Community and Public Health Advisory Committees Meeting

Wednesday 29 March 2017

10.00am

Venue

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

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

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

Well Being to All.
Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 29/03/17

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna
Time: 10.00am

Committee Members
Sharon Shea – Committee Chair (ADHB Board member)
Max Abbott – WDHB Board member
Judith Bassett – ADHB Board member
Edward Benson Cooper - WDHB Board member
Zoe Brownlie – ADHB Board member
Sandra Coney – WDHB Board member
Warren Flaunty - Committee Deputy Chair (WDHB Board member)
Matire Harwood - WDHB Board member
Lee Mathias - ADHB Board member
Robyn Northey - ADHB Board member
Allison Roe - WDHB Board member

Apologies: Ailsa Claire

AGENDA

KARAKIA

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

Items to be considered in public meeting

1. AGENDA ORDER AND TIMING

2. CONFIRMATION OF MINUTES
10.00am 2.1 Confirmation of Minutes of the meeting held on 23/11/2016
Actions Arising from previous meetings

3. DECISION PAPERS
10.00am 3.1 Equally Well Consensus Position paper

4. INFORMATION PAPERS
10.30am 4.1 Pacific Health Action Plan 2016-2020

5. STANDARD REPORTS
10.45am 5.1 Planning, Funding and Outcomes Update

6. RESOLUTION TO EXCLUDE THE PUBLIC
# Auckland and Waitemata District Health Boards
## Community and Public Health Committees
### Member Attendance Schedule 2016

<table>
<thead>
<tr>
<th>NAME</th>
<th>FEB</th>
<th>MAR</th>
<th>APRIL</th>
<th>JUNE</th>
<th>JULY</th>
<th>AUG</th>
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<td>Robyn Northey</td>
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<td>Christine Rankin</td>
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<td>Elsie Ho</td>
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<td>Rev. Featunai Liuaana</td>
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<td>Dr Tim Jelleyman</td>
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✓ attended  
∗ absent  
* attended part of the meeting only  
^ leave of absence  
# absent on Board business  
+ ex-officio member
## Community and Public Health Advisory Committee (CPHAC)

### REGISTER OF INTERESTS

<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
</tr>
</thead>
</table>
| Max Abbott       | Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology  
Patron – Raeburn House  
Advisor – Health Workforce New Zealand  
Board Member, AUT Millennium Ownership Trust  
Chair – Social Services Online Trust  
Board member – Rotary National Science and Technology Forum Trust | 19/03/14     |
| Judith Bassett   | Shareholder - Fisher and Paykel Healthcare  
Shareholder - Westpac Banking Corporation  
Husband – Fletcher Building  
Husband - shareholder of Westpac Banking Corporation  
Granddaughter - shareholder of Westpac Corporation  
Daughter – Human Resources Manager at Auckland DHB | 26/01/17     |
| Edward Benson-Cooper | Chiropractor – Milford, Auckland (with private practice commitments) | 07/12/16     |
| Zoe Brownlie     | Community Health Worker – Auckland DHB  
Member – PSA Union  
Partner – Youth Connections, Auckland Council  
Son – Aro Arataki Childcare Centre | 20/01/17     |
| Sandra Coney     | Member – Waitakere Ranges Local Board, Auckland Council  
Patron – Women’s Health Action Trust  
Member – Portage Licensing Trust  
Member – West Auckland Trusts Services | 15/12/16     |
| Warren Flaunty   | Member – Henderson–Massey Local Board Auckland Council  
Trustee (Vice President) - Waitakere Licensing Trust  
Shareholder - EBOS Group  
Shareholder – Green Cross Health  
Director – Life Pharmacy Northwest  
Director – Westgate Pharmacy Ltd  
Chair – Three Harbours Health Foundation  
Director - Trusts Community Foundation Ltd | 06/12/16     |
| Dr Matire Harwood| Senior Lecturer – Auckland University  
Board Director – Health Research Council  
Director – Ngarongoa Limited, which is contractor providing services to National Hauora Coalition.  
GP at Papakura Marae Health Clinic  
Advisory Committee Member – State Foundation NZ (Maori Health)  
Member Te Ora, Maori Medical Practitioners | 09/12/16     |
| Lee Mathias      | Chair - Health Promotion Agency  
Chair - Unitec  
Acting Chair - Health Innovation Hub  
Director - Health Alliance Limited (ex officio Counties Manukau DHB)  
Director/shareholder - Pictor Limited  
Director - Lee Mathias Limited  
Director - John Seabrook Holdings Limited  
Trustee - Lee Mathias Family Trust  
Trustee - Awamoana Family Trust  
Trustee - Mathias Martin Family Trust  
Member – New Zealand National Party | 15/03/17     |
<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robyn Northey</td>
<td>Trustee - A+ Charitable Trust, Shareholder of Fisher &amp; Paykel Healthcare, Member – New Zealand Labour Party, Husband - member Waitemata Local Board, Husband – shareholder of Fisher &amp; Paykel Healthcare, Husband – shareholder of Fletcher Building, Husband – Chair, Problem Gambling Foundation, Husband – Chair, Community Housing Foundation</td>
<td>22/02/17</td>
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<tr>
<td>Sharon Shea</td>
<td>Principal - Shea Pita Associates Ltd, Contracted to Manaia PHO – delivery of workforce development training, Provider - Maori Integrated contracts for Auckland and Waitemata DHBs, Provider – Ministry of Health National Results Based Accountability training for Maori health organisations, Provider – Plunket outcomes implementation framework, Member - Children’s Action Plan Directorate Advisory Group, Safe Communities Foundation NZ – Work on pilot outcomes framework, Project member – Auckland and Waitemata DHB Maori Workforce Development project, Project member - Te Runanga o Te Rarawa Outcomes Project, Provider - multiple management consulting projects for Te Putahitanga o Te Waipounamu Whanau Ora Commissioning Agency, Strategic Advisor – Alliance Health Plus PHO Strategic Planning Project, Iwi Affiliations: Ngati Ranginui, Ngati Hine, Ngati Hako and Ngati Haua, Husband - Part owner Turuki Pharmacy Ltd, Auckland, Husband - Board member, Waitemata DHB, Husband – Director Healthcare Applications Ltd</td>
<td>22/02/17</td>
</tr>
<tr>
<td>Allison Roe</td>
<td>Chairperson – Matakanawa Coast Trail Trust, Member - Rodney Local Board, Auckland Council</td>
<td>02/11/16</td>
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2.1 Auckland DHB and Waitemata DHB Community and Public Health Advisory Committees Meeting 23 November 2016

Recommendation:
That the draft minutes of the Community and Public Health Advisory Committee meeting held on 23 November 2016 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 23 November 2016

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.04 p.m.

Part I - Items considered in Public Meeting

COMMITTEE MEMBERS:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Max Abbott (WDHB Board member) (present from 2.10pm)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Lee Mathias (ADHB Deputy Chair)
Christine Rankin (WDHB Board member) (until 3.30pm, Item 4.1)
Tim Jelleyman (Co-opted member)

ALSO PRESENT:

Dale Bramley (WDHB Chief Executive Officer)
Ailsa Claire (ADHB Chief Executive) (from 2.08pm)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Karen Bartholomew (ADHB and WDHB, Acting Director Health Outcomes)
Peta Molloy (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

WELCOME:

The Committee Chair opened the meeting with reflection and acknowledgement of the recent earthquake in the South Island.

The Committee Chair also noted that Simon Bowen (Director of Health Outcomes) had been seconded to work on the Regional Long Term Investment Plan and that Karen Bartholomew was Acting Director of Health Outcomes. The Committee thanked Simon Bowen for his contributions.

APOLOGIES:

Resolution (Moved Lee Mathias/Seconded Jo Agnew)

That apologies be received and accepted from Lester Levy, Warren Flaunty, Elsie Ho, Rev. Featunai Liuaana, Allison Roe, Robyn Northey and for early departure from Christine Rankin.

Carried
DISCLOSURE OF INTERESTS

Sandra Coney advised that she was now a member of the Portage Licencing Trust.

There were no declarations of interests relating to the agenda.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 12/10/16 (agenda pages 7-13)

Resolution (Moved Lee Mathias/Seconded Peter Aitken)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 12 October 2016 be approved.

Carried

Matters Arising (agenda pages 14-15)

The updates for the matters arising were noted.

3 INFORMATION ITEMS

3.1 Prevalence and management of diabetes (agenda pages 16-24)

(Sarah Gray (Public Health Physician), Jagpal Benipal (Senior Programme Manager), Dr Catherine McNamara (Diabetologist) and Dr Allan Moffit (Clinical Director, ProCare Health) were present for this item.

Dr Allan Moffit introduced the paper, matters that he highlighted included:

- That the report provides the Committees’ with an update on the prevalence and management of diabetes and that although there has been some issues with the accuracy of data collection, it is known that there are approximately 50,000 people with diabetes across the Auckland and Waitemata DHB districts.
- That it is important to note the disease is highest amongst Maori and Pacific (with Pacific at 15%) and Indian (11%) populations.
- That there is an increase in diagnoses of approximately 7% per annum
- That the recording of definitions by PHOs has been revisited and reset to ensure data accuracy; it is anticipated that accurate data reporting will commence in 2017.
- Noting the five work streams identified in the report (pages 21 to 24) being: systems redesign; clinical optimisation including care planning; self-management support and diabetes self-management education; workforce development and Mana Tu.
Matters covered in discussion and response to questions included:

- That the emerging model of care will challenge the status quo; there has been work undertaken by professionals in the co-design space with people who have diabetes and a workshop was also held.
- Noting that steps are being taken to increase the quality of foot checks undertaken as part of a diabetic annual review within primary care.

The Committee Chair requested an update on the prevalence and management of diabetes also be provided to the Manawa Ora Committees.

Ailsa Claire acknowledged the work of Dr Moffitt and the team.

Resolution (Moved Lee Mathias/Seconded Jo Agnew)

That the report be received.

Carried

3.2 Auckland DHB Integrated Child and Youth Mental Health & Addictions Directions 2013-23 Update (agenda pages 25 to 54)

Trish Palmer (Funder Mental health and Addictions and Chair of the Implementation Governance Group) presented this item.

Matters covered in discussion and response to questions included:

- Noting that youth particularly engage with the use of e-tools and that the recent innovation with Spark has had a lot of uptake, but a low completion rate; this has led to an App being developed.
- That there has been a small decline in youth suicide rates.
- That work is being undertaken to look at self-harm data and interventions in place in this area.
- That with regard to child health, a mental health programme update is in the early stages of development across the sector.

Trish Palmer was thanked for this report.

Resolution (Moved Tim Jelleyman/Seconded Max Abbott)

That the report be received.

Carried

3.3 Cervical Screening Update - Primary HPV screening (agenda pages 55 to 61)

Dr Karen Bartholomew (Public Health Physician, Health Gain Team) presented this item.

Matters covered in discussion and response to questions included:

- That with regard to rates of immunisation there was a good coverage for Maori and Pacific women with Auckland DHB have the highest rate nationally.
Noting that the cervical screening rate as it stands has shown remarkable results, however, there was still an inequity gap.

Karen Bartholomew was thanked for this report.

Resolution (Moved Max Abbott/Seconded Jo Agnew)

That the report be received.

Carried

4. STANDARD REPORTS

4.1 Planning, Funding and Outcomes Update (agenda pages 62 to 76)

Dr Debbie Holdsworth (Director, Funding) and Aroha Haggie (Manager Maori Health Gain) summarised this item.

Matters covered in discussion and response to questions included:

- That a programme of work is underway to determine the reasons for the decline rate for referral as part of the Raising Health Kids target. It was noted that it is a new programme. It was further noted that the importance of bringing awareness to health from preconception and earliest childhood is recognised.
- That a report will be provided to the Committees in 2017 providing an update and regional status on programmes such as Green Prescription, Active Families, Preschool Active Families and the like. The DHBs are in the process of going to market to retender these contracts.

Resolution (Moved Judith Bassett/Seconded Peter Aitken)

That the report be received.

Carried

4.2 Primary Care Update (agenda pages 77 to 120)

Tim Wood (Deputy Director and Funding and Development Manager - Primary Care, Waitemata and Auckland DHB) and Dr Stuart Jenkins (Clinical Director – Primary Care) summarised this item.

Matters covered in discussion and response to questions included:

- That with regard to system level measures, there is a baseline for each of the metro-Auckland DHBs. Clarification was sought on whether Auckland DHB separates acute bed days that are tertiary and secondary, this information will be provided by via email to Lee Mathias.
- That with regard to PHO financial incentives, this was agreed when transitioning to system level measures.
- That with regard to the percentage of government funding for primary care practices, that analysis has been undertaken in the past and that funding amounts vary depending on the practice.
Tim Wood and the team involved in this report were thanked.

**Resolution** (Moved Peter Aitken/Seconded Lee Mathias)

That the report be received.

Carried

5. **GENERAL BUSINESS**

In response to a question about Auckland Localities and the ASH rate, Tim Wood noted that an update would be provided to the Committees’.

Dr Chris Chambers and Peter Aitken noted that this was their final meeting; the Committee Chair thanked them both for their contribution and commitment to the Committee. Sandra Coney also acknowledged the Committee Chair for her work over the past year.

The Committee Chair thanked those present for their participation in the meeting.

The meeting concluded at 3.42 pm.
## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 22 March 2017

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<tr>
<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
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<th>Comment</th>
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<tr>
<td>CPHAC 23/11/16</td>
<td>4.1</td>
<td>Update on regional status on programmes such as Green Prescription, Active Families, Preschool Families and the like.</td>
<td>Tim Wood</td>
<td>Verbal update to be provided at the meeting.</td>
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<tr>
<td>CPHAC 23/11/16</td>
<td>4.2</td>
<td>Clarification on whether Auckland DHB separates acute bed days that are tertiary and secondary.</td>
<td>Tim Wood</td>
<td>To be emailed directly to Lee Mathias.</td>
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<tr>
<td>CPHAC 23/11/16</td>
<td>5</td>
<td>Update to be provided about Auckland Localities and the ASH rate.</td>
<td>Tim Wood</td>
<td>Tamaki locality update provided at the Auckland DHB Board meeting. Comparative ASH rates are included in the system level measures reporting.</td>
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3.1 Equally Well Consensus Position Paper

Recommendation:

That it be recommended to the Auckland and Waitemata District Health Boards:

That the Board endorses the Equally Well consensus position paper.

Prepared by: Lee Reygate (Portfolio Manager – Mental Health and Addictions) and Trish Palmer (Funding and Development Manager – Mental Health and Addictions)

Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

CVD - Cardio Vascular Disease
DHB - District Health Board
GP - General Practitioner
NGO - Non-Government Organisations
OHiM - Our Health in Mind five year strategic action plan 2016 to 2021
Service users - people who use mental health and/or addiction services
Te Pou o Te Whakaaro Nui - the national centre of evidence based workforce development for the mental health, addiction and disability sectors in New Zealand.
WSN - Waitemata Stake Holder Network

1. Executive Summary

This report requests the endorsement for the Equally Well consensus position paper (see Appendix 1) developed by Te Pou o Te Whakaaro Nui.

The Equally Well consensus position paper was developed to meet the physical health needs priorities within Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012-2017 through collective action. The purpose of the Equally Well consensus paper is to establish a New Zealand collaborative response to reduce the inequity of physical health outcomes between people who experience mental health and addiction problems and those who do not. Currently over 100 organisations have endorsed the consensus position paper, including Counties Manukau Health.

There is a great deal of evidence to show that people who experience serious mental illness and/or addictions have a life expectancy of up to 30 years shorter than the general population. New Zealand and international literature shows that the majority of this early mortality is due to lifestyle factors (e.g. smoking) and treatable physical illnesses (e.g. cardiovascular disease, cancers and diabetes).

The Equally Well consensus paper aligns closely with both DHBs strategic themes and to the Waitemata “Our Health in Mind” strategic plan. It also aligns and supports the current Annual Plans and proposed Annual Plans and Government priority activities for 2017/18 to improve physical health outcomes of people who access specialist mental health and addictions services.

Through the endorsement of the Equally Well position consensus paper the DHBs are making a formal commitment to finding solutions for health disparities for people who experience mental...
health and addiction problems. The endorsement is also an opportunity for the DHBs to use its organisational influence and knowledge to be a leader in Equally Well initiatives and progress.

2. **Strategic Alignment**

Strategically the Equally Well consensus position paper aligns with Waitemata DHBs promise to provide **best care for everyone** (see Table 1).

<table>
<thead>
<tr>
<th>Emphasis and investment on both treatment and keeping people healthy</th>
<th>Equally Well aims to decrease the early morbidity by increasing the physical wellbeing of people with mental illness and/or addictions.</th>
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</thead>
<tbody>
<tr>
<td>Evidence informed decision making and practice</td>
<td>Following a collaborative response Equally Well supports the on-going development of evidence and the development of service models that incorporate a physical health focus</td>
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<tr>
<td>Outward focus and flexible, service orientation</td>
<td>To put people with serious mental illness and/or addictions first we must change the focus on mental illness and/or addictions to one that includes physical health</td>
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3. **Background**

Research demonstrates that people with serious mental illness and addictions have a 10 to 30 year shortened life expectancy. In recent decades this gap appears to be widening, even in countries, like NZ, with good quality health systems. Approximately 60% of the shortened life expectancy is due to physical illness.

The list of physical illnesses that have an increased prevalence in people with serious mental illness and/or addictions is long, examples include:

- Diabetes mellitus - people with depression have 1.2 to 2.6 fold increased risk of diabetes mellitus
- Cardiovascular disease (CVD) – people with schizophrenia or bipolar disorder have two to three fold increased likelihood of CVD, particularly younger people
- Hepatitis - hepatitis B and hepatitis C infection rates are approximately five and eleven times the overall estimated population rates

There are many, complex reasons for this. Lifestyle factors (for example high rates of smoking and obesity) as well treatment specific factors (for example drowsiness being a common side-effect of psychotropic medication) account for much of this increased risk. These effects are compounded through people with serious mental illness and/or addictions receiving less screening and often lower levels of care for physical issues.

Within *Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012-2017* the physical health of service users is a priority area. To meet this priority Te Pou o Te Whakaaro Nui, a national centre of evidence based workforce development for the mental health, addiction and disability sectors in New Zealand published the ‘Equally Well’ consensus paper, a unique New Zealand initiative. The development of this paper was supported by a number of organisations including the New Zealand Medical Association, NZ Nurses Organisation, Te Ao Maramatanga NZ College of MH Nursing, NZ College of Public Health Medicine, The Royal NZ College of GPs and the Royal Australian and New Zealand College of Psychiatrists.
The purpose of the Equally Well consensus paper is to establish a collaborative response to the inequity of physical health outcomes for those with mental health and/or addiction issues. Currently over 100 organisations have endorsed Equally Well, including Primary Health Organisations (including ProCare Networks Ltd and Pegasus Health Ltd), Professional Bodies (including The Royal Australian and NZ College of Psychiatrists and The Royal NZ College of General Practitioners), Non-Government Organisations (including Emerge Aotearoa, Dayspring Trust, Equip, Supporting Families in Mental Illness, WALSH Trust and Pathways Health) and 11 DHBs (including Counties Manukau Health).

Equally Well has also received two international awards in 2016:
- The Integrated Care Award at the fourth World Congress on Integrated Care
- The Innovation and Excellence Award at the TheMHS Learning Network Conference (TheMHS Learning Network Inc. is an international learning network for improving mental health services in Australia and New Zealand)

4. Risks

The endorsement of the Equally Well position consensus paper does not commit the DHBs to any future action or cost and therefore is considered to be low risk.

While it is likely that Equally Well initiatives will incur some future cost this will be handled through the development of appropriate business cases and/or met through existing funding streams.

5. Conclusion

The Equally Well position consensus paper is well aligned to both DHBs strategic themes (including Our Health in Mind for Waitemata DHB) and our existing Annual Plans to improve the physical health of mental health and addictions service users; and the Governments planning priority (mental health and addictions) 2017/18 to improve physical health outcomes of mental health and addictions service users. In endorsing the Equally Well position consensus paper, the DHBs are making a formal commitment to finding solutions for the health disparities between people who experience mental health and addiction problems and those who do not. The DHBs also become part of a collective response to this inequity and have the opportunity to use our combined organisational influence and knowledge to lead the improvement of this significant health disparity. In return the DHBs gain the support of a wide group of committed agencies.
Equally Well

Take action to improve physical health outcomes for New Zealanders who experience mental illness and/or addiction

A consensus position paper

This consensus position paper is based on the findings of an evidence review undertaken by Te Pou (2014)¹ and has been written in consultation with representatives from the following organisations:

Matua Raik Consumer Leadership Group
New Zealand Medical Association
New Zealand Nurses Organisation
Nga Hau e Wha National Service User Group
Platform Trust
Royal Australian and New Zealand College of Psychiatrists
Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc
Te Pou

¹Te Pou o Te Whakaaro Nui. 2014. *The physical health of people with a serious mental illness and/or addiction: An evidence review.* Auckland: Te Pou.

11 September 2014
Introduction

People experiencing challenges with mental health and/or drug and alcohol use also often experience physical health problems. The associations between mental illness and/or addiction and relatively poor physical health outcomes have been well-established over many decades. However, these issues and the people who experience them have not yet been formally acknowledged as a priority.

Platform¹ and Te Pou² have been working together over the past year to develop Equally Well, an informed, collaborative response to this challenge. Equally Well aims to draw on expertise and knowledge across the health and related sectors to translate the available evidence into action.

The first phase of Equally Well was a call for New Zealand evidence and a review of published research from here and overseas to understand the physical health issues, contributing factors to poor health, and effective interventions. This review has brought together overseas and national data on the extent of the issue here, and what local services are doing to address it.

Equally Well now calls for a concerted and sustained effort by all those who can effect change including policy makers, academics, and the whole health workforce particularly primary care and mental health and addiction treatment services in partnership with the people who experience these challenges. Together we seek to make the necessary changes at policy, service delivery and individual levels³.

This consensus position paper is supported by organisations and representative bodies committed to working together to influence change in order to support better physical health outcomes for people affected. The signatories to this paper recognise there is an urgent need for coordinated action that will contribute to improved life expectancy and physical health. The driving principles of the Equally Well collaboration are that people who experience mental illness and/or addiction need:

- To be identified as a priority group at a national policy level based on significant health risks and relatively poor physical health outcomes
- To have access to the same quality of care and treatment for physical illnesses as everybody else, and in particular to have a right to assessment, screening and monitoring for physical illnesses
- To be offered support to make the connection to how they are affected physically and guidance on personal goals and changes to enhance their physical wellbeing.

We acknowledge Te Tiriti o Waitangi as the founding document of Aotearoa/New Zealand, and the rights of all New Zealanders to reach their full health potential.⁴

¹ (www.platform.org.nz) The peak body for mental health and addictions non-government organisations
² (www.tepou.co.nz) A national mental health workforce development centre which incorporates Matua Raigi, national addictions workforce development centre
³ The definition used in the evidence review of ‘people who experience serious mental illness and/or addiction’ includes those who have been diagnosed with schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder and/or addiction with the primary focus on alcohol, cannabis and methamphetamine addiction. However, it is likely that many people with other mental health conditions and/or addiction face similar challenges.
⁴ In accordance with Te Tiriti o Waitangi principles, Aotearoa and New Zealand are used interchangeably in this document.
Evidence review findings: mortality and morbidity

The situation in New Zealand is very similar to other relatively wealthy countries. People who experience serious mental illness and/or addiction die much earlier than their counterparts in the general population, with a two to three times greater risk of premature death, 5 6 Two-thirds of this premature mortality is due to cardiovascular disease, cancer, and other physical illnesses.

Māori who experience mental illness and/or addiction have a higher mortality rate than Māori in the general population (one-third greater) [1].

This group also have significantly higher rates of physical illnesses including metabolic syndrome, viral and oral health diseases, respiratory diseases, diabetes and cardiovascular disease [2,3,4,10]. A significant association has been found between anti-psychotic use and risk of diabetes [5]. The evidence is mixed regarding the prevalence of cancer; what is clear is that the outcomes for this group are much worse, indicating that timely access to diagnosis and effective treatment is problematic [1,5].

Alcohol use is causally related to more than 60 different medical conditions including gastrointestinal and liver diseases, central nervous system effects, a range of cancers, coronary heart disease and sexually transmitted diseases [23]. It is estimated that a quarter of alcohol-related deaths in New Zealand are due to cancer and a further quarter to other chronic diseases. Alcohol-related deaths for Māori are over four times the rate of non-Māori [22].

The physical health effects of illicit substance use vary according to the specific substance, method, frequency and level of use. For example, intravenous drug use has a number of health risks including transmission of blood-borne viruses [23]; methamphetamine addiction is linked to oral health disease, heart disease, and cerebrovascular complications [25,26]. The most probable effects of chronic cannabis use are bronchitis and impaired respiratory function, respiratory cancers and cardiovascular disease [23,28]. High rates of hepatitis C have been found among people who inject substances including those in opioid treatment [29].

There are notable gaps in research relating to, for example, Māori and Pacific populations as well as people with a dual diagnosis of mental illness and intellectual disability, and people with a dual diagnosis of substance use and mental illness. 8

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5 Premature death is defined as dying before the age of 65.
6 These data include people with a primary diagnosis of substance use who had premature mortality rates over two and a half times that of the population as a whole.
7 Metabolic syndrome is a disorder of energy utilization and storage, diagnosed by a co-occurrence of three out of five of the following medical conditions: abdominal (central) obesity, elevated blood pressure, elevated fasting plasma glucose, high serum triglycerides, and low high-density cholesterol (HDL) levels.
8 Although there is a growing evidence base for responding to co-existing mental illness and addiction, much of the research tends to focus on either one or the other. We acknowledge the work going on at a service delivery level to better meet the treatment needs of people with co-existing problems [31].
Evidence review findings: factors contributing to the disparity

The links between socio-economic status and mental health have been widely reported both in terms of the effects of socio-economic status on mental health and vice-versa. **Mental illness and/or addiction can further compound the disadvantages associated with low socio-economic status**, for example, through increased exposure to risk factors [24].

**The socio-economic consequences associated with mental illness and/or addiction can have a serious impact on the physical health of people affected.** Consequences include restricted access to employment, social stigma and isolation, poverty and poor housing [7]. However socio-economic status does not fully explain the disparities in health status or outcomes [6].

**People who experience mental illness and/or addiction have a greater exposure to risk factors associated with physical illnesses** such as tobacco smoking, poor nutrition, reduced physical activity, and higher levels of alcohol use [3].

'Within group' variations have also been identified such as high levels of alcohol abstinence as well as alcohol dependence. Therefore, there is a need to avoid generalisations and stereotyping [3,4].

Smoking prevalence for people who experience mental illness has been estimated at 40-50 per cent, three times the general population rate [2,3] with many people also being heavy smokers [8,9,10]. There is also evidence that many are trying to quit and/or would like help to quit and can be effectively supported with no detrimental impact to their mental health [10,11,12].

Recent systematic reviews have identified a **negative impact of psychotropic medications on physical health** due to their contribution to obesity, cardiovascular disease, poor oral health, and type II diabetes [8].

**Access to healthcare** can be problematic for people with serious mental illness and/or addiction, due to stigma and discrimination, financial constraints, and practical issues such as lack of transport [14]. Stigma and discrimination by health professionals has been identified as a key barrier in accessing adequate healthcare for people who have an addiction to an illicit substance [29]. Systemic issues such as the physical separation of physical and mental health and addiction services are also barriers to access.

**There is a lack of clarity over health professional roles and responsibilities** for the physical health needs of people who experience mental illness and/or addiction. This appears to be contributing to the disparity [15] as well as to inconsistent assessment, monitoring and documentation of physical health status.

**There is a growing body of research examining the quality of health care received by people who experience mental illness and/or addiction** with stigma and discrimination being a key factor along with diagnostic overshadowing. The quality of medical care received can be compromised, particularly in relation to general medicine and cardiovascular care, but also for cancer and diabetes care [6,13,16].
Evidence review findings: promising interventions

There is an emerging body of literature on effective strategies and interventions for improving the physical health of this group. Interventions need to occur at the level of the individual and at a systemic level, with a core aim to reduce exposure to known risk factors as well as the impact of psychotropic medications.

Systems level changes

It is clear that people who experience mental illness and/or addiction should be identified at a national policy level as a ‘priority’ health group across the whole health system, who require specialised and properly-resourced interventions in relation to their physical health [16].

Policies that can reduce health inequalities amongst groups most affected by social exclusion, vulnerability, and disadvantage should be drawn on to improve physical health outcomes for this group. These include addressing the ‘causes of the causes, i.e. the conditions in which people are born, grow, live, work and age and inequities in power, money and resources that give rise to them’ [17]. Universal approaches to public health need to be tailored to people at a level and intensity proportionate to need. It is important to avoid focusing on the individual attributes and behaviours of people who are socially excluded [17].

Changes are needed in the way health care services are structured and funded to improve integration between mental health, addiction and physical health care services, particularly in developing shared care arrangements between primary and secondary care. Methods of integration should be adapted to local needs and capacities [18] and can include:

- all relevant parties endorsing the need for linked services at a senior level, and supporting this at all levels of the service
- planning and accountability at both local and regional levels e.g. through PHOs and DHBs
- ensuring people who experience mental illness and/or addiction are at the centre of care, around which services collaborate
- promoting models of clinical collaboration such as practice nurse or GP liaison with psychiatric services, or vice-versa with psychiatry liaison into primary care
- identifying and responding to the training needs of all health professionals regarding the physical health care of people who experience mental illness and/or addiction [19].

Clinical guidelines are needed to clearly identify roles and responsibilities of all health professionals in relation to the monitoring and ongoing management of the physical health care of people who experience mental health problems and/or addiction.
Reducing exposure to risk factors

Personal interventions

Identifying and making changes can be supported by combinations of personalised support for smoking cessation, increasing physical activity, nutrition, and general wellbeing. Those based on good evidence, which are service-user directed and work towards achieving long-term sustainable lifestyle changes, have been shown to be successful at a personal and small group level [20,21]. However no simple or single approach has demonstrated long-term effectiveness. Findings from evaluations of diet and exercise programmes indicate that the following characteristics are likely to facilitate greater success:

- Build on existing therapeutic alliance
- Incorporate both cognitive and behavioural strategies
- Combine exercise, dietary counselling and health promotion
- Specific, realistic and measurable goals identified by the person seeking change and supported by the therapeutic alliance
- Are flexible in accommodating individual needs and differences and are culturally appropriate
- Are long-term and provide ongoing support beyond the initial intervention
- Include support through participation in a group and/or social component
- Acknowledge and address wherever possible the barriers faced by people participating in such programmes
- Have an active peer support component alongside health professional support [20, 21].

Conclusion

Addressing the inequalities that lead to and arise from mental illnesses and addiction is a key part of a sustainable health strategy; it is also a key part of the work of healthcare professionals in primary and secondary care, and of colleagues in other professions such as public health and government [24].
References


4.1  Pacific Health Action Plan 2016 - 2020

Recommendation:

That the Committee notes draft 2016-2020 Pacific Health Action Plan.

Prepared by: Lita Foliaki (Pacific Health Gain Manager) and Bruce Levi (General Manager Pacific Health)
Endorsed by: Dr Debbie Holdsworth (Director of Funding)

Glossary

ADHB - Auckland District Health Board
AH+ - Alliance Health Plus Primary Health Organisation
Aiga Challenge - Enua Ola and HVAZ weight loss competition
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
Enua Ola - Waitemata DHB Pacific health promotion programme
HVAZ - Healthy Village Action Zones, ADHB’s Pacific health promotion programme
PHO - Primary Health Organisation
PHAP - Pacific Health Action Plan
WDHB - Waitemata District Health Board

1.  Background

The first joint Pacific Health Action Plan (PHAP) for Waitemata and Auckland DHBs was approved in May 2014, with a timeframe of 2013-2016. It was developed after wide consultation with Pacific communities, specifically those churches and community groups that are part of the Enua Ola and HVAZ programmes. The Plan had six priorities. Wide consultation was also undertaken with communities and churches between July and September 2016 for a refresh of the 2013-2016 Plan. Consultation consisted of face to face meetings as well as an online component.

A working group, which included six people from the community, representatives of ProCare and AH+ PHOs, representatives of Pacific providers, DHB Planning and Funding, and DHB provider arm personnel received the results of the consultation and oversaw the development of the draft Pacific Health Action Plan 2016-2020, which is presented to this CPHAC meeting. The Working Group was chaired by Rev Featuna’i Liuaana, Pacific community representative on CPHAC.

2.  Draft Pacific Health Action Plan 2016 - 2020

The 2016 consultation confirmed the six priorities of the 2013-2016 PHAP, with an additional two identified. The eight priorities are:

- That Pacific children are safe and well and that families are free of violence
- That Pacific people are smoke free
- That Pacific people are active and eat well
- That Pacific people access care early
- That Pacific people use hospital services when required
- That Pacific people live in warm houses that are not overcrowded.
- Pacific People experience optimal mind health and wellbeing
- Pacific elders are valued and experience optimal health and wellbeing
In terms of the ownership and style of the 2016-2020 Plan, we retain the recommendations of the Working Group that oversaw the development of the 2013-2016 Plan:

- The Pacific Health Action Plan 2016-2020 be jointly owned by the DHBs and the Pacific communities
- The Plan be easily understood by people in the community as well as DHB personnel
- The Plan does not focus on negative Pacific health statistics that but that reality is not denied (and these statistics can be accessed from many other DHB documents/reports)
- The DHBs consider seriously recommendations from the community even if the recommendations do not have identified funding currently

The Vision of this draft Plan remains as that of the 2013-2016 Plan and it is that:

| “Pacific families live longer and healthier lives.” |

The focus therefore has been to update the priority actions and these are contained within Appendix 1.

3. How the Pacific Health Action Plan 2016 – 2020 relates to Other DHB Plans

There are existing DHB Plans that relate directly to most of the priorities put forward in this draft PHAP 2016 – 2020, they are:

- Auckland and Waitemata DHBs’ Child Health Improvement Plan 2012-2017
- Auckland DHB and Waitemata DHB Tobacco Control Plan 2015-2018
- Waitemata DHB’s Our Health in Mind Strategic Action Plan 2016-2021

Other plans are being developed and will need alignment with the PHAP 2016 – 2020, these include: the Pre-school Oral Health Strategy and the Childhood Obesity Plan. Recommendations from current service reviews will also impact on activities put forward in this Plan such as the Diabetes Service review and the review of Health of Older People Day Care Services.

The activities/actions put forward in the draft PHAP 2016 - 2020 are aligned with the goals and objectives of existing plans and contribute to implementing the objectives of those Plans. The PHAP has a focus on activities delivered in the Pacific community, a strength of the PHAP is the logistics of implementation are negotiated with churches and community groups to suit the community’s needs in terms of time, venue and content (to some extent). The content of some of the programmes such as the Living without Violence has been developed with community input. The Plan has a strong health promotion framework, whilst other DHB Plans have a stronger focus on service delivery. There is compatibility between the actions of PHAP and those of DHB Plans as the Pacific Team participates in the development of those plans.

In relation to Rheumatic Fever, the Pacific Team is jointly involved with the Planning and Funding Child Health Team as well as DHB providers in the implementation of the Rheumatic Fever Resolution Plan.

3.1 Joint Pacific Plan with Counties Manukau DHB

As part of closer alignment with Counties Manukau DHB, it was initially thought that the development of a joint PHAP would be a good way of bringing about alignment. Following discussions with Counties Manukau Pacific General Manager, agreement was reached to start with the development of a joint Child Health Plan. Two initial meetings have been positive.
4. Conclusion

The draft 2016-2020 Pacific Health Action Plan addresses some of the key areas of concern for Pacific Health through the eight priorities identified, which have been developed through widespread consultation. This Committee is asked to note the Plan, which will provide a framework for reducing inequalities and strengthening Pacific Health Gain.
Appendix 1

Pacific Health Action Plan Priorities
2016 – 2020

1. Children are Well and Safe and Families are Free of Violence

As our first priority, we want to promise every child the very best start in life. Health and well-being for children includes physical health, spiritual health, family health and mental health. In addition to activities identified in the Auckland and Waitemata DHBs’ Child Health Improvement Plan 2012 – 2017, the Pacific Health Action Plan will also deliver on the activities identified below.

1.1. Integrated and seamless maternity services
1.1.1. Work with providers to ensure that Pacific pregnant women are engaged with antenatal Services.
1.1.2. Strengthen referrals from the high risk diabetes maternity clinic at Auckland City Hospital to the AH+ Fanau Ola service.
1.1.3. Continue to implement the Healthy Babies and Healthy Futures programme for pregnant women and their families.

1.2. Rheumatic Fever
1.2.1. Actively participate in the implementation of the Rheumatic Fever Resolution Plan.

1.3. Childhood Obesity
1.3.1. Work with Healthy Families West Auckland to develop and implement nutrition and physical activity policies and practices in the Pacific Early Childhood Education Centres in West Auckland.
1.3.2. Work with the providers of the Active Families programme to engage Pacific children and families in the programme.

1.4. Oral Health
1.4.1. Work with the Auckland Regional Dental Service to develop and implement the pre-school oral health strategy.
1.4.2. Work with Pacific providers and Pacific communities to increase awareness of the importance of the dental health of children and to increase enrolment and access to community dental clinics.

1.5. Parenting Programmes
1.5.1. Work with Te Whanau o Waipareira Health Trust and The Werry Centre to deliver 5 Triple P parenting programmes in West Auckland and on the North Shore each year.
1.5.2. Deliver 5 Triple P parenting programmes in the Auckland DHB area each year.
1.5.3. Collaborate with Vaka Tautua and Penina (Tangata Ole Moana) to implement their Samoan and Tongan language parenting programmes.

1.6. Violence Free Families
1.6.1. Continue to work with the Catholic Social Services to train and mentor more facilitators to deliver the Living Without Violence programme.
1.6.2. Implement 6 Living Without Violence programmes in the Waitemata area and 6 in the Auckland area, each year.
1.6.3. Work with West Fono to align the contract that they have with the Corrections Department with the parenting programmes and Living without Violence programmes that the DHB funds.

1.6.4. Work with Tongan Health Society to implement two parenting programmes and two without Violence programmes per year for families that are identified through their services as needing support.

1.6.5. Continue to maintain links with MSD, ACC, West Fono, Vaka Tautua, Tongan Health Society so as to be informed of any family violence prevention programmes that they fund and/or implement.

1.6.6. Participate in inter-sectoral forums about family violence prevention.

2. Pacific People are Smoke-free

The smoking rates for Pacific people have dropped from 29.3% to 22.4 % but still, about 1 in 5 Pacific adults continue to smoke. In addition to activities identified in the Auckland and Waitemata DHBs’ Tobacco Control Plan 2015 – 2018, the Pacific Health Action Plan will also deliver on the activities identified below.

2.1 Smoke-free Churches
2.1.1 Work with new churches that join the HVAZ and Enua Ola programmes to ensure that they are smoke-free.
2.1.2 Create and review referral protocols between church members who want to quit smoking and the The Fono and Procare stop smoke services.

2.2 Ethnic Specific Approaches to Stop Smoking Services
2.2.1 Work with The Fono to engage Tongan men in a talanoa (dialogue) process to identify whether they want to stop smoking and if they do, to further engage them in a stop-smoke co-design process.
2.2.2 Work with The Fono to engage Cook Is women in a co-design process to inform a specific approach to increase the engagement of Cook Is women in stop smoke services.
2.2.3 Work with The Fono to engage Samoan people in a co-design process to inform a specific approach to increase the engagement of Cook Is women in stop smoke services.

3. Pacific People Eat Healthy and Stay Active

3.1 Continue to implement the Enua Ola and HVAZ healthy lifestyle programmes
3.1.1 In addition to the current programme, explore how older people can better participate in the Programmes.

3.2 Aiga Challenge Weight Loss Competition
3.2.1 Finalise analysis of the results of the Aiga Challenge over the last four years and re-design the competition to take into account findings of the analysis.
3.2.2 Increase the number of people who participate in the Aiga Challenge.
3.2.3 Increase the number and % of people who maintain weight loss since the beginning of the Aiga competition.

3.3 Aiga Challenge for Young People
3.3.1 Co-design, with young people (16 – 24 years) who have participated in the Aiga Challenge, a specific programme to assist them to maintain their weight loss and to lose more weight if appropriate.
3.4 **Collaboration**

3.4.1 Continue to collaborate with other organisations to promote healthy lifestyle such as Pacific Heartbeat, Vaka Tautua, Active Auckland, regional sports organisations, School of Population Health, researchers and Auckland Council.

3.4.2 Collaborate with Active Auckland, Green Prescription providers and Vaka Tautua to support Pacific paraplegic people, people with disability and mental health clients, with their physical activities needs.

3.4.3 Work with Pacific providers to develop and support in-house wellness programmes, to include physical, mental and spiritual wellness and also improve their financial planning/management capabilities.

4. **Pacific People Get Help Early**

The participation of eligible Pacific people in the publically funded screening programmes, such as cervical cancer screening has improved over the years and for some programmes such as breast screening, the target have been reached and exceeded. This is also true for cardiovascular risk assessment, but for the bowel screening programme in Waitemata DHB, participation is low.

Participation in community-based self-management education for those with diabetes and other chronic conditions, is improving but the reach is still very limited.

In terms of stroke, whilst the incidence in the European population has decreased over the past 20 years, in the same period, Pacific populations have shown a near doubling of stroke incidence. Strokes occur on average up to 10 to 15 years earlier than Europeans. The increased risk of stroke in Pacific people is partly attributed to a higher prevalence of obesity, diabetes and high blood pressure.

In response to the above issues, Waitemata and Auckland DHBs, as well as PHOs and other providers will undertake the activities identified below.

4.1 **Screening**

4.1.1 Waitemata DHB will continue to fund its breast screening community education service and will support women to further investigation and access to breast cancer treatment services.

4.1.2 In Auckland DHB, the parish community nursing service will continue to include breast screening education as part of its community education programme.

4.1.3 The parish community nursing services in both Auckland and Waitemata DHB will include cervical screening education as part of their service.

4.1.4 Waitemata DHB’s bowel screening programme will continue to work with The Fono and other stakeholders to find ways of improving participation from the current 36% coverage rate. This may include ethnic and gender specific approaches, as the target population largely consists of immigrant people and this is the first screening programme that includes men.
4.2 Self-Management Education
4.2.1 Ten self/diabetes-management education programmes will be delivered in the Auckland DHB area and ten will be delivered in the Waitemata area annually
4.2.2 Ten lay SME facilitators will be trained and eight current facilitators will be trained to become master trainers
4.2.3 Explore pathway for a Pacific T-Trainer who will support the SME/DSME Programmes across Auckland and Waitemata DHBs.
4.2.4 The parish community nurses will continue to provide the nursing component of the diabetes self-management education programme

4.3 Stroke Awareness and Prevention Education
4.3.1 Waitemata and Auckland DHBs will co-fund with the Stroke Foundation, the implementation of a community-based stroke awareness and prevention programme
4.3.2 The Stroke Foundation will work closely with Pacific providers, especially the Enua Ola and HVAZ programmes and the community parish nursing service, to ensure that the education programmes are aligned.

4.4 Community Cardiovascular Disease Assessment and Management
4.4.1 The parish community nursing service will continue to undertake CVD risk assessment in churches and communities and will undertake active follow-up with high risk individuals
4.4.2 A review of the parish community nursing will be undertaken to investigate whether the scope of the service is responding to priority needs and to improve its effectiveness.

5. Pacific People use hospital services when needed

Patients’ feedback on their experience of using health care services is recognised as a key marker of the quality of those services and a vital source of information for quality improvement; so improving Pacific patients’ experience of hospital services is a key priority. The competence of staff in working with Pacific patients is an essential component of improving patients’ experience.

5.1 Patient Experience
In order to improve Pacific patients’ experience of hospital services we will:
5.1.1 Engage Pacific patients, service users and their families in the review and design/redesign of services
5.1.2 Capture patient stories
5.1.3 Hold In Your Shoes engagement once a year in each of Waitemata and Auckland DHBs
5.1.4 Develop Fanau Care standards

5.2 Pacific Best Practice
5.2.1 Pacific and non-Pacific staff will be highly competent in working with Pacific patients and their families thorough the Delivery of Pacific Best Practice training to at least 200 staff per DHB annually

5.3 Violence Free Families
To support Pacific families to be violence free, Takanga ‘a Fohe, the Pacific hospital based service, will
5.3.1 Undertake violence screening in hospital setting
5.3.2 Deliver violence-free training to DHB staff
5.4 **Oral Health**
To contribute to improving oral health of Pacific children, Takanga ‘a Fohe will

5.4.1 Follow-up children who are admitted to hospital for oral health issues
5.4.2 95% of those will be referred to the ARDS

5.5 **Older people and their families will be supported specifically through**

5.5.1 Better advance care planning
5.5.2 More informed decision making by patients and families about accessing palliative care
5.5.3 Training of staff to improve competency in undertaking advance care planning and palliative care decision-making alongside patients and their families
5.5.4 Continued advice from the Matua Advisory Council to affect on-going responsiveness to the needs of older people

5.6 **Pacific patients with cancer will be supported to**

5.6.1 Receive timely access to assessment and treatment services
5.6.2 Meet the cancer care assessment and treatment targets
5.6.3 Ensure Pacific patients and their families are fully informed and engaged in decision making about treatment options and that they are supported to follow through with the treatment options that they choose
5.6.4 Identify barriers to access and those barriers are addressed
5.6.5 Engage Pacific patients / families in re-design or co-design processes
5.6.6 The Surgical and Ambulatory Service (SAS) will continue to support the Pacific Cancer Nurse Coordinator role by
   - continuing to employ a nurse with cultural and Pacific language skills to work with Pacific patients with cancer and their families as well as cancer care specialists and SAS staff to effect the above goals
   - Providing opportunities for on-going training for the Pacific cancer nurse coordinator to increase her clinical competency in working with cancer patients / families
   - Enabling the nurse coordinator to participate in Pacific specific forums within the hospital and in the community when appropriate in order to contribute to improving services in general
5.6.7 Work with Pacific providers to support cancer patients in the community.

5.7 **Pacific Workforce**
Auckland and Waitemata DHBs will continue to grow Pacific work force in the DHBs by addressing supply, recruitment, development and retention.

5.7.1 At the point of supply, the Pacific Health Science Academies will target 25 students per year per school to reach 300 students by June 2020.
5.7.2 Pacific secondary school students will be supported to engage in the Rangatahi Programme, specifically the introduction to health work days, the one week work experience and the cadetship components
5.7.3 In terms of recruitment, the Pacific Clinical Nurse Director will continue to contribute to the Working and Achieving Together (WAAT) programme for health students from Auckland University, AUT, MIT, Massey University and Unitec.
5.7.4 The Pacific Clinical Nurse Director will continue to participate in the shortlisting and interviewing of new entrance to practice nurses and new entrance to specialist programme nurses.
5.7.5 In terms of staff development, at least 10 Pacific staff would have participated in the DHB coaching programme by 2019
5.7.6 Two fono will be held each year to assist staff in career planning and progressing
5.7.7 The Pacific Health Leadership Advisory Group, currently in place in Waitemata DHB will be established at Auckland DHB
5.7.8 The Nurse Leadership Group currently in place at Auckland DHB and in Waitemata DHB will provide input into nursing development

5.7.9 Allied Health Leadership Group is established at Waitemata and will be established at Auckland DHBs and will provide input into development of allied health workers

5.8 In relation to staff wellness, the following activities will be implemented

5.8.1 Two workshops will be run annually focusing on men’s and women’s health

5.8.2 Two workshops on resilience will be implemented annually

5.8.3 The physical wellness group will continue to be held at the Greenlane Clinical Centre site weekly

5.8.4 Two financial capability workshops will be held annually for Pacific staff

5.8.5 One workshop will be held annually on the art of negotiation

5.8.6 Managers of Pacific teams will ensure that there is an ongoing focus on the wellness of team members.

6. Our families live in warm healthy houses that are not overcrowded

The strong relationship between poor housing and poor health outcomes are well established.

6.1 Kainga Ora: Healthy Homes Initiative Service

6.1.1 Auckland and Waitemata DHBs will fund the Kainga Ora Healthy Homes

6.2 Advocacy

6.2.1 The DHB representatives on the Auckland Intersectoral Population Health Group will continue to advocate for housing improvements across the three DHB areas.

6.2.2 The Child Health Stakeholder Group will continue its advocacy work which focuses on making Auckland DHB homes dry and well insulated.

7. Pacific People will experience optimal mind health and wellbeing

Both DHBs have a priority focused on mental health and wellbeing. For Waitemata DHB this is through the Our Health in Mind Strategic Plan and in Auckland DHB, this is through the Tamaki Mental Health and Wellbeing – Awhi Ora. The Pacific teams will facilitate Pacific community engagement in these initiatives through the HVAZ, Enua Ola and church community networks as a priority.

8. Pacific Elders are Valued and Experience Optimal Health and Wellbeing

The vision of the Ministry of Health’s Healthy Ageing Strategy is that older people live well, age well and have a respectful end of life in age-friendly communities. The focus of the Strategy is building and maintaining people’s physical and mental function and capacity, maintaining independence and preventing and delaying disease and the onset of disability.

8.1 Day Programmes for Elderly People

8.1.1 Dependent on the outcome of the current review of day programmes for older people, the Pacific Health Gain Team will work with the Health of Older Person team to ensure these programmes are reconfigured to ensure better outcomes for older Pacific people.
5.1 Planning, Funding and Outcomes Update

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Trish Palmer (Funding and Development Manager Mental Health and Addiction Services), Ruth Bijl (Funding and Development Manager Child, Youth and Women’s Health), Tim Wood (Funding and Development Manager Primary Care), Kate Sladden (Funding and Development Manager Health of Older People), Aroha Haggie (Manager Maori Health Gain), Lita Foliaki (Manager Pacific Health Gain), Samantha Bennett (Manager Asian Health Gain) and Jane McEntee (General Manager Auckland Regional Public Health Service).

Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Acting Director Health Outcomes).

Glossary

ACC - Accident Compensation Corporation
ALT - Alliance Leadership Team
AOD - Alcohol and Other Drugs
ARC - Aged Residential Care
ARD - Auckland Regional Dental Service
AL - Alcohol Regulatory Licensing Authority
ARPHS - Auckland Regional Public Health Service
ASH - Ambulatory Sensitive Hospitalisations
CPHAC - Community and Public Health Advisory Committee
DAR - Diabetes Annual Review
DHB - District Health Board
DLSA - Diabetes Service Level Alliance
HAT - Healthy Auckland Together
HCS - Home and Community Support Services
HEADSSS - Home Education and Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide/Depression, Safety
HNA - Health Needs Assessment
HV - Healthy Village Action Zones
ICS - Interim Care Scheme
LAP - Local Alcohol Policy
LARC - Long Acting Reversible Contraception
LCS - Local Coordinated Service
LMC - Lead Maternity Carer
MA - Methamphetamine
MHA - Mental Health and Addictions
MoH - Ministry of Health
PHAP - Pacific Health Action Plan
PHO - Primary Health Organisation
RFP - Request for Proposal
SACAT - Substance Addiction Compulsory Assessment and Treatment
SLM - System Level Measures
SPE - Statement of Performance Expectations
TAG - Technical Advisory Group
TAS - Technical Advisory Service
WTCO - Well Child Tamariki Ora
1. Executive Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata District Health Boards’ (DHB) planning and funding activities and areas of priority, since its last meeting on 11 November 2016.

Highlights

- Auckland and Waitemata DHBs topped the country for the Raising Healthy Kids (obesity) health target, with the MoH noting this was an “outstanding” result. Waitemata DHB achieved 100% and Auckland DHB 97% against a target of 95%.
- Auckland DHB, achieved the immunisation health target in Q2, with 95% of infants fully immunised at eight months of age. Only one DHB achieved a higher result.
- The 2017/18 System Level Measure (SLM) Improvement Plan is being developed by the three metro Auckland DHBs and their Primary Care Alliance leadership teams. The Ministry of Health have provided very positive feedback on the draft plan and identified it as an example of best practice nationally.

2. Planning

2.1 Annual Plans

The first draft of the 2017/18 Annual Plans have been developed, with the draft 2017/18 Auckland DHB Annual Plan presented to this meeting as a separate paper for final sign off and approval to submit to the Ministry of Health (MoH) on 31 March. Annual Plans are required to be much briefer this year, the Statements of Intent and financial sections now appear in the Appendices. We are working closely with Counties Manukau Health to ensure we explore all opportunities for alignment and identify any collaborative activities across the region.

The Statement of Performance Expectations (SPE – module of the Annual Plan) scorecard was presented for the first time to respective Board meetings. This will be further refined to provide some information on performance across the three metro Auckland DHBs for health targets and a suite of other key measures.

2.2 System Level Measure Improvement Plans

The 2017/18 System Level Measures (SLM) Improvement Plan is currently being drafted under the Auckland and Waitemata Primary Care Alliance Leadership Team (ALT) and Counties Manukau Health Alliance. The SLM Steering Group overseas six working groups related to the six SLM measures. The System Level Measures from July 2016 are:

1. Ambulatory Sensitive Hospitalisations (ASH) rates for 0-4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality

Two new developmental measures for 2017/18 (not yet finalised by the MoH):
5. Youth access to and utilisation of youth-appropriate health services
6. Proportion of babies who live in a smoke free household at six weeks post birth

We are working with Counties Manukau Health to develop a tool to report SLM head measures and the selected contributory measures developed in the Improvement Plans on a quarterly basis along with progress to date on planned activities to improve performance.
3. Primary Care

3.1 Primary Care Scorecard

The Primary Care Scorecard (Figure 1) is a standardised tool that is used by both Auckland and Waitemata DHBs to internally review and track performance against a range of measures including the National Health Target. The Scorecard shows for each measure the actual performance of both DHBs during Quarter Two (Q2) 2016/17.

Figure 1: Auckland and Waitemata DHB Primary Care Scorecard (Q2, 2016/17)

<table>
<thead>
<tr>
<th>Health Targets - Auckland DHB</th>
<th>Health Targets - Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual</strong></td>
<td><strong>Target</strong></td>
</tr>
<tr>
<td>Better help for smokers to quit - primary care</td>
<td>Better help for smokers to quit - primary care</td>
</tr>
<tr>
<td>88%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Keys notes**

- **Health Targets**
  - Waitemata DHB
  - Best Care - Waitemata DHB
  - Service Delivery - Waitemata DHB

- **Trend indicators**
  - **Actual**
  - **Target**
  - **Trend**

**Service Delivery - Auckland DHB**

<table>
<thead>
<tr>
<th><strong>Enrolment</strong></th>
<th><strong>Actual</strong></th>
<th><strong>Target</strong></th>
<th><strong>Trend</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO enrolment - Total</td>
<td>85%</td>
<td>95%</td>
<td>--</td>
</tr>
<tr>
<td>PHO enrolment - Māori</td>
<td>77%</td>
<td>95%</td>
<td>--</td>
</tr>
<tr>
<td>PHO enrolment - Pacific</td>
<td>107%</td>
<td>95%</td>
<td>--</td>
</tr>
<tr>
<td>PHO enrolment - Asian</td>
<td>69%</td>
<td>95%</td>
<td>--</td>
</tr>
<tr>
<td>PHO enrolment - Other</td>
<td>92%</td>
<td>95%</td>
<td>--</td>
</tr>
</tbody>
</table>

**Service Delivery - Waitemata DHB**

<table>
<thead>
<tr>
<th><strong>Enrolment</strong></th>
<th><strong>Actual</strong></th>
<th><strong>Target</strong></th>
<th><strong>Trend</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO enrolment - Total</td>
<td>92%</td>
<td>95%</td>
<td>--</td>
</tr>
<tr>
<td>PHO enrolment - Māori</td>
<td>87%</td>
<td>90%</td>
<td>--</td>
</tr>
<tr>
<td>PHO enrolment - Pacific</td>
<td>90%</td>
<td>90%</td>
<td>--</td>
</tr>
<tr>
<td>PHO enrolment - Other</td>
<td>92%</td>
<td>90%</td>
<td>--</td>
</tr>
</tbody>
</table>

**How to read**

- **Performance Indicators**
  - Achieved On track
  - Substantially Achieved but off target
  - Not Achieved but progress made
  - Not Achieved Off track
  - Performance improved compared to previous month
  - Performance decline compared to previous month
  - Performance maintained

**Key notes**

- **Source:** MOH quarterly report
- **Contact:** Victoria Child, Reporting Analyst, Planning & Health Intelligence Team, victoria.child@waitematadhb.govt.nz

**A question?**

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 29/03/17
3.1.1 Better Help for Smokers to Quit

DHB Target: 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

The ‘Better Help for Smokers to Quit’ result is reported as a National Health target. Both Auckland and Waitemata DHBs have not achieved the primary care ‘Better Help for Smokers to Quit’ health target in Q2, 2016/17. Final results provided by the Ministry, showed Auckland DHB performance at 87.7% and Waitemata DHB at 88.3%. Auckland DHB is ranked 7th and Waitemata DHB is ranked 5th nationally for Q2. Both Auckland and Waitemata DHBs have made improvements with this target in Q2, 2016/17.

None of the Auckland PHOs achieved the 90% target; ProCare has successfully achieved 91.3% in Waitemata DHB. Results by PHO are as follows:

Table 5: PHO Results for Better Help for Smokers to Quit 90% Target, Q2, 2016/17

<table>
<thead>
<tr>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland PHO</td>
<td>ProCare</td>
</tr>
<tr>
<td>Alliance Health Plus</td>
<td>83.6%</td>
</tr>
<tr>
<td>National Hauora Coalition</td>
<td>79.8%</td>
</tr>
<tr>
<td>ProCare</td>
<td>89.5%</td>
</tr>
<tr>
<td>Waitemata PHO</td>
<td>84.7%</td>
</tr>
</tbody>
</table>

The PHOs are undertaking similar activities to the previous quarters to support their practices. The PHOs are prioritising activities and events as per their Smokefree plans to proactively reach more smokers and achieve the target. The Primary Care team is monitoring PHO performance closely and have requested for the PHOs to provide weekly reports on their activities. The weekly updates provide information on the progress being made and interventions and activities applied at a practice level by the PHOs.

Results related to ethnicity data reported by PHOs for Q2 2016/17 for Maori and Pacific are shown in the Table 6:

Table 6: Auckland and Waitemata DHBs ‘Better Help for Smokers to Quit’ Ethnicity Data (Q2, 2016/17)

<table>
<thead>
<tr>
<th>District Health Board</th>
<th>Maori</th>
<th>Pacific</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>87.8%</td>
<td>87.9%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>89.0%</td>
<td>89.9%</td>
<td>88.3%</td>
</tr>
</tbody>
</table>
3.1.2 Improving Population Health – Diabetes Management

DHB Target: A minimum of 75% of people who have had a Diabetes Annual Review (DAR) will have an HbA1c of <= 64mmol/mol.

Improving the health outcomes of people with diabetes continues to be a priority area for both Auckland and Waitemata DHBs. To support this priority the Diabetes Service Level Alliance (DSLA) is working towards developing strategies/interventions/processes to achieve this goal.

One of the barriers to improving the health of people with diabetes is sub-optimal data quality/reliability. The CPHAC paper titled “Prevalence and management of diabetes” identified these data extraction issues (Waitemata DHB Community and Public Health Advisory Committee Meeting, November 2016). A standardised reporting template is being developed which will be used by all PHOs across both Auckland and Waitemata DHBs. This approach aims to bring consistency to data reporting for both the diabetes and CVD indicators. Subject to being able to implement this consistently across all general practices we expect to be able to report more accurately on the HbA1c status of our population by the end of Q4, 2016/17.

3.1.3 PHO enrolment

PHO enrolment remains below target, particularly for our Asian population. Analyses undertaken related to Asian PHO enrolments are discussed in section 9.2 of this report.

3.2 Integrated Pharmacist Services in the Community Background

Over the past year, forums held regionally and nationally identified collaborative opportunities for pharmacists to maximise their contribution across the health and social sectors. During these forums, DHBs’, the MoH, PHARMAC and a range of stakeholders across primary care, including consumers, worked in partnership with the pharmacy sector, to better understand ways pharmacists can contribute to meet growing health needs of the population. Consumers were invited to both local

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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 29/03/17
DHB and national stakeholder forums to share their experience of accessing current services offered by pharmacists, including how these services could be improved further to fully meet their health needs. It is vital to have combined forums with health professionals and consumers to achieve integration of pharmacist services into multidisciplinary teams that delivers services to consumers who are at the centre of healthcare.

As a result of these forums, a new vision called ‘Integrated Pharmacist Services in the Community’ was developed. This vision recognises that pharmacists have the capability and capacity to make a valuable contribution to the achievement of the New Zealand Health Strategy. This is likely to be achieved through the integration of pharmacists with members of multidisciplinary primary care teams. Being members of these teams, they are likely to have opportunities to lead and participate in a wide range of health services that focus on supporting the health and wellness of New Zealanders, promote pharmacists as experts in medicines management and improved access to services delivering improved health outcomes.

**Integrated Pharmacist Services in the Community**

In September 2016, the vision booklet was released by the Technical Advisory Service (TAS), on behalf of the 20 DHBs, to all key stakeholders. This vision booklet is called ‘Integrated Pharmacist Services in the Community: evolving consumer focused pharmacist services’ and outlines a model that places people at the centre, and one that supports pharmacists to strengthen their role as key members of the wider primary care team and experts in medicines management. Some of the key discussion themes included:

- Ways primary care and community services can work better to make the most of pharmacist services in the broader primary care environment
- Local engagement and initiatives to help shape the future of pharmacist services in the community
- Aligning pharmacist services to support delivery of care across wider primary care and, where appropriate, to deliver on key government strategies, such as the New Zealand Health Strategy, Implementing Medicines NZ and the Pharmacy Action Plan 2016 to 2020.

**Next Steps**

Various stakeholders will be working together with DHBs to develop the future service model, and this model will be implemented over the coming years to achieve the vision. DHBs in collaboration with the pharmacy sector have established a new governance structure to support, govern and inform the required programme of work. This governance structure consists of an Expert Advisory Group and the Contract Group. DHBs’ have started discussions with the pharmacy sector as part of the development of a new contract as the current contract expires on 30 June 2017. Consumers will continue to play an important role in the development of pharmacist services to help DHBs achieve their vision for pharmacists to offer an ever-expanding range of clinical services to support the community.

**4. Children, Youth and Women**

Figure 2 below, The Auckland and Waitemata DHB Child, Youth and Women’s Health Scorecard, presents information on significant health outcomes for children, youth and women. The indicators cover the life-course of maternity, child and youth health, as well as women’s health. All indicators are presented as a Total with separations by Māori, Pacific and Asian ethnicity.
### Auckland and Waitemata DHBs Child, Youth and Women's Health Scorecard (Q2, 2016/17)

**March 2017**

#### How to read

- **[ ]** indicates new information.
- **<** indicates performance better than the previous period.
- **>** indicates performance worse than the previous period.
- **≈** indicates performance similar to the previous period.
- **↑** indicates performance improving.
- **↓** indicates performance declining.
- **−** indicates performance has not been calculated.
- **<** indicates performance has not been calculated.
- **Target** indicates the target achievement level.
- **Period** indicates the period of performance.
- **Actual** indicates the actual achievement level.

#### Auckland DHB

<table>
<thead>
<tr>
<th>Indicator Title</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully immunised by 8 months - Health Target</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>95%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Maori</td>
<td>87%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Pacific</td>
<td>96%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Asian</td>
<td>96%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Other</td>
<td>94%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Fully immunised at 2 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>94%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Maori</td>
<td>90%</td>
<td>95%</td>
<td>Q2 2016/17</td>
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<tr>
<td>Pacific</td>
<td>96%</td>
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<tr>
<td>Asian</td>
<td>96%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Other</td>
<td>91%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Fully immunised at 5 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>86%</td>
<td>90%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Maori</td>
<td>86%</td>
<td>90%</td>
<td>Q2 2016/17</td>
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<tr>
<td>Pacific</td>
<td>86%</td>
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<td>Q2 2016/17</td>
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<tr>
<td>Asian</td>
<td>86%</td>
<td>90%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Other</td>
<td>81%</td>
<td>90%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Raising Healthy Kids - Health Target</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>97%</td>
<td>95%</td>
<td>CY2016</td>
</tr>
<tr>
<td>Maori</td>
<td>94%</td>
<td>95%</td>
<td>CY2016</td>
</tr>
<tr>
<td>Pacific</td>
<td>99%</td>
<td>95%</td>
<td>CY2016</td>
</tr>
<tr>
<td>Other</td>
<td>97%</td>
<td>95%</td>
<td>CY2016</td>
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<tr>
<td>Rheumatic Fever rate*</td>
<td>5.40</td>
<td>1.10</td>
<td>CY2016</td>
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</table>

*acute cases per 100,000 population

#### Waitemata DHB

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<th>Actual</th>
<th>Target</th>
<th>Period</th>
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<td><strong>Children</strong></td>
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<tr>
<td>Fully immunised by 8 months - Health Target</td>
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</tr>
<tr>
<td>Total</td>
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<td>Q2 2016/17</td>
</tr>
<tr>
<td>Fully immunised at 2 years</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>93%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Maori</td>
<td>90%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
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<td>95%</td>
<td>95%</td>
<td>Q2 2016/17</td>
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<td>Asian</td>
<td>96%</td>
<td>95%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Other</td>
<td>87%</td>
<td>95%</td>
<td>Q2 2016/17</td>
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<td>Fully immunised at 5 years</td>
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<td></td>
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<tr>
<td>Total</td>
<td>86%</td>
<td>90%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Maori</td>
<td>86%</td>
<td>90%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Pacific</td>
<td>91%</td>
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<td>Asian</td>
<td>89%</td>
<td>95%</td>
<td>Q2 2016/17</td>
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<td>Other</td>
<td>96%</td>
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</tr>
<tr>
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<td></td>
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</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Maori</td>
<td>98%</td>
<td>100%</td>
<td>Q2 2016/17</td>
</tr>
<tr>
<td>Pacific</td>
<td>100%</td>
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</tr>
<tr>
<td>Other</td>
<td>101%</td>
<td>100%</td>
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<tr>
<td>Rheumatic Fever rate*</td>
<td>3.10</td>
<td>0.70</td>
<td>CY2016</td>
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</table>

*acute cases per 100,000 population

#### Women

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<th>Target</th>
<th>Period</th>
</tr>
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<tbody>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical screening rate (25-69 years: 3 year coverage)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>71%</td>
<td>80%</td>
<td>Dec-16</td>
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<td>Maori</td>
<td>66%</td>
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<td>Pacific</td>
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<td>Breast screening rate (50-69 years: 2 year coverage)</td>
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<tr>
<td>Total</td>
<td>64%</td>
<td>70%</td>
<td>Dec-16</td>
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<td>65%</td>
<td>70%</td>
<td>Dec-16</td>
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<td>Pacific</td>
<td>74%</td>
<td>70%</td>
<td>Dec-16</td>
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<tr>
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<td>63%</td>
<td>70%</td>
<td>Dec-16</td>
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#### Youth

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<th>Period</th>
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<tbody>
<tr>
<td><strong>Youth</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>HEEDASS coverage in DHB funded school health services</td>
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<td></td>
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</tr>
<tr>
<td>Total</td>
<td>93%</td>
<td>95%</td>
<td>CY2016</td>
</tr>
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</table>
4.1 Immunisation Health Target
The immunisation health target is a continuing challenge as new cohorts of infants enter the health system and require a series of three vaccinations at six weeks, three months and five months of age. This target will continue to be a priority for the team. For Auckland, the immunisation health target was achieved in Q2, with 95% of infants fully immunised at eight months of age. Only one DHB achieved a higher result. In Waitemata, we did not achieve the target, with 92% of infants fully immunised. The difference can be accounted for by different patterns of declines in Waitemata. Rates at eight months, against the 95% target are shown in the scorecard. Results for Pacific and Asian exceed the target, however are lower for Maori (91% in Auckland and 87% in Waitemata). In Waitemata DHB a social marketing campaign has been commissioned particularly targeting younger parents and those who are delaying immunising their baby. Increasing efforts will be going into pregnancy immunisation and consideration is being given to establishing a Saturday morning clinic at Waitakere.

4.2 Obesity Health Target – ‘Raising Healthy Kids’
Both Auckland DHB and Waitemata DHB topped the country for the Raising Healthy Kids (obesity) health target, with the MoH noting this was an “outstanding” result. Auckland DHB achieved 97% and Waitemata DHB 100% of obese children identified had their referral acknowledged.

The target is; by December 2017, 95 percent of obese children identified in the Before School check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. Data is based on all acknowledged referrals for obese children up to the end of the quarter from Before School checks occurring in the six months between 1 June and 30 November 2016.

The processes and additional resources that the DHBs have put into this programme of work have meant this health target has been achieved a year ahead of the required timeframe. Efforts over 2017 will focus on maintaining these excellent results as well as exploring and evaluating issues around referrals being declined by families. Declines are nearly 20%. At this time, declines are excluded from the target, unlike the immunisation target. This may change over time as other DHBs get closer to achieving the Raising Healthy Kids’ target. In Q3 we are undertaking further work on declines, including investigating which referral pathways families prefer and developing an understanding of their experience of interacting with a health professional.

4.3 Rheumatic Fever
We have not achieved a reduction in reported first hospitalisations for episodes of Rheumatic Fever, with rates of 5.4 in Auckland DHB and of 3.1 per 100,000 in Waitemata DHB in the 2016 calendar year. This is in spite of a range of activities designed to deliver improvements and health gain from prevention through to on-going management.

4.4 Child Health
The focus continues to build on multiple enrolments for newborn infants, which is also part of the Ambulatory Sensitive Hospitalisation (ASH) SLM Improvement Plan. In 2016, both Auckland and Waitemata DHBs implemented communications to better inform new parents about free health services for their baby. Building on this success, Auckland DHB has started a one year pilot New Born Enrolment Coordination role. This is a midwife led service based in the Community Midwifery team, with the aim of improving early connections with Well Child and General Practices. The priority focus is for Maori, Pacific babies and those living in lower socio-economic areas. A parallel role is under consideration in Waitemata DHB.

In 2016 the new-born enrolment process with oral health was streamlined. This new process was rolled out in Waitemata DHB from October 2016 and in Auckland DHB from November 2016 and has
shown a dramatic increase in enrolment by one year of age. It will take a full year to show the full effect in the data reported. It is expected that 95% of one year olds will be enrolled by December 2017, which is the measure reflected for oral health in the ASH SLM Improvement Plan. There are marked inequalities in enrolment so further strategies are being developed for Maori and Pacific babies. Further analysis is also being undertaken to ensure ethnicity is captured accurately. Work is also occurring with Well Child Tamariki Ora providers to ensure the Auckland Regional Dental Service (ARDS) are notified of babies who are not enrolled, for example babies who are new to the area. Early enrolment is the first step towards improving utilisation by one year of age.

To improve the oral health status of pre-schoolers in the metro Auckland region an oral health preschool strategy is being developed. This has a strong focus on Pacific children, reducing inequalities and ensuring earlier access to the oral health service. Components of the strategy are included in the ASH SLM Improvement Plan In addition a new Professional Lead has been employed who is reviewing the model of care for ARDS.

4.5 Youth Health
The Youth Health Alliance established between Auckland DHB and Auckland PHOs continues to work well, an evaluation commissioned by the Youth Health Alliance produced by Malatest International demonstrated extremely positive results in relation to the psychologist in schools service, including increased access and utilisation for males, Maori, Pacific and Asian young people.

Following a procurement process last year, Waitemata has entered into an agreement for Integrated Youth Primary Health Care Services. This is inclusive of primary mental health and school based health services. HealthWEST continues to be the provider. Under the refined service specification, HealthWEST will deliver more primary health care to young people through their youth clinics. They will also provide services out of more locations including Henderson, Glenfield, Orewa, and New Lynn. There is some flexibility regarding service location and these may be further refined over time.

In 2016, 1,974 young people in Auckland and 1,161 in Waitemata had a comprehensive wellness check or HEADSSS assessment. Of Year 9 students, this represents 93% of the students in the ten Auckland DHB funded school based health service schools and 88% in Waitemata DHB. Results for both DHBs were very pleasing.

4.6 Women’s Health
Information reported to CPHAC under this heading includes maternity and cervical and breast screening. Last year CPHAC received information regarding changes to the cervical screening programme being planned for introduction in 2018. Maori women in particular are not screened at the same levels as other ethnicities. As part of the focus groups within the HPV Self-Sampling research being undertaken by Dr Karen Bartholomew, women are being asked about the barriers to screening and how these might be overcome. Low cervical screening coverage for Asian women is discussed further in section 9.2 of this report.

The Pregnancy and First Year of Life Alliance focuses on what we need to do to improve health outcomes during the first 1000 days (pregnancy and the first two years of life). The group, comprised of DHB and community managers and clinicians has received a range of evidence based information and is in the process of agreeing a number of priority projects. These currently include:

1. Working to improve information flows between Lead Maternity Carer (LMC)/GP/Well Child Tamariki Ora (WCTO)/DHB
2. Further developing the pregnancy and parenting information website and app, including modules for pre-conception and the first 1000 days
3. Improving access to free Long Acting Reversible Contraction (LARC)

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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 29/03/17
4. Identifying anxiety and depression and increasing services for women (and partners) experiencing mild to moderate anxiety and/or depression during pregnancy and the first 12 months post-partum
5. Progress a Maternal Oral Health business case
6. Reviewing coverage and volume of services provided for Family Violence
7. Developing a ‘whole of whānau’ attachment and perinatal Mental Health service
8. Developing hands on delivery of parenting skills for teen mums/at risk women and families.

5. Health of Older People

5.1 Home and Community Support Services (HCSS)
As part of the Settlement Agreement for Inbetween Travel, guaranteed hours for support workers will be implemented on 1 April 2017. During February meetings were held with regional HCSS providers to discuss the planning and implementation process. Providers and unions have been hosting workshops for employees.

Guaranteed hours are defined as the greater of either
• 80% of the employee’s average total hours (including any paid leave) over the 3 months prior to 1 December 2016; or
• the regular client hours as agreed by the employer and the employee.
Genuine casual workers are excluded from guaranteed hours.

The MoH will vary the Crown Funding Agreement to pass funding onto DHBs but this will be fiscally neutral to DHBs. There will be a wash up mechanism at 30 June 2017 and 30 June 2018.

Current contracts with HCSS providers will be varied by 31 March 2017. Providers will claim for cancelled clients visits (according to an Operational Policy Document) using the same system as currently used for Inbetween Travel claims. This will enable the workforce to be paid a wage as opposed to the current workforce which is paid on piecemeal basis as assignment workers.

5.2 Aged residential Care
5.2.1 Age Residential Care Funding Model Review
An Aged Residential Care (ARC) Funding Model Review project is underway. The Review will consider issues identified with the current funding model and attempt to address them in a manner which is both fair and equitable. Terms of Reference have been finalised for the Review, which will actively consider the relationship with other parts of the system such as primary and acute hospital care. A Steering Group will manage the project on behalf of consumers, DHBs and providers. The Review will be completed by December 2017.

5.2.2 interRAI (standardised clinical assessment)
interRAI education and support services transitioned from DHBs to Technical Advisory Services (TAS) on 1 October 2016. Previously DHBs were funded to employ an interRAI Lead Practitioner and Systems Clinician, however, the delivery of this service is now being managed at a national level by TAS. The aim is to have a more consistent, integrated service nationally and make greater use of interRAI data including benchmarking across DHBs. The Northern Region HoP Programme Managers have set up quarterly meetings with the national interRAI team to enable regular sharing of information and address any emerging issues.

At the end of February individual ARC facility interRAI reports were released and are accessible to facilities. These reports are at an aggregated level and enable ARC providers to compare their
residents’ health status with other similar facilities and against the DHB, other DHBs and all New Zealand.

**interRAI Measures**
There are currently three interRAI measures required by the Ministry of Health; these are reported in the tables below.

Table 1: The proportion of people receiving HCSS who have had an interRAI assessment (reported one quarter in arrears)

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1 2016/17</th>
<th>Quarter 2 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>97.3%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>97.9%</td>
<td>97.9%</td>
</tr>
</tbody>
</table>

Table 2: The proportion of people admitted to an ARC facility from the community who have had an interRAI Home Care Assessment in the six months prior to the ARC facility admission date

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1 2016/17</th>
<th>Quarter 2 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>83%</td>
<td>86%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>88%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Table 3: The proportion of people in aged residential care who have a subsequent Long Term Care Facility (LTCF) Assessment completed within 230 days of their previous assessment

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1 2016/17</th>
<th>Quarter 2 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>83%</td>
<td>85%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>82%</td>
<td>82%</td>
</tr>
</tbody>
</table>

5.2.3 Audits
20 ARC facilities have been audited in the second quarter of 2016/17 across Auckland and Waitemata DHBs. Of the 11 audits occurring at Waitemata DHB, two were for new facilities:
- Bert Sutcliffe (Ryman) – opened on 31 October 2016 with 41 rest home and hospital beds and secure dementia beds are to open in March 2017
- Hugh Green (Bupa) – opened on 28 November, with 24 secure dementia beds and 76 rest home/hospital beds.

<table>
<thead>
<tr>
<th></th>
<th>ADHB</th>
<th>WDHB</th>
<th>ADHB</th>
<th>WDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of audits</td>
<td>11</td>
<td>9</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Average number of corrective action per audit</td>
<td>1.6</td>
<td>5</td>
<td>2.5</td>
<td>3.5</td>
</tr>
<tr>
<td>facilities &gt; 5 corrective actions</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Corrective actions relating to health and safety (% of total CAs)</td>
<td>4 (22%)</td>
<td>21 (49%)</td>
<td>16 (59%)</td>
<td>16 (42%)</td>
</tr>
<tr>
<td>Facilities with no corrective actions</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Facilities achieving a continuous improvement*</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Number of complaints the DHB received on ARRC</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

** The gold standard attainment against an audit criterion is ‘continuous improvement’ (CI). CI is achieved when a criterion is fully attained and continuous improvements against the Health and Disability Sector Standards are demonstrated indicating quality improvement processes in place against service provision and consumer safety or satisfaction.
5.4 Other Health of Older People Activity
Both Auckland and Waitemata DHBs have signed the Partnering Agreement with ACC for the Falls Prevention Programme. In-Home Strength and Balance programmes to reduce falls in frail older adults have been launched in both DHBs. These services are currently being promoted to GPs.

The Health of Older People team is reviewing the Interim Care Scheme (ICS) across both DHBs to identify improvements and inform a future procurement process. ICS is short term admissions of inpatients into residential care (hospital level certified) when a patient does not have an acute medical condition that requires an acute hospital bed but are unable to be managed safely and appropriately at home e.g. a patient who is non-weight bearing for a period of time. Other areas currently being reviewed are day service contracts and respite care.

6. Mental Health and Addictions

6.1 Auckland DHB Tāmaki Mental Health and Wellbeing Initiative
The Tāmaki Mental Health and Wellbeing initiative, Primary Care/NGO integration pilot began in September 2015. This pilot linked three NGOs with two GP practices and has led to significant learning and further Tāmaki practices requesting to join the trial.

Currently 13 practices and seven NGOs have been linked to the Tamaki pilot. The expanded pilot includes all four Auckland DHB PHOs and all Auckland DHB contracted NGO support hours providers, it also now extends into other localities. Other practices have indicated that they wish to be part of the expansion of this pilot and it is expected that over 10% of Auckland DHB practices will be involved by June 2017.

NGO providers report they have insufficient Support Hours to meet the support needs of service users under Auckland DHB specialist services and to further increase the support to Primary Care. The continued growth of the Tāmaki primary care/NGO integration initiative will require further investment in Support Hours by Auckland DHB. A business case is being considered for this.

6.2 Auckland DHB Review of Residential Rehabilitation
The review of Auckland DHB Residential Rehabilitation services began in early 2016/17. The rationale for this review was the large aging cohort of people with high support needs who are expected to gradually exit Residential Rehabilitation services. As this cohort of people exit residential services an approach will be taken to reduce the number of beds with the reallocation of this funding to Support Hours based services.

The purposes of this review, led by the DHB Mental Health Local Coordination Service (LCS), are to identify:
- The number of Residential Rehabilitation beds required once the identified cohort has exited
- Existing Residential Rehabilitation services that could be reconfigured to Support Hours based services as the identified cohort exits services.

To date the following actions have occurred:
- Ten beds with Framework Services Ltd were identified by LCS as suitable to be reconfigured. These beds were transitioned to Support Hours in August 2016, with Board approval
- Five beds with Affinity Services Ltd have been identified by LCS as suitable to be reconfigured pending Board approval
- Six beds with Emerge Aotearoa Ltd been identified by LCS as suitable to be reconfigured, Auckland DHB Board approval will be sought for this transition.
The review process will continue until all NGO Residential Rehabilitation services have been reviewed. The review will be repeated in future years to inform future transitions.

6.3 Health Needs Assessment Project
To support planning across both Auckland DHB and Waitemata DHB primary and specialist care in the Mental Health and Addiction Services, the Health Gain Team is undertaking a focused physical Health Needs Assessment (HNA) for all Mental Health specialist service users engaged with services for greater than one year.

This project responds to the fact that people with serious mental illness typically live between 10 and 32 years less than the general population. Around 80% of this higher mortality rate is attributed to the much higher rates of physical illnesses, such as cardiovascular and respiratory diseases and cancer experienced by people with serious mental illness. This is a global phenomenon, it is increasingly recognised that much more needs to be done to address the gap in physical health and life expectancy between those who live with a mental illness and those who don’t. Overall prevalence of mental illness and addictions is 20.7% of adults, but is much higher for Māori (30%) and Pacific peoples (24%). Enabling good data on ethnicity and age groups of people will support funding bids for future targeted programme delivery.

The project is focused on the physical health status of people with chronic serious mental health conditions (that is greater than one year) to:
- Establish a baseline of what we know and can measure now in Waitemata and Auckland DHBs
- Quantify areas of need and service gaps
- Allow the estimation of cohort population numbers e.g. by ethnicity, age group or setting, to inform targeting of future activity
- Support primary care delivery of services
- Inform a monitoring and evaluation strategy to measure the impact of Equally Well interventions.

6.4 Fit for the Future
The MoH is seeking to identify innovative, sustainable solutions to help address the increasing demand on specialist Mental Health and Addictions (MHA) services. The Fit for the Future programme of work is about improving responses and outcomes for people whose mental health and addiction needs are not easily met in primary care, but who do not meet the threshold for specialist mental health care. The Fit for the Future proposition is that increased support through primary and community care will enable this group to experience improved outcomes and will help to rebalance demand pressures across the continuum of care. Auckland and Waitemata DHBs were both selected to progress through to the next stage, a closed Request for Proposal (RFP) in the MoH programme: Existing Initiatives for Investment in Building an Evidence Base (People with moderate mental health issues,).

The Auckland DHB RFP response seeks funding to upscale and evaluate the Awhi Ora – Supporting Wellbeing project and includes providing the following service delivery model:
- Providing access to community support options without having to refer to secondary/specialist Mental Health services and care
- Developing integrated service navigators
- Increasing the range and depth of support available at primary and community level
- Developing wrap-around services (co-ordinated approaches) for those with complex (or multiple) needs
- Integrating mental health and addiction professionals into primary care and community settings
- Ensuring the workforce is well equipped and supported to design and deliver integrated responses.
Waitemata DHB has a strategic action plan, *Our Health in Mind*, to specifically address community and primary Mental Health and Addictions needs for the next five years (2016-2021). The focus is achieving a system that provides a broader range of integrated responses, improves primary (including NGO) and specialist services working together and delivers outcomes particularly for Māori and Pacific people. Waitemata DHB’s RFP response proposed evaluation of this suite of initiatives (from the approved business case for the first year of *Our Health in Mind*). Those most closely aligned to the objectives of “Fit for the Future” are listed below. Waitemata DHB’s aim is to be responsive at the earliest possible intervention point with relevant services and supports underpinned by a commitment to workforce development and extensive evaluation.

1. Improving direct phone access to specialist advice for GPs management queries.
2. Support improved working between primary and secondary care
3. Additional funding for delivery of support and care packages in primary care and access to increase NGO support hours
4. Enhanced support for innovative programme developments for Maori and Pacific communities to encourage earlier presentation of and intervention for serious and common mental health and addiction disorders.

### 6.5 Substance Addiction Compulsory Assessment and Treatment (SACAT) Legislation

The SACAT legislation was enacted on 8 February 2017. The Act will come into effect on 1 March 2018. The development of the Northern Region SACAT model of care is continuing. The draft model of care is being developed by the SACAT Technical Advisory Group (TAG) on the basis of contributions and engagement from a range of alcohol and other drug (AOD) stakeholders from the Northern Region, who participated in Regional Workshops held from September to November 2016.

The purpose of the Model of Care is to:
- Describe the principles, aims and overall components of the SACAT pathway in the Northern Region
- Describe the interventions to be delivered, who will deliver them, timeframes and locations
- Describe the skills, knowledge and behaviour required to deliver each stage of the service user journey
- Provide a consistent SACAT response in the Northern Region
- Assist clinicians and other stakeholders to interpret the legislation as it relates to alcohol and other drug assessment and treatment.

The draft model describes the key stages of the SACAT response, from the point of referral to the point at which a person successfully exits from the Act. It also provides details on continuing care treatment and support options post discharge.

The draft model of care along with an estimated additional funding framework was tabled at the Northern Region MHA Clinical Network meeting in December 2016 and approved as a working draft. A teleconference was subsequently held with representatives from the Involuntary Drug and Alcohol Treatment Programme from New South Wales Health to further improve the SACAT Model of Care, including refining predicted treatment volumes. The rate of referrals, assessments and treatment episodes in New South Wales based on four years of evaluation data, are significantly lower than Northern Region DHBs original estimates. The Northern Region estimated volumes and budget has been revised accordingly.

A national workshop hosted by the MoH will take place on 8 March 2017. The purpose of this workshop is to develop a nationwide service specification for the model of care, to discuss workforce development opportunities and what a treatment programme for this cohort of people will include. Following this meeting, the TAG will further refine the Model of Care and costs with the intention of...
finalising the model and submitting for approval from the Regional Mental Health and Addiction Network by the end of April 2017.

The 12-month timeline for implementation and commencement of the legislation will be challenging, particularly the commissioning, design and development of a new Regional facility and additional new MoH funding will be required to fund DHB and NGO AOD Service Providers, to develop new and expanded services.

7. **Māori Health Gain**

7.1 **Annual Planning**

In 2017/18 the MoH planning guidance amended this requirement to no longer require a separate DHB Māori health plan by integrating Māori health planning into the Annual Plan. However, in December 2016 the Board Chair communicated his intention at the Auckland and Waitemata DHB Board meetings to continue with Māori health plans and to align these across the three metro Auckland DHBs in 2017/18. Respective DHB Māori health, planning and funding teams met over December-January to explore opportunities to realise that objective.

Through these meetings the Metro Auckland District Health Boards are proposing to our respective Māori Health Gain Advisory Committees that we:

- Continue with a common flow to the Māori health planning documents. This will make it easier for community, clinical, operational and executive leaders working across the region to review and engage with the respective plans
- Adopt a “life course” approach to the presentation of activities and indicators. This will better reflect the NZ Health Strategy and local DHB strategy focus on health equity and Māori world view of collective well-being than the current “indicator” list method of the current MoH template
- Maintain the nationally determined priority areas and indicators from the 2016/17 Māori Health Plan, with the incorporation of System Level Measure (SLM) actions
- Continue to have a limited number of local priorities for each District Health Board to support the needs and opportunities for their respective Māori communities
- Provide a list of potential priority areas where regional collaboration could be beneficial. Further discussion will be required to determine which of these are included in the 2017/18 Māori Health Plans as regional priorities, however it is likely that workforce development will be our major collaboration area.

As with previous years, we will continue to consult with the relevant internal and external partners throughout the development of the Māori health plans including our Memoranda of Understanding partners, Te Runanga o Ngāti Whātua and Te Whānau o Waipareira Trust.

7.2 **Child Health**

We have played a key role in the Auckland DHB Starship Community Services Redesign process. Our role has included participation on the Steering Group, leading the Māori Workforce engagement process, analysis and interpretation of the feedback received and supporting the development of the Starship Community Services Redesign Decision Document. The final change document was released in January 2017 and a Governance group has been established to guide the ongoing change process to support a localities based approach, the General Manager Māori Health and Pacific Health are the Governance Group members.
8. Pacific Health Gain

8.1 Renewing Pacific Health Action Plan (PHAP)
The draft Pacific Health Action Plan 2016 – 2020 is being presented for approval to this CPHAC meeting.

8.2 PHAP Priority 1 – Children are safe and well and families are free of violence
Four Incredible Years parenting programmes were delivered through the Enua Ola programme, with another two delivered through the Healthy Village Action Zones (HVAZ) programme in the 2015/16 financial year. This programme ran over 14 weeks, participant feedback indicated this was too long, this was also reflected in attendance rates.

In the current financial year, the Triple P parenting programme, a four week programme endorsed by the MoH is being offered. Five programmes are being implemented through the Enua Ola programme and three through the HVAZ programme, to be completed by the end of this financial year. Three churches are on a waiting list for the 2017/18 financial year, as resources were only available for eight programmes in this financial year.

Five Living without Violence programmes were delivered in the 2015/16 financial year, three in Waitemata and two in Auckland. Eight programmes are being delivered in the current financial year, five in Waitemata and three in Auckland. 12 additional groups wanted to receive this programme and have been added to a waiting list for the 2017/18 financial year. The Catholic Social Services has received further funding from the Todd Foundation to train more facilitators. They also received funding to translate the training modules in Samoan and Tongan languages, this will be done before the next facilitator training in June 2017.

In relation to rheumatic fever, we have participated in a number of meetings with the MoH, Pacific providers and community groups. We work closely with Planning and Funding Child Health in the implementation of the Rheumatic Fever Resolution Plan.

8.3 PHAP Priority 2 – Pacific People are smoke-free
A report from consultation with Tongan male smokers has been submitted by The Fono, who were contracted to undertake this work. The main recommendation was the implementation of a specific group based quit smoking competition for Tongan men. Components of this can be met by The Fono from its current quit smoking contract with the MoH. We are currently working with the Fono to develop a business case to be presented to the DHBs and the MoH.

8.4 Priority 3 – Pacific people are active and eat healthy
The current contracts for the physical activity and nutrition component of the Enua Ola and HVAZ programmes come to an end June 2017. Initial discussions have been held with the groups about the need to focus on obesity in children and young people. A working group including representatives from churches/community groups, HVAZ/Enua Ola co-ordinators, parish community nurses and DHBs is being set up to undertake a review of practices to date in light of this focus. This will include the results of the Aiga Challenge from the last four years.

8.5 PHAP Priority 4–People seek medical and other help early
We are working with Alliance Health Plus to review and develop the new service specifications for the Integrated Services Fanau Ola contract from 1 July 2017 onwards. We are also working with the bowel screening pilot to explore what can be further undertaken to increase participation in the bowel screening programme.
8.6 PHAP Priority 5 - Pacific people use hospital services when needed
The Pacific General Manager for Hospital Services reports on this priority.

8.7 PHAP Priority 6 – That Pacific people live in houses that are warm and are not over crowded
We are involved in the development of the Healthy Homes Kainga Ora Initiative and will assist in dissemination of information about the programme.

9. Asian, Migrant and Refugee Health Gain

9.1 Increase the DHBs’ capability and capacity to deliver responsive systems and strategies to targeted Asian, migrant and refugee populations

9.1.1 Waitemata DHB executive delegation to China
A Waitemata DHB executive delegation consisting of Dr Lester Levy, Dr Dale Bramley, Dr Andrew Bryant and Dr Lifeng Zhou travelled to China - Beijing and Shanghai cities between 4-12 March. The intention was to visit respective Chinese hospital delegations from the two cities who visited Waitemata DHB over the past years for reciprocal cross-cultural exchange across areas of leadership, management, operations and building capacity and capability.

9.1.2 Asian Benchmarking Report
The International Benchmarking of Asian Health Outcomes Waitemata and Auckland DHBs report was presented to the December Board meetings, this tells us how we are performing internationally. When we aggregate Asian as one homogenous group the findings showcase we are leaders in health status and health outcomes. Though, this hides subgroup inequalities. There are disparities for areas such as CVD, diabetes, youth mental health, and childhood obesity which are identified in the report.

The report has a number of recommendations, our top three areas for action are:
1. Access to healthcare services, e.g. PHO enrolment and access to youth mental health, cervical screening
2. Prevention, tailored or targeted preventive healthy lifestyle activities
3. Granular data monitoring to level 4 ethnicity coding, making sure our data tells us about the subgroups we are interested in.

9.2 Increase Access and Utilisation to Health Services
Indicator: Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 75% (Auckland DHB) and 85% (Waitemata DHB) targets by 30 June, 2017 (current rates 69% (Auckland DHB) and 84% (Waitemata DHB) as at Q1 2017)

The Statistics New Zealand population projections have substantially underestimated the migration for Asian populations, particularly impacting Auckland DHB. The 2016 updates resulted in what appears to be an addition of more than 10,000 Asian people in Auckland DHB in one quarter. We have analysed this further, the results of which are summarised below.
The figure above shows the most recent migration figures, demonstrating very high and sustained migration numbers from 2014-2017, substantially higher than the assumptions built in to the Statistics NZ and MoH population projection numbers. The 2016 projection update has corrected this substantial underestimate, and much of the impact of this impacts Auckland DHB and the Asian population. Further analyses have demonstrated that the growth is in the younger population. Table 1 below shows the difference between projections in one quarter.

**Table 1 Change of projected Asian populations from Q4 2016 to Q1 2017, Auckland and Waitemata DHBs (based on two projections/updates)**

<table>
<thead>
<tr>
<th>Year and quarter</th>
<th>Auckland Asian PHO enrolees</th>
<th>Auckland Asian Population</th>
<th>Waitemata Asian PHO enrolees</th>
<th>Waitemata Asian Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Q4*</td>
<td>114,480</td>
<td>156,285</td>
<td>105,594</td>
<td>125,455</td>
</tr>
<tr>
<td>2017 Q1**</td>
<td>115,651</td>
<td>166,450</td>
<td>107,812</td>
<td>128,970</td>
</tr>
<tr>
<td>Absolute increase</td>
<td>1,171</td>
<td>10,165</td>
<td>2,218</td>
<td>3,515</td>
</tr>
<tr>
<td>Increase ratio</td>
<td>1%</td>
<td>7%</td>
<td>2%</td>
<td>3%</td>
</tr>
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</table>

* Based on ‘2015 Update’; ** based on ‘2016 Update’

The impact of the change of the Statistics New Zealand’s population projections update from 2015 to 2016 for Asians of Auckland DHB has resulted in a drop of the Asian PHO rate from 73% as at Q4 2016 (based on ‘2015 Update’ population projection by Statistics New Zealand) to 69% as at Q1 2017 (based on ‘2016 Update’ population projection by Statistics New Zealand).

**Cervical Screening**

The impact of the large population denominator change for Auckland DHB is also seen on other indicators, including cervical screening. December 2016 cervical screening coverage is now at 59.2% for Auckland DHB with 9,740 Asian women requiring a cervical screen to reach 80% coverage. This is an increase of 3,728 women requiring a cervical screen to reach the 80% target since December 2015 (when 6,012 women were required to be screened and coverage was 66%). Waitemata DHB has gone up 2% for Asian since Sept 2016 (66 to 68%). 4,512 additional screens are required to reach 80% target.
Next steps

- Deliver a multilingual Healthcare – where should I go? campaign to the broader Asian migrant and student populations domiciled in the Auckland DHB from April-June 2017
- Leverage on the Healthcare campaign to promote targeted messaging about cervical screening to women aged 20-29yrs
- Deliver NZ Health and Disability System presentations to universities, Private Training Establishments (PTE), settlement partners, ethnic associations and libraries (ongoing, approx. 4/month)
- Work with Statistics NZ to extricate the international student population from the Asian figures.

10. Auckland Regional Public Health Service (ARPHS)

10.1 Auckland Plan refresh

The Auckland Plan, first adopted on 29 March 2012, sets the region’s strategic direction over the next 30 years. Auckland Council is now in the beginning stages of updating the Auckland Plan (named the Auckland Plan refresh) to help guide the Long-term Plan 2018-2028 review.

The Auckland Plan refresh is progressing through five work streams: protect and restore; skills and jobs; homes and places; belonging and access; and connectivity. ARPHS, with the support from the three DHBs, has had input into the belonging and access, and connectivity work streams. Critical strategic directions for the work streams have been set, and will be reviewed by councillors and local board chairs on 15 March 2017.

In addition, ARPHS has provided feedback into a cabinet paper prepared by the Department of Internal Affairs on the government’s engagement with Auckland Council’s refresh of its Auckland Plan. The paper sets out draft terms of reference in relation to how central government and Auckland Council will work together to inform the development of key aspects of the Auckland Plan, including transport, housing, and development capacity for both residential and business land uses. ARPHS and the DHBs support a closer working relationship between central and local government on such strategic issues.

10.2 Local Alcohol Policy (LAP) appeal

The local alcohol policy (LAP) will influence when, where and how alcohol is sold across the region and is in place for six years. Once in place, the LAP will have the ability to influence trading hours and density of licensed premises throughout Auckland. ARPHS is supportive of the overall direction of Auckland Council’s proposed LAP. Adoption of the LAP will be a positive step forward for alcohol harm minimisation in the Auckland region. However, ARPHS has appealed two key elements of the LAP in order to strengthen the final policy.

The Alcohol Regulatory Licencing Authority (ARLA) set aside three weeks for hearing all parties’ appeals of the LAP. The first week of hearing commenced on 13 February, initially focusing on the appeals of the proposed off-licence hours. Toward the end of the first week the Police and Medical Officer of Health (MOH) made a joint opening statement on the matters jointly appealed:

- proposed on licence hours, and;
- seeking further additions to the list of priority areas in Auckland to receive additional restrictions.

Health, police and Social Sector appellants and interested parties have continued to provide a coordinated approach to the Auckland appeal with supporting witnesses giving evidence for the majority of the second week. Evidence given on behalf of the MoH focused on ARPHS and Auckland City Hospital Emergency Department’s study, which highlights the nature of Auckland’s alcohol
related harm, as well as interpreting relevant local and international research for the Auckland context.

There has been positive feedback from the legal team and health orientated partners about the quality of ARPHS work, coordination, and witnesses to date. While the outcome of both the LAP and ARPHS appeal continues to be uncertain, the outcome of the Christchurch and Dunedin LAP hearings show the impact that industry can have on the Authority to make considerable changes when unopposed. As an appellant to proceedings, ARPHS is well positioned to have an influence on the outcome.

10.3 Healthy Auckland Together (HAT) update
Healthy Auckland Together (HAT) presented at a local board plan advisors’ workshop. HAT suggested ways of including health and wellbeing outcomes into board plans that are currently being developed. The strategic three-year plans reflect the priorities and preferences of the local board’s community. This has offered an opportunity to work more closely with local boards to offer strategic advice on health planning at a local government level.

10.4 Project Auaha update
Project Auaha, an initiative to address obesity, was instigated by ARPHS in response to the chair of Auckland’s three DHBs invitation for Healthy Auckland Together to present a proposal for addressing obesity in the Auckland region. The initiative needs to be collaborative, capable of being delivered at scale and able to connect hearts and minds to achieve meaningful change.

Nine options were considered by a working group comprising of Maori, Pasifika, DHBs, Auckland Transport (AT), Auckland Council and university representatives. After reviewing the proposals the working group agreed to endorse the ‘displacing sugary sweetened beverages with tap water’ and the ‘building a prevention system for Auckland’ proposals.

The ‘tap water’ proposal is being developed into a business case. Further consideration is being given to the ‘prevention system’ proposal.

10.5 Communicable diseases - Mumps outbreak in Auckland
New Zealand is experiencing an increase in the number of Mumps cases, most of these in Auckland, with 19 confirmed cases notified in Auckland since 1 January 2017. The age range is 2-51 years with over half occurring in those aged 12 to 30 years. The main source of the outbreak relates to incursions from overseas, in particular Fiji, as well as Japan, Tuvalu and Tonga. These countries do not include mumps in their childhood immunisation schedule. Other countries such as the US and Canada are also experiencing increasing outbreaks of Mumps. ARPHS is monitoring the situation and updating the MoH. A health professional’s advisory notice was sent to all Auckland clinical services on 23 February 2017.
### 10.6 Submissions

ARPHS completed and submitted six submissions during November 2016 to February 2017.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Brief note</th>
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<tr>
<td>5 December</td>
<td>Proposals for changes to food safety regulations</td>
<td>The Ministry sought feedback on the Proposals for changes to food safety regulations. ARPHS recommended: a) Amending Food Regulations 2015 ensuring all food businesses (including vehicles) should be kept clean, hygienic and free from pests. b) Reduced record keeping for lower-risk businesses was not advisable. c) As not all cases of infectious disease are notified through the Health Act 1956, the Ministry for Primary Industries need to ensure adequate mechanisms are in place to explicitly manage the exclusion of food handlers with diarrhoea or other infectious diseases. d) It should be up to the food manufacturers to ensure that the chemical composition of the reticulated water they use is appropriate for their product.</td>
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<td>16 December</td>
<td>Consultation on proposed F9/AS1 and F9/AS2 Acceptable Solutions for residential pool barriers</td>
<td>In line with the Building (Pools) Amendment Act (which came into effect on 1 January 2017) and the Building Code, the Ministry of Business Innovation and Employment proposed new ‘Acceptable Solutions’ for barriers that restrict young children from accessing residential pools and small heated pools. Along with other stakeholders, ARPHS provided feedback to Watersafe Auckland on the proposed Acceptable Solutions. Watersafe Auckland incorporated stakeholders’ comments into a joint submission.</td>
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<tr>
<td>16 December</td>
<td>Consultation for update of Te Whāriki</td>
<td>Te Whāriki is the national curriculum document for early childhood education. ARPHS supported the development of a comprehensive, online website to support teachers, and via this platform, expressed a willingness to share information and resources on nutritional environments in early childhood centres and preventing communicable childhood illness.</td>
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<td>1 February</td>
<td>Energy Innovation (Electric Vehicles and Other Matters) Amendment Bill</td>
<td>Part of this omnibus bill introduced measures to encourage the uptake of electric vehicles. ARPHS supported the Bill’s intent to introduce incentives to encourage the uptake of electric vehicles, but did not support the</td>
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specific policy of allowing EVs to access special vehicle lanes. ARPHS is concerned that this policy would adversely affect the efficiency of existing transport networks and strategies designed to enhance overall mobility.

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<tr>
<th>2 February</th>
<th><strong>Health (Fluoridation of Drinking Water) Amendment Bill</strong></th>
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<td></td>
<td>The proposed Bill amends Part 2A of the Health Act 1956 by inserting a power for DHBs to make decisions and give directions about the fluoridation of local government drinking water supplies in their areas. ARPHS and the three Auckland district health boards recommended that:</td>
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<td>• Section 69ZJA(3) of the Bill be reworded to operate as intended, and ensure that agreement between DHBs to fluoridate a water supply is not necessary when the water supply system in question does not cross DHB boundaries</td>
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<td></td>
<td>• DHB assessments to determine whether to fluoridate a drinking water supply are restricted to the assessment of health benefits</td>
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<td>• Greater consideration be given to the financial implications of the Bill for DHBs.</td>
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<th>20 February</th>
<th><strong>Testing and decontamination of methamphetamine-contaminated properties – Draft New Zealand Standard</strong></th>
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<td></td>
<td>The purpose of this standard is to provide guidance on reducing people’s risks of exposure to harm caused by the presence of unacceptable levels of methamphetamine (MA) residues in properties and other assets. ARPHS outlined the importance of the MoH’s 2010 guideline clean-up level of 0.5 µg/100cm², which has been applied throughout the Auckland region for all premises found to be contaminated with MA (regardless of whether there is existing evidence of MA production). However, the NZS proposed interim approach is for TLAs to use the lower level of 0.5 µg/100cm² only when there is existing evidence of MA production. ARPHS did not support adopting the interim approach, and recommended guidance on appropriate testing/criteria to determine MA manufacture, such that in the absence of visible signs or Police records, human health continues to be adequately protected.</td>
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6. Resolution to Exclude the Public

Recommendation:

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

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

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
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<td>Rheumatic Fever Prevention Programme</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Obligation of Confidence The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment where the making available of the information would be likely to; (i) prejudice the supply of similar information, or information from the same source, and where it is in the public interest that such information should continue to be supplied; or (ii) otherwise damage the public interest. [Official Information Act 1982 S.9 (2) (ba)]</td>
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Negotiations

The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations.

[Official Information Act 1982 S.9 (2) (j)]