below.

*Figure 1. Long Term Conditions model of care redesign timeline*

**Data validation activity:**

The District Health Board is working closely with practices that have developed innovative models of care and demonstrated improved patient engagement and satisfaction. This activity, supported by Population Health and data analyst colleagues, is a collaborative process with the providers and the team are currently reviewing available information and data that has been provided by identified providers which include:

- Papakura Marae Clinic
- Turuki Health Care
- South Seas Health
- Greenstone Family Health
- Mangere Health Centre
- Total Health Care
- Otara Family and Christian Health Centre

This information is important in providing the Board with a level of confidence in the outcomes of these models of care that are currently operational in the region. The output of this work stream will be added into the design of the new proposal.

**Outcomes framework:**

Work is underway on the development of an outcomes framework. The consumer voice and their needs as articulated through the co-design process need to be reflected in the framework. As such the development and use of patient reported outcome measures is being explored, this includes initial conversations with Victoria University of Wellington. Ko Awatea is supporting the development of the framework, and the Long Term Conditions Clinical Governance Group will provide clinical input. The outcomes framework will be instrumental to the funding and contracting approach, as well as underpinning the evaluation of the new investments.
Implementation/commissioning/investment Approach:

Employing the correct implementation/commissioning approach is critical. Traditional approaches have led to the current system of provision and challenges that we are being addressed through this process. Therefore it is important that any process that is followed:

- Meets the needs of the target population
- Enables the DHB to achieve its strategic priorities and the objectives of the services being funded
- Doesn’t further exacerbate inequities
- Ensures the DHB develops lasting, meaningful and productive relationships with providers in the community
- Treats partners as equals, respecting each other’s roles, capabilities, and expertise
- Drives and fosters innovation
- Is responsive, agile and value for money

The process must also be consistent with Government Rules of Sourcing and ensure probity. Broadly there are three main options available for procuring services including:

1. An open contestable provider selection process, whereby all interested suppliers are given the opportunity to submit a proposal to meet the DHB’s requirements.

2. A closed contestable provider selection process, whereby pre-selected parties are invited to submit a service proposal to meet Counties Manukau Health’s requirements.

3. A non-contestable provider selection process, whereby selected providers are directly identified and engaged to meet Counties Manukau Health’s requirements.

Each of above procurement options, including the perceived benefits, risks and mitigations associated with each option will be explored in greater detail. A preferred procurement approach will be outlined in the Long Term Conditions Business Case and presented to Board for endorsement.

Discussion

The paper sets out the risks and mitigation strategies identified through Primary Health Organisation meetings and feedback from primary care providers as well as District Health Board analysis as the District Health Board exits the four long term condition contracts, including the development of a transitional agreement with the Primary Health Organisations. The mitigation strategies will be progressed in partnership with Primary Health Organisations and steps will be implemented to monitor the impact on Emergency Department attendances and referrals to secondary care services as well as clinical outcomes.

High level comparative analysis has been undertaken against the funding of comparable services within Auckland and Waitemata District Health Boards per quarter see Appendix 5.

In parallel, work is underway on the co-design of new services to support people living with complex long term conditions.

Timeline and next steps:

There are several work streams contributing to produce a business case for the Board’s consideration in July 2019. Components that will be included in the business case and progress made against these are included in figure 1 above.
In addition as the transition business case for 2019/20 and the new models of care business case are developed the following two areas are being examined:

- The alignment of models of care, funding, and contracts across primary, Maaori Health and Pacific Health – where services and support are supporting the same whaanau, where models of care are complimentary, or where there is an ability to create greater value from aligning funding and contracts for whaanau and/or providers these opportunities need to be realised.

- The implications of the new Ministry of Health’s planning guidance and expectations for 2019/20, this has been recently received and sets additional expectations for the coming year, as an example there is a new focus on providing self-management support services to all people with diabetes in the district, as well as ensuring equity, the service coverage and funding implications of this guidance are being considered and options will be presented in future papers.

All of the above information will be included in the business case that will identify a framework and outline a process for early adopter providers to deliver models of care that will support our target population to live well and stay well in their own communities.
Appendices

Appendix 1: Transition risk register

Key risks and potential mitigations during the transition period include:

<table>
<thead>
<tr>
<th>Transition risk</th>
<th>Potential mitigations</th>
</tr>
</thead>
</table>
| Discontinuity in additional support for consumers and whaanau currently receiving services that are in the new target population, i.e. people might not access services. | • Engagement and communication with consumers and whaanau in the target population to explain the changes will lead to better care and some of these changes will start in July 2019.  
• Actual number of PPC enrolments declining. October 2018 PPC enrolment is 16443 – decreased by over 500 patients from August 2018 figures which may be reflecting the messaging around targeting Māori, Pacific and people living in Q5.  
• Impact per patient is estimated to be 1.2 visits per patient during three month period, i.e. current activity demonstrated that there are 6,700 GP and nurse consults a month across the region for three months. This equates to 20,100 consults between 16450 people. This may be under estimated as the DHB lacks visibility on the use of the capacity building payment. Feedback from NHC, Total Health Heath Care has indicated this can be absorbed within 'standards care' and PHO FFP.  
• New CSC and under 14 funding will mitigate access issues where cost is a barrier (total additional funding indicated to be $3-4m³).  
• Continuity of support for primary care teams to work with patients and their whaanau; by understanding (through ALT) the opportunity to consider alternative funding streams for patients who meet the Board endorsed criteria during Quarter 4 2018/19. This may include options such as the Flexible Funding Pool and any Care Plus funding available for allocation.  
• Continuing a proportion of funding for diabetes allied health services, home visits, insulin starts and support for people identified through combined predictive risk. |
| Lack of support for palliative care patients                                    | • Re-prioritising Primary Healthcare Organisations’ Flexible Funding Pool,  
• Continuing a proportion of funding for palliative care patients.               |
| Patients stop picking up their medications                                      | • Patients can be directed to Pharmacies that have no prescription co payments  
• Re-prioritising Primary Healthcare Organisations’ Flexible Funding Pool.       |
| People who have historically received support who are not part of the new target population disengage from their health care journey or become unable to self-manage. | • Strategies to achieve planned proactive care as part of business as usual.  
• Additional investment for Community Service Card holders and under 14’s will address some need.  
• Further work with Primary Healthcare Organisations to ensure the other larger and less targeted primary care funding streams – Flexible Funding Pools, Care Plus, Capitation, new investments in Community Service Card holders support – deliver value for all those with complex health needs and high quality long term condition care. |
| Sustainability of primary care workforce, particularly nurses                  | • Work with Primary Healthcare Organisations to gain better understanding of specific workforce implications and identify opportunities within core PHO funding to address transition sustainability issues.  
• Work with Primary Healthcare Organisations to support practices to look at their underlying model of care and address factors impacting financial sustainability.  
• Consider continuing proportion of model of care (Enhanced Primary Care) funding to continue workforce re configuration activities for key practices engaged in most innovative models of care. |
| Practices unclear on who to target                                             | • Use the demographic profile of the current Planned Proactive Care |

³ Based on CMH contracted providers, likely to be underestimated as doesn’t include ProCare patients in Counties Manukau.
enrolees by practice, work out in the first instance those who are not Māori, Pacific, or living in QS and the implications for practices from this, i.e. there will be some practices with very low numbers of the priority groups, who may currently be receiving significant PPC funding who will need to review how they provide that care under the revised programme.

N.B. The proxy for complexity used for high level planning (Two or more of the selected long term conditions) will not be available to be applied at this point.

- For those people currently on Planned Proactive Care who may be eligible to receive support under the revised programme, this is an opportunity for review about exit criteria (as per the Consumer Council feedback), and then decisions about whether they revert to ‘standard care’ or some transition version of PPC until the revised programme is underway.

### Delays to new services starting

- Robust project methodology approach to ensure major milestones are met.
- Consider extra resource support from Ko Awatea to ensure key deliverables are achieved.
- Incremental approach to implementation, phasing work to prioritise those providers able and willing to demonstrate capability with new models of care, and then grow over time as the efficacy of the model is demonstrated.
- Keep timeline, and associated risks and mitigations under review.

### Engagement with primary care sector, providers and consumers

- Key messages to general practice outlining the importance of their role and value they deliver and the importance of an equity based approach.
- Continue engagement and relationship building, recognise efforts and excellence.
- Engagement with consumers and whaanau in the target population to explain the changes will lead to better care and some of these changes will start in July 2019.
- Consider continuing Enhanced Primary Care funding for 16 practices.

### Primary Health Organisations disengage from DHB priority areas and reduce their cooperation, i.e. discontinue current data sharing arrangements

- Data sharing is part of a metro Auckland process and as such should be less susceptible to local funding arrangements.
- Where possible ensure that data sharing is a contractual requirement.
- Continue engagement at the national level to shape policy around data sharing.
- Continue collaborative working and relationship development through the Alliance Leadership forum.

### Reputational risk

- Engagement with Primary Healthcare Organisations and clear key messages around objectives to improve quality and address equity.
- Engagement with consumers and whaanau in the target population to explain the changes will lead to better care and some of these changes will start in July 2019.
- Work with the communications team to develop a communications plan and prepare materials and approaches.
## Appendix 2: Risk analysis and proposed mitigations

<table>
<thead>
<tr>
<th>Risk</th>
<th>Details</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Risk score</th>
<th>Proposed mitigation</th>
<th>Funding</th>
<th>Post mitigation Likelihood</th>
<th>Post mitigation Impact</th>
<th>Residual Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative care patients with strained incomes will no longer receive support from Primary Care, this may result in admissions to specialist services including the hospital</td>
<td>270 claims for palliative care in Quarter 1 under PPC. Limited funding provision within capitation to support palliative care patients in Primary Care and this has been a part of PPC for five years.</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Provide fee for service funding for palliative care patients who are unable to fund their own care, particularly those patients requiring home visits</td>
<td>$40,000</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Patients receiving home visits – Primary Healthcare Organisations are providing more detail but this group are potentially higher need and may be hospitalised if services cannot be provided at their place of residence</td>
<td>For those patients who have mobility issues, carer responsibilities or complex health conditions and not engaged in care as well as patients experiencing acute deterioration due to their LTC(s). Some people within this group are likely to be hospitalised if home services are not offered</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Provide fee for service funding for home visits for Maaori, Pacific and Q5 patients Links to community central and community health teams</td>
<td>$65,000</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>People at risk of hospitalisation in the target population will not receive enhanced support from primary care resulting in deteriorated health and possibly hospitalisation</td>
<td>Modelling based on the Combined Predictive Risk algorithm has highlighted that we currently have just over 2,700 patients within the target population who are enrolled in PPC with a risk score in the top 5%</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Provide fee for service interventions for patients with a high risk of hospitalisation</td>
<td>$270,00</td>
<td>2</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Reduced accessibility for people for whom cost is a barrier.</td>
<td>Over 70% of the PPC funding is utilised to support patients accessing services in the community</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Implementation of Government’s Community Service Card and under 14s policy.</td>
<td>None</td>
<td>2</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Older people</td>
<td>44% of the current interventions funding is spent on people over the age of 65.</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Implementation of Government’s Community Service Card Policy</td>
<td>None</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>
### Impact on access for pathway care

<table>
<thead>
<tr>
<th>Risk</th>
<th>Details</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Risk Score</th>
<th>Proposed mitigation</th>
<th>Funding</th>
<th>Post Mitigation Likelihood</th>
<th>Post Mitigation Impact</th>
<th>Residual Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with diabetes with moderate to high risk feet will not access podiatry services</td>
<td>The allied health component of the programme provides podiatry, dietetics and health psychology. The key concern has been raised around foot checks, where reintroduction of co-pays is likely to impact uptake. Further data has been requested from PHOs, DHB analysis indicates 800 high needs people per quarter.</td>
<td>5</td>
<td>5</td>
<td>25</td>
<td>Providing fee for service funding for podiatry and dietetics for Māori, Pacific people and Quintile 5. 52% of people receiving PPC support have diabetes. District has over 38,000 people with diabetes. Further information requested from PHOs.</td>
<td>$90,000</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Diabetic patients in the target population who cannot afford the nurse consult for insulin initiation will be referred to secondary care or will continue to have poorly controlled diabetes</td>
<td>Under PPC practice staff have been claiming for insulin initiation and titration as this is an intensive intervention and costly for patients due to the follow up contacts</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>The key mitigation is to fund insulin initiation and titration for Māori, Pacific and Q5 patients</td>
<td>$15,000</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>PHOs and practices are currently offering group Self-Management Education including a SMRC Licensed programme which is evidenced based. They</td>
<td>Self-management support: Infrastructure such as Stanford licensing, electronic workflow enablers including data collection and on-going self-management enables PHOs to continue to deliver evidenced based group</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>The key mitigation for is to continue to fund the budgeted infrastructure</td>
<td>$9,250, outside scope of transition contract</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
are reliant on the DHB for the license, resources and IT infrastructure to support the group courses

<table>
<thead>
<tr>
<th>Workforce considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
</tr>
<tr>
<td>Loss of nursing, health coach and health care assistant workforce.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationships with Primary Care/trust and confidence in the District Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
</tr>
</tbody>
</table>
| Change fatigue in Primary Care, seen as counter to government policy. | Some PHOs and practices have expressed their frustration and disappointment with the DHB’s decision to exist out of the current contracts and expressed a reluctance to engage in DHB change initiatives and programmes due to the risks and uncertainty around continuity | 5 | 5 | 25 | Mitigations could include  
• Close, joint working with Primary Healthcare Organisations to develop communications and engagement strategy.  
• Provide clarity about next steps  
• Transitional contracts  
• EPC support for key practices | Enhancing Primary Care $25,000 | 4 | 5 | 20 |

**Appendix 3: Summarised feedback from Primary Healthcare Organisations**
<table>
<thead>
<tr>
<th>Primary Health Organisation</th>
<th>Transition risks identified</th>
<th>Suggested mitigation</th>
<th>Next steps</th>
</tr>
</thead>
</table>
| NHC                         | • Practices will continue to provide care  
  • Podiatry will be impacted as patients are unlikely to pay ~$70 co-payment, pathway care an issue  
  • Combined predictive risk analysis required | • Continue with podiatry component of Allied Health contract  
  • Continue for patients identified through the combined predictive risk tool  
  • Support for nurse interventions | • None |
| Alliance Health Plus        | • Practices will continue to provide care however at a reduced level  
  • Nursing and non-regulated workforce impacted – risk of redundancies  
  • Vulnerable patients will be those receiving home visits  
  • Palliative care will be impacted  
  • Podiatry will be impacted  
  • Engagement and faith within PC could be impacted  
  • Sustainability of VLCA practices could be impacted  
  • Need certainty about next steps and future arrangements  
  • Combined predictive risk analysis required | • Continue with podiatry component of Allied Health contract  
  • Continue to support palliative care  
  • Continue some funding for Q4, potentially use any underspend from current contract to support  
  • Continue with home visiting services  
  • Continue for patients identified through the combined predictive risk tool | • Information on Flexible Funding Pool provisions and expenditure for Q1-3 requested, and plans for quarter 4 |
| ProCare                     | • Patients being faced with increased costs and potential withdrawal of support that they were expecting.  
  • Disinvestment in nursing services – making staff redundant.  
  • Pass on of costs to patients many of whom cannot afford the additional costs - many will seek ED services and or avoid assistance altogether  
  • Adverse impact on palliative care  
  • Change may be perceived by general practices (and the public) to be a disinvestment in primary care at a time when the government is saying that this is a key priority  
  • Breach of faith by the DHB | • Continue with Allied Health  
  • Continue palliative support  
  • Continue for patients identified through the combined predictive risk tool  
  • Continue with support for home visiting  
  • CSC card holding funding from Government  
  • FFP | • Information on Flexible Funding Pool provisions and expenditure for Q1-3 requested, and plans for quarter 4 |
| Total Health Care           | • Practices will continue to provide care  
  • Podiatry will be impacted, FFP is funding $400K already, however there will be a gap without additional DHB investment  
  • Self-management education will be impacted if the DHB do not continue to fund patient resources, licenses and IT. This is a key part of their model  
  • Feedback predicated on a new model and funding available in the near future that supports the most vulnerable. Need certainty about what will be next. | • CSC  
  • FFP  
  • Continue podiatry and SME  
  • Timely decision around future model and funding | • Information on Flexible Funding Pool provisions and expenditure for Q1-3 requested, and plans for quarter 4 |
<table>
<thead>
<tr>
<th>East Health</th>
<th>Combined predictive risk analysis required</th>
<th>Re-shaping FFP funding to support patients</th>
<th>Health economic evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Older patients with multiple co-morbidities receiving enhanced support, may become unwell and then be admitted to Middlemore</td>
<td>CSC</td>
<td>Information on Flexible Funding Pool provisions and expenditure for Q1-3 requested, and plans for quarter 4</td>
</tr>
<tr>
<td></td>
<td>Palliative care and home visits will be impacted</td>
<td>Continue podiatry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry and Dietetics</td>
<td>Continue palliative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practice engagement in future programmes</td>
<td>Undertaking health economic evaluation frail older people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workforce issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Combined predictive risk analysis required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Current and budgeted Long Term Condition contract investment for 2018/19

<table>
<thead>
<tr>
<th>Contract</th>
<th>2018/19 Annualised amount (000’s)</th>
<th>2018/19 Nine month value (000’s)</th>
<th>2018/19 Residual (Q4) (000’s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Proactive Care</td>
<td>$5,042</td>
<td>$3,781</td>
<td>$1,260</td>
</tr>
<tr>
<td>Allied Health (Diabetes)</td>
<td>$650</td>
<td>$488</td>
<td>$163</td>
</tr>
<tr>
<td>Model of care change and quality improvement (including Enhancing Primary Care)</td>
<td>$1,125</td>
<td>$844</td>
<td>$281</td>
</tr>
<tr>
<td>Self-management education</td>
<td>$80</td>
<td>$60</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$6,897</strong></td>
<td><strong>$5,173</strong></td>
<td><strong>$1,724</strong></td>
</tr>
</tbody>
</table>

Appendix 5: Comparison of Metro Auckland DHB Investment

WDHB and ADHB have agreements in place with the five PHOs for Palliative Care, Diabetes and CVD services within primary care. Financial details for the 18/19 year have been included below.

<table>
<thead>
<tr>
<th>Service</th>
<th>ADHB</th>
<th>WDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care</td>
<td>$238,680</td>
<td>$184,800</td>
</tr>
<tr>
<td>Diabetes Allied Health Services including podiatry and dietetics</td>
<td>$346,334</td>
<td>$665,133</td>
</tr>
<tr>
<td>General Practice Diabetes Services</td>
<td>$657,923</td>
<td>$896,311</td>
</tr>
<tr>
<td>Diabetes Self-Management Education</td>
<td>$149,935</td>
<td>$264,242</td>
</tr>
<tr>
<td>Workforce Training</td>
<td></td>
<td>$185,707</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td></td>
<td>$85,147</td>
</tr>
<tr>
<td>CVD Risk Management</td>
<td>$611,078</td>
<td>$1,125,827</td>
</tr>
<tr>
<td><strong>Total investment</strong></td>
<td>$2,003,950</td>
<td>$3,407,167</td>
</tr>
<tr>
<td>Estimated quarterly investment</td>
<td>$501,000</td>
<td>$850,000</td>
</tr>
</tbody>
</table>
Appendix 6: Summary of providers’ perspectives on the current model of care

What has been working well?

- Team based care
  - Holistic and patient-centred
  - Shared care and team based care including health coaches
  - Supports continuity
- Care planning
  - “Collaborative process driving self-management support”
  - Patient-centeredness and an opportunity to problem solve with patient
- Care Co-ordination
  - Clinical and health coach partnership
  - Warm handovers
  - Whaanau ora principles (e.g.: coordination and family centred where possible)
- Flexibility
  - Use funding for a variety of purposes, e.g.: transport and medication; home visits by health care assistant to provide outreach service for those not engaging or hard to reach
  - Allows for innovative model development
  - Supports addressing social determinants of health

What has not been working so well?

- Administrative burden takes away from time to care for patients
  - Too many contracts, too many KPIs, too many unhelpful assessments, not enough alignment
- Lack of clear goals and programme logic
  - Problems not clearly identified – what are we trying to solve?
  - Large target population, limited funding
  - “Goal posts” changing
  - Outcomes difficult to quantify and accurately measure
- Lack of practice level data to direct and support quality improvement
- Variation in models of care
- Shared Care platform not fit for purpose

What are the opportunities for change?

- Greater focus on patients and whaanau
  - Funding better aligned to patient need and better targeted
  - Work with a smaller number of patients/whaanau but more meaningfully
  - Reduce fee for service, fund for FTE and outcome
  - Providing more services outside of clinical settings and support the social determinants
  - Increase culturally safe services
  - Take a wellness and psychosocial approach
  - Reduce administration
- Support innovative models of care
  - Capture “gold nuggets” of practices who improved their model of care
  - Build on Enhanced Primary Care model of care changes
- Equity-based primary care funding
- Engaging with patients to become “activated” and self-managing
- Build change capability and leadership
- Implement health coach/navigator role
- Intersectoral assessment, planning and delivery involvement (i.e.: social, justice, education etc)
- Greater Consumer input
  - Co-design with population at risk
- Measure a range of outcomes
Key themes from all stakeholders:

Flexibility and addressing wellness and the social determinants:
- Funding directed towards equity – people with the greatest health need and/or where the funding would have greatest impact
- Flexibility to apply funding for whatever service or support is required, this will include addressing in a modest manner social determinants
- Funding to follow the patient/whaanau, so people can access services wherever necessary (need to address low trust environment between practices who fear ‘patient poaching’)
- Whaanau centred funding, linking individual funding for people from the same whaanau
- Better utilise and connect resources in other sectors and from other agencies

Engagement and relationship building:
- Outreach; reach people wherever they are and do whatever it takes
- Different engagement techniques for people who access services differently; planned care for those who regularly engage with practices, opportunistic care for those who seldom engage but do so with an acute need, alternatively outreach for those who rarely engage
- Building relationships fundamental to creating engaged patients and whaanau then, and only then, can we assess and successfully co-plan

Assessment and planning:
- Comprehensive family/whaanau assessment – single, integrated assessment, easily completed to understand the needs of the whole whaanau, their strengths and their challenges
- Joint care planning and priority setting, these goals are not typically health related, but in addressing the most important issues the health gains are likely to follow

Team based care:
- Comprehensive team based support/care, GP, nurse, navigator, whaanau ora, social worker, peer support, kaiāwhina, integrated into general practice
- Whaanau Ora practitioners, grow numbers, link with health coaches

Culturally safe models of care:
- Culture of practice, the philosophy of its approach critical to engagement
- Culture of practitioners to deliver culturally safe services, non-judgemental, do whatever it takes, use same language, flexibility of lead professional
- Mainstream General Practice need to be supported to provide culturally appropriate services, or easily access whaanau ora services for patients/whaanau that need them

Coordination and continuity:
- Continuity of care supported by team based care and access to relevant information
- Better shared health record required
- Coordination both externally and internally

Accountability:
- Flexibility in the types of outcomes measured
- DHB to be clear on priorities and not ‘chop and change’
- All providers lining up support behind patient/whaanau, reduce silos and align contracts
- Align and consolidate the number of contracts and key performance indicators
Vicky and Karen

Here are the two letters in response to my queries about the provision of health services provided for women in prison - 65% of whom are Maori women. Following this response, I have changed tack a little in that we are looking at ways to keep them out of prison and find other ways to detain them where required, but also provide primary health care. I have information that Tainui and Ngati Porou have already purchased or are looking for land/houses to provide alternatives to prison.

I have also attached a policy resolution I have proposed to Business and Professional Women NZ to take up this issue as an equity/health issue at the 2019 AGM. This explains why we are focussing on women in prison, and Maori women in particular.

Reagrds
Dianne Glenn ONZM JP
CMDHB Member
WOI Finalist Button 2015

Vicky and Karen

Thank you for your email enquiring about the services provided in relation to cervical screening, breast screening and eye testing at ARWCF. We provide services comparable to those in the wider community.

All our wahine who are eligible for smear tests and breast screening are offered these services. Smear tests are undertaken at the health centre on site. Many wahine have never had a smear test before coming to prison and this is an area where significant success has been made for women's health. Any results that require further follow up are referred to the colposcopy clinic at Manukau Super Clinic for specialist investigation. This service is provided by Counties Manukau DHB (CMDHB).

All Breast screening is undertaken at Manukau Super Clinic too by CMDHB for wahine aged 45 years and older. Again any further follow up indicated from the results of the mammogram are automatically referred to a breast specialist at CMDHB.

Those who have diabetes, and therefore at increased risk of glaucoma, have annual assessments at the eye clinic through CMDHB. Others who wish to have their eyes tested can do so through the optometrist who visits the site regularly. All those in prison are entitled up to $500 for the purchase of prescription glasses.

Dianne, you don’t ask about access to dental care. But this, like many of the health services people
access whilst with us, is a service that they often don't access whilst in their home community. Good dental care has a huge impact on people’s well being. Also mental health input for wahine at ARWCF is significant where counselling for anxiety and depression, trauma counselling or forensic mental health support and assessment. These services are provided by the Department of Corrections counsellors, external mental health NGOs and the DHBs (Waitemata and Counties).

We have a number of people who require specialist health services ranging from surgery, cancer care and maternity services and these are provided to meet as far as practical the same as in the community. Like the wider community we have an aging population and one with increasing complex health needs which means our wahine have increasing attendance at outpatients clinics to be seen by secondary or tertiary specialists at the DHB.

Our wahine at ARWCF do not pay for any of the health services discussed above. There are no charges to see a GP or nurse whilst residing in a prison.

Many women have poor health literacy (as do our men) and our goal is to provide care comparable to what a person would expect to receive from their GP/Practice Nurse. This would include understanding their individual needs and tailoring the information provided to enable the person to understand more about their health and feel empowered to manage their health needs.

This is a brief summary but I do hope it answers your questions Dianne. Please feel free to contact me should you require further clarification.

Nga mihi, Carmel

Carmel Vyas RN RM MA MPH MHP prac (Nursing) | Regional Clinical Director Health Northern Regional Office | Department of Corrections Ara Poutama Aotearoa | Central Park Corporate Centre, Building 2, Level 3, 660 - 670 Great South Road, Penrose, Auckland |
PO Box 11 612, Ellerslie, Auckland 1542 |
Phone 09 306 8380 | Ext 38480 | Mob 027 579 8428

From: RIACH, Alastair (NREGRO)
Sent: 23 November 2018 10:59 a.m.
To: 'Dianne Glenn'
Cc: VYAS, Carmel (AUCKPP)
Subject: RE: Screening Female Prisoners

Kia ora Dianne

Thanks very much for your email and for your concern for the women in our care. Reducing our prison population relies on our communities as well as the Corrections department and I am pleased that you’ve taken the time to reach out about these health issues as part of your advocacy for women.

Women (and men) who receive prison sentences are often from a socially deprived background and
may not have been accessing health services they are entitled to in the community. People may be with us for short periods such as a few weeks or for some years. Each prison has a healthcare centre with registered nurses employed by Corrections. Doctors and dentists are contracted to provide medical and dental care. The health service is comparable to that offered by a medical centre in the community.

Carmel Vyas, our Regional Clinical Director of Health, will reply to you in more detail about the points you have raised as soon as she is able.

Kind regards

Alastair Riach | Acting Regional Commissioner |
Tau waea Phone 09 375 6305 | Ext 39305 | Cell 021 768 227 |
RESOLUTION: Provision of Alternatives to Detention.

“THAT the New Zealand Federation of Business and Professional Women (BPW NZ) Inc. urge the New Zealand Government to implement the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules) and provide alternatives to detention to reduce the high number of Maori women detainees.”

Proposed by BPW NZ Life Member/Past President Dianne Glenn
Seconded by Possibly BPW Franklin

Rationale:

Women who receive prison sentences are often from a socially deprived background and may be in prison for short periods such as a few weeks or some for some years. Maori women at 10% of the total prison population, but within the Women’s prisons, 65% of the detainees are Maori women (wahine). They are frequently in prison for different reasons to other women, and especially to male prisoners. Their crimes are often petty, non-violent, often resulting from an accumulation of traffic offences and fines, some for drink-driving or under the influence of drugs. They are frequently unable to pay fines because they are unemployed, do not have a home or live in a household/relationship with little or no control over finances. The Courts are unable to confine them on Home Detention as they do not have suitable accommodation or may live in a violent relationship, and therefore also unsuitable for Parole, meaning a longer prison sentence. Children are often denied access to their mothers, with maternal care interrupted and family relationships breaking down.

Currently there are iwi who are acquiring land for housing and rehabilitation for Maori women to provide alternatives to prison. As part of the Government's implementation of the Bangkok Rules, it would be a positive move for a partnership between iwi and the Ministry of Justice and Department of Corrections, to seek and develop alternatives to imprisonment. Within these alternatives, there should be the same provision of health services as within the Women’s Prisons of New Zealand – screening for breast, cervical and bowel cancer, eye tests for poor sight (and the $500 provision for glasses), testing for glaucoma and macular degeneration, dental care and mental/trauma treatment, by prison healthcare clinics or District Health Boards, whichever in appropriate.

The UN Committee on the Elimination of Discrimination of Women (CEDAW) within its Concluding Observations of the eighth periodic report of New Zealand (20 July 2018) expressed concern in Cl.43… “that Maori women continue to be disproportionately affected by incarceration and that 65% of female inmates are Maori.” In Cl.44. the Committee recommended “the State party to implement the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules) and provide alternatives to detention to reduce the high number of Maori women detainees.”

The SDGs are committed to leave no-one behind – and yet here is one group of women who are already behind even before imprisonment. It is well documented that women in prisons have poorer health than the general population and are often suffering from substance abuse and mental health issues. They are frequently victims of violence, rape or sexual assault, many have head injuries with cognitive, behavioural and emotional consequences.

This resolution supports BPW NZ Policy Section 15.24 Mental Health : Women in Prisons (2014) which was then also adopted as Resolution 5 at the Cairo Congress (2017)

Action Plan:

1. Resolution to be put forward to NCWNZ and/or BPW International (with appropriate change in wording to reflect the Bangkok Rules)
2. BPW NZ to write to the Minister of Justice, the Minister of Women, the Minister of Health requesting them to work with the Department of Corrections Ara Poutama Aotearoa to implement the Bangkok Rules
3. and to encourage them to work positively with those iwi who have already indicated a desire to acquire land/accommodation to provide alternatives to prison for women detainees and to seek other partners.
4. BPW NZ to support Maori Women’s Welfare League in this quest.

Cost to BPW: Letter writing at no cost.

Signed: ____________________________ Date: ________________
Recommendation

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

**Note** the information contained in this update.

**Prepared and submitted by:** Dr Kate Yang, Business Manager, CM Health

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<td>Nurses</td>
<td>Jackie Venter (RN) &amp; Nikki Roy (EN)</td>
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### Student ethnicity

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### Overview of School-Based Health Services (SBHS)

CMH funds nursing services in deciles 1-5 high schools, teen parent unit and alternative education facilities within the CMH catchment. Schools are responsible for establishing, co-ordinating and delivering a SBHS according to the Ministry of Health (MOH) national service model. Nurses are employed by schools or community organisations and provide an on-site health clinic. Nurses are supported clinically by two CMH Clinical Nurse Specialists. There are approximately 44 nurses (32 FTE) employed across 24 schools, with services delivered to approximately 16,000 students.

SBHS-funded high schools also deliver the Rheumatic Fever Prevention Programme. This programme is part of the CMH Mana Kidz programme and is delivered by school nurses as an extension of their daily work, rather than by separate community health organisations (as per the primary school component).

### SBHS statistics for 2019

- Just over 14,000 students had access to an on-site health service.
- The average number of visits per student (across all high schools with a DHB-funded health service) was 4.8.
- Sexual health consultations accounted for 4.9% of all consultations whilst mental health consultations accounted for 4.1%.

### An overview of Papatoetoe High School health clinic- 2018

- Completion of Year 9 HEEADSSS assessments¹: 307 comprehensive assessments completed
- Snapshot of 2018 statistics:
  - 5855 visits to the health centre
  - 295 consultations for sexual health
  - 83 consultations for mental health
  - 90 consultations for ACC
- Access to GP/Nurse Practitioner services:
  - Papatoetoe High School does not have access to an on-site GP or Nurse Practitioner (of the 24 funded schools in the CMH catchment, 19 have a weekly GP or NP clinic). The establishment of such a service is a goal for the DHB Youth Health portfolio in 2019, if funding is secured.

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¹ HEEADSSS (Home, Education, Eating, Activities, Drugs and Alcohol, Suicide and Depression, Sexuality and Safety) is an assessment framework for working with young people and allows for early identification of mental health, Alcohol and Other Drug (AOD) issues and other information to assist young people in their development.