Community and Public Health Advisory Committees Meeting

Wednesday 04 April 2018

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 DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
04 April 2018

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

MANAGEMENT
Dale Bramley - WDHB, Chief Executive
Ailsa Claire - ADHB, Chief Executive
Debbie Holdsworth - ADHB and WDHB, Director Funding
Karen Bartholomew - ADHB and WDHB, Acting Director Health Outcomes
Peta Molloy - WDHB, Board Secretary

Apologies:

AGENDA

KARAKIA

ACKNOWLEDGEMENTS

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 06/12/2017
          Actions Arising from previous meetings

3. STANDARD REPORTS
10.05am 3.1 Planning, Funding and Outcomes Update

4. DEEP DIVE REPORT
11.05am 4.1 Equity Focus in System Level Measures Planning Process

5. GENERAL BUSINESS
11.45am
Auckland and Waitemata District Health Boards  
Community and Public Health Committees  
Member Attendance Schedule 2017

<table>
<thead>
<tr>
<th>NAME</th>
<th>MAR</th>
<th>JUNE</th>
<th>SEP</th>
<th>DEC</th>
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<tr>
<td>Sharon Shea</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Max Abbott</td>
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<tr>
<td>Edward Benson Cooper</td>
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<tr>
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<tr>
<td>Warren Flaunty</td>
<td>✓</td>
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<tr>
<td>Matire Harwood</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Lee Mathias</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Robyn Northey</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Allison Roe</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</table>

✓ 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   | Trustee – A+ Charitable Trust  
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 | 17/05/17 |
| Edward Benson-Cooper | Chiropractor – Milford, Auckland (with private practice commitments) | 07/12/16 |
| Zoe Brownlie     | Community Health Worker – Auckland DHB  
Member – PSA Union  
Board member - RockEnrol  
Partner – Youth Connections, Auckland Council  
Partner – Aro Arataki Children's Centre Committee  
Son – Aro Arataki Childcare Centre | 09/06/17 |
| 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 |
<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
</tr>
</thead>
</table>
| Lee Mathias       | Chair - Health Promotion Agency  
Chair - Unitec  
Chair - Health Innovation Hub (until the end of the Viclink contract in line with the director appointment)  
Chair – Medicines New Zealand  
Director - Health Alliance Limited (ex officio Auckland DHB)  
Director/shareholder - Pictor Limited  
Director – Pictor Diagnostics – Pictor India Ltd  
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 | 25/10/17 |
| Robyn Northey     | Shareholder of Fisher & Paykel Healthcare  
Shareholder of Oceania  
Member – New Zealand Labour Party  
Husband - member Waitemata Local Board  
Husband – shareholder of Fisher & Paykel Healthcare  
Husband – shareholder of Fletcher Building  
Husband – Chair, Problem Gambling Foundation  
Husband – Chair, Community Housing Foundation | 05/07/17 |
| Sharon Shea       | Principal - Shea Pita Associates Ltd  
Provider - Maori Integrated contracts for Auckland and Waitemata DHBs  
Provider - multiple management consulting projects for Te Putahitanga o Te Waipounamu Whanau Ora Commissioning Agency  
Provider – Hapai Te Hauora for National SUDI project; supporting data design for regional provision (which includes potential reporting datasets for DHBs)  
Board member – Alliance Health Plus  
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 | 14/09/17 |
| Allison Roe       | Chairperson – Matakana Coast Trail Trust  
Member - Rodney Local Board, Auckland Council | 02/11/16 |
2.1 Auckland DHB and Waitemata DHB Community and Public Health Advisory Committee Meeting 06 December 2017

Recommendation:
That the draft minutes of the Community and Public Health Advisory Committee meeting held on 06 December 2017 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

**Community and Public Health Advisory Committees**

**Wednesday 06 December 2017**

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 10am

**Part I - Items considered in Public Meeting**

**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 Flaunting (Committee Deputy Chair - WDHB Board member)
- Lee Mathias (ADHB Board member)
- Robyn Northey (ADHB Board member)
- Allison Roe (WDHB Board member)

**ALSO PRESENT:**
- Dale Bramley (WDHB Chief Executive Officer)
- Debbie Holdsworth (ADHB and WDHB, Director Funding)
- Karen Bartholomew (ADHB and WDHB, Acting Director Health Outcomes)
- Catherine Joseph (Secretariat)
- (Staff members who attended for a particular item are named at the start of the minute for that item)

**PUBLIC AND MEDIA REPRESENTATIVES:**
- Sue Claridge (Auckland Women’s Health Council)
- Tracy McIntyre (Waitakere Health Link)

**WELCOME:**
- The Committee Chair welcomed those in attendance at the meeting.

**KARAKIA:**
- The Committee Chair opened the meeting with a Karakia.

**APOLOGIES:**
- An apology was received and accepted from Ailsa Claire.

**DISCLOSURE OF INTERESTS**
- The Committee chair advised that Plunket and Auckland DHB Maori Workforce development could now be removed for her register of interests. She also requested that it be recorded.
she is now working with Hapai Te Hauora on National Sudi (Sudden Unexpected Death in Infancy) Prevention Contract.

There were no declarations of interests relating to the agenda.

The Committee chair acknowledged the sad passing of Edith McNeil who had long history of working with whanau and Waipereira.

The Committee chair also acknowledged Dr. Matire Harwood being awarded a fellowship in L’Oreal UNESCO for Women in Science programme for her research into health inequities between indigenous and non-indigenous people. She also congratulated Dr Lester Levy appointment to the Ministerial Advisory Group for Health.

Judith Bassett acknowledged sad passing of Dame Sister Pauline Francis, Principal of Carmel College noting her positive influence for Carmel College students.

1. AGENDA ORDER AND TIMING

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

The Committee Chair has requested that a deep dive presentation be included as an agenda item at each meeting going forward.

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 13/09/17 (agenda pages 7 to 15)

Resolution (Moved Warren Flaunty/Seconded Lee Mathias)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 13 September 2017 be approved.

Carried

Matters Arising (agenda pages 16)

Matters were noted.

3 INFORMATION ITEMS

3.1 Suicide Epidemiology Update (agenda pages 19 to 25)

Dr Sheryl Jury (Public Health Physician) and Manu Fotu (Programme Manager, Suicide Prevention) presented this paper

Warren Flaunty noted that people who committed suicide were often either receiving or had received mental health support. He queried how the team could ensure support was provided to people receiving mental health with known suicidal tendencies. Manu Fotu advised that the Zero Suicide Framework would encourage discussions on supporting the community and lead to service improvement process.
Sandra Coney expressed an interest in knowing the new plans and strategy. In response Debbie Holdsworth advised that the team were looking forward to a national direction in this regard. She acknowledged work carried out by Manu Fotu in interacting with schools and affected families.

Sheryl Jury advised the committee that a summary report will be presented on key intervention and contributions at the next meeting.

In response to a query from Zoe Brownlie whether preventative work was carried out in schools, Manu Fotu advised that the DHB that the key was working together with other agencies was important to deliver the plan.

Matire Harwood emphasized the importance of addressing inequities seen in the suicide data and making it a priority for the committee.

The committee chair recommended a deep dive be presented to the committee next year to review the issue further and its future progress.

The paper was received

3.2 **Green Prescription Effectiveness of Service delivery** (agenda page 26 to 31)

Leanne Catchpole (Programme Manager, Primary Care Team) and Dr Felicity Williamson (Public Health Registrar) were present for this paper.

In response to question from Lee Mathias about services provided under the programme, Leanne Catchpole advised that Sports Trusts provide gym memberships, West Wave Leisure Centre provides face to face consultation and Harbour Sport conduct a Shore to Shore run each year.

Dr Felicity Williamson advised that the team works with Primary Care providers to encourage their staff to refer people to the Green prescription.

In response to a query from Sandra Coney about whether housework, gardening and walking to work is integrated in the programme, Leanne Catchpole advised that that program promotes physical activities that can be incorporated into day to day activities like gardening, dog walking along with gym membership.

The Committee chair requested inclusion of ethnicity data in the reporting of Green prescription providers in future reports.

4. **STANDARD REPORTS**

4.1 **Planning, Funding and Outcomes Update** (agenda pages 32 to 64)

Dr Debbie Holdsworth (Director, Funding) summarised this item.
Tim Wood advised that meetings have been held with Counties Manukau Health to exchange ideas related to the Health Literacy programme providing an opportunity for the three DHBs to work closely.

Debbie Holdsworth noted the upward trend for oral health initiatives with Saturday clinics being well attended.

The Committee Chair requested an update be provided on documented side effects of the HPV vaccine at the next meeting.

Kate Sladden advised that six aged care facilities in Waitemata DHB and five aged care facilities in Auckland DHB received transitional funding to address the issue of pay equity.

Karen Bartholomew noted that 69 Maori women have now completed HPV self-testing.

Karen Bartholomew advised that the team is working with Indigenous Health Research, Bendigo, Australia to share learning. She further noted that to address the issue of high DNA in women who agree to participate in the HPV self sampling, an additional model is introduced where screening is offered to women when they visit their GPs (Opportunistic Screening).

Karen Bartholomew noted there are 990 mumps cases to date. Catherine Jackson noted challenges experienced in identifying people who are immunized as often affected people do not know if they were immunised. Work is underway to improve the immunization strategy.

Sandra Coney recommended bringing to Auckland Regional Public Health Service’s attention, the ethical practices involved in filming tobacco advertisements locally in New Zealand which are then shown overseas.

5. GENERAL BUSINESS

5.1 Academic Paper of Interest to the Committee (agenda pages 65 to 72)

Achieving health equity in Aotearoa: strengthening responsiveness to Maori in health research

The Committee chair acknowledged an article by Dr Matire Harwood titled ‘Achieving health equity in Aotearoa: strengthening responsiveness to Maori in health research’.

Robyn Northey requested that the paper on ‘The burden of gambling harm in New Zealand’ be uploaded on Resources in Diligent Boardbooks.

The meeting concluded at 11.26am.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS’ COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 06 DECEMBER 2017

_____________________________CHAIR
## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 29 March 2018

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
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</thead>
</table>
| 06/12/17 | 1 | Agenda order and timing  
Request to include Deep Dive presentation in future agendas | | | Being presented in agenda item 4.1 |
| 06/12/17 | 3.1 | Suicide Epidemiology Update  
A summary report on key intervention and contributions | Sheryl Jury | 04/04/18 | Actioned. See agenda item 3.1 |
| 06/12/17 | 4.1 | PFO Update  
An update on documented side effects of HPV vaccine | Ruth Bijl | 04/04/18 | A verbal update will be provided at the April 2018 meeting |
| 06/12/17 | 5.1 | Academic Paper of Interest to the Committee  
Request to upload paper on 'The burden of gambling harm in New Zealand' to Resource Centre in Diligent boardbooks. | | 04/04/18 | Uploaded to Resource Centre in Diligent Boardbooks |

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*Note: The actions arising and carried forward from the meetings are summarized above.*
3.1 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 & 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), Bruce Levi (Pacific General Manager), 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

AAA - Abdominal Aortic Aneurysm
AIPHG - Auckland Intersectoral Public Health Group
ARC - Aged Residential Care
ARDS - Auckland Regional Dental Service
ARPHS - Auckland Regional Public Health Service
ASH - Ambulatory Sensitive Hospitalisation
CPHAC - Community and Public Health Advisory Committee
CVD - Cardiovascular Disease
HAT - Healthy Auckland Together
HCSS - Home and Community Support Services
HMB - Healthy Mums and Babies
HNA - Health Needs Assessment
HVAZ - Healthy Village Action Zones
IANZ - International Accreditation New Zealand
MACGF - Metro Auckland Clinical Governance Forum
MELAA - Middle Eastern, Latin American and African
MMR - Mumps Measles and Rubella
MoH - Ministry of Health
NCHIP - National Child Health Information Platform
NHI - National Health Index
PHAP - Pacific Health Action Plan
PHO - Primary Health Organisation
PMHI - Primary Mental Health Initiatives
R-POCT - Rural Point Of Care Testing
SUDI - Sudden Unexplained Death in Infancy

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 6 December 2017. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting’s agenda.
Highlights

- The Rural Point of Care Testing Service was implemented in December 2017 at the first test site. The service will be rolled out to all other Waitemata DHB rural general practices before the end of April 2018.
- The primary care Diabetes Service Level Alliance (DLSA) Clinical Indicator data for Auckland DHB and Waitemata DHB is presented in this report for the first time, highlighting areas of focus and areas with improved performance.
- Both Hibiscus Hospice and North Shore Hospice Trust have established a strengthened strategic partnership based on a common vision and long-term view of delivering services to better meet community needs.
- Within the obesity space Auckland and Waitakere DHBs both continue to exceed the Raising Healthy Kids target for all ethnicities.
- The extended AAA and AF Screening Project for Māori re-commenced screening on 15 January 2018 with very positive feedback from patients, and will be concluded by mid April. There has also been positive media coverage around both this project and the Precision Driven AAA Screening (non-Māori).

2. Planning

2.1 Annual Plans
Both Auckland and Waitemata 2017/18 Annual Plans have been approved and signed by the Minister of Health. They are now available on respective District Health Board (DHB) websites.

2.2 Annual Report
First draft timetable has been developed and initial meetings with auditors scheduled.

2.3 System Level Measure Improvement Plans
A Quarter 2 update on progress against the System Level Measures included in the 2017/18 System Level Measures (SLM) Improvement Plan will be presented to the April Board. A deep dive on equity in the SLM work programme is included on the agenda.

Second phase work to update StatPlanet – the dynamic reporting tool – is almost complete. A number of analyses of National Health Index (NHI) level Ministry of Health (MoH) and other datasets are ongoing. Further indicator definitions are still being developed and agreed as required. 2018/19 planning work has commenced.

2.4 Auckland and Waitakere DHB Quarterly Performance Scorecard
The Auckland and Waitakere (DHB) CPHAC Scorecard is a standardised tool used to internally review and track performance against a range of measures including National Health Targets for both Auckland and Waitemata DHBs. The Scorecard below shows indicator performance against target for each DHB for Quarter 2 of the 2017/18 year.
### Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 04/04/18

#### Auckland and Waitemata DHB Quarterly Performance Scorecard

**CPHAC Outcome Scorecard**

**December 2017**

### Health Targets - Auckland DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better help for smokers to quit - primary care</td>
<td>87%</td>
<td>90%</td>
<td>↓</td>
</tr>
</tbody>
</table>

#### Performance was

- **Achieved (On track)**: 87%
- **Not achieved (Off target)**: 9%
- **Substantially missed (Less than 80% of target)**: 4%

### Health Targets - Waitemata DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better help for smokers to quit - primary care</td>
<td>88%</td>
<td>90%</td>
<td>↓</td>
</tr>
</tbody>
</table>

#### Performance was

- **Achieved (On track)**: 88%
- **Not achieved (Off target)**: 9%
- **Substantially missed (Less than 80% of target)**: 3%

### Primary Care - Auckland DHB

#### PHO enrolment

<table>
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<th>Target</th>
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<tbody>
<tr>
<td>Total</td>
<td>82%</td>
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</tr>
<tr>
<td>Māori</td>
<td>70%</td>
<td>80%</td>
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<tr>
<td>Pacific</td>
<td>100%</td>
<td>90%</td>
<td>↓</td>
</tr>
<tr>
<td>Asian</td>
<td>60%</td>
<td>90%</td>
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<tr>
<td>Other</td>
<td>90%</td>
<td>90%</td>
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</tr>
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</table>

- **Achieved (On track)**: 82%
- **Not achieved (Off target)**: 9%
- **Substantially missed (Less than 80% of target)**: 4%

### Primary Care - Waitemata DHB

#### PHO enrolment

<table>
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<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Total</td>
<td>92%</td>
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</tr>
<tr>
<td>Māori</td>
<td>81%</td>
<td>90%</td>
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<tr>
<td>Pacific</td>
<td>100%</td>
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<tr>
<td>Asian</td>
<td>80%</td>
<td>90%</td>
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<tr>
<td>Other</td>
<td>94%</td>
<td>90%</td>
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</tbody>
</table>

- **Achieved (On track)**: 92%
- **Not achieved (Off target)**: 9%
- **Substantially missed (Less than 80% of target)**: 0%

### Rheumatic Fever rate

<table>
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<th>Target</th>
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<tbody>
<tr>
<td>Total</td>
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</tr>
<tr>
<td>Māori</td>
<td>47%</td>
<td>75%</td>
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</tr>
<tr>
<td>Pacific</td>
<td>52%</td>
<td>75%</td>
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<tr>
<td>Asian</td>
<td>62%</td>
<td>75%</td>
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<tr>
<td>Other</td>
<td>67%</td>
<td>75%</td>
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</tr>
</tbody>
</table>

- **Achieved (On track)**: 56%
- **Not achieved (Off target)**: 44%
- **Substantially missed (Less than 80% of target)**: 38%

### Oral Health - % utilisation by 2 years

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<th>Category</th>
<th>Actual</th>
<th>Target</th>
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<tbody>
<tr>
<td>Total</td>
<td>67%</td>
<td>80%</td>
<td>↓</td>
</tr>
<tr>
<td>Māori</td>
<td>54%</td>
<td>80%</td>
<td>↓</td>
</tr>
<tr>
<td>Pacific</td>
<td>70%</td>
<td>80%</td>
<td>↓</td>
</tr>
<tr>
<td>Asian</td>
<td>54%</td>
<td>80%</td>
<td>↓</td>
</tr>
<tr>
<td>Other</td>
<td>77%</td>
<td>80%</td>
<td>↓</td>
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</tbody>
</table>

- **Achieved (On track)**: 67%
- **Not achieved (Off target)**: 33%
- **Substantially missed (Less than 80% of target)**: 33%

### HBSS clients with Clinical interRAI in last 2 yr

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>93%</td>
<td>95%</td>
<td>↓</td>
</tr>
<tr>
<td>Māori</td>
<td>90%</td>
<td>95%</td>
<td>↓</td>
</tr>
<tr>
<td>Pacific</td>
<td>98%</td>
<td>95%</td>
<td>↓</td>
</tr>
<tr>
<td>Asian</td>
<td>91%</td>
<td>98%</td>
<td>↓</td>
</tr>
</tbody>
</table>

- **Achieved (On track)**: 93%
- **Not achieved (Off target)**: 7%
- **Substantially missed (Less than 80% of target)**: 7%

### Health of Older People - Auckland DHB

- **Not Achieved/ Off track**
- **Substantially Achieved but off target**
- **Not Achieved but progress made**
- **Improvement appreciated compared to previous month**
- **Improvement clearly evident compared to previous months**
- **Not achieved (Off target)**
- **Substantially missed (Less than 80% of target)**
- **Performance not maintained**

#### How to read

1. **Māori and Pacific targets are reported for the reported month/quarter (scorecard header).**
2. **Actuals and targets in grey (total) are for the most recent reporting period available where data is missing or delayed.**
3. **Trend lines represent the data available for the latest 12 months period. All trend lines use adjusted outcomes: the vertical scale is adjusted to the data minimum maximum range being represented. Trend data range may represent small variations perceived to be large.**

#### Key notes

- **Source MOH quarterly report.**
- **Planning, Funding and Health Outcomes, Waitemata DHB**
- **Contact:** victoria.child@waitematadhb.govt.nz
- **3.1 December 2018**
- **4. 2017**
- **5. Align with KSD1 indicator; differs from MoH indicator.**
- **6. ≤100% due to exclusions of the underlying population groupings and primary care database eligibility.**

**Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 04/04/18**
3. Primary Care

3.1 Rural Point of Care Testing Service (R-POCT)

Background
The Rural Point of Care Testing Service (R-POCT) is the first Auckland Waitemata Rural Alliance project to be supported across both Auckland and Waitemata DHBs. Providing Point of Care Testing (POCT) in rural general practices will enable rapid decision-making from assessment and diagnostics to treatment. It also minimises unnecessary emergency department presentations and/or hospitalisations, and facilitates the provision of appropriate care at the right time, in the right place (whether that is at their general practice or by referral to hospital).

Using the services stocktake, the Rural Alliance identified the most clinically valuable POCT tests for the management of people presenting acutely unwell in a rural setting. The service uses the POCT analysers to provide rapid results to assist clinical diagnosis either by ruling out conditions, confirming conditions or determining whether further investigations are needed, i.e. enabling the right management to be initiated sooner. The following R-POCT tests are carried out by the rural practices:

a) Troponin (Trop)
Blood test to detect troponin, a protein found in heart muscle and released into the blood when there is damage to the heart. This is the preferred test for a suspected heart attack because it is more specific for heart injuries than other tests, and the marker rises within two to six hours of myocardial injury.

b) D-Dimer
A blood test used to rule out active blood clot formation for deep vein thrombosis and pulmonary embolism. This test is also used to confirm whether additional testing may be needed to see if a blood clot exists.

c) International Normalised Ratio (INR)
A blood test that checks how long it takes for blood to clot via the extrinsic pathway. The higher the International Normalised Ratio, the longer it will take for blood to clot and the higher the risk of bleeding. Primarily used for patients taking warfarin to prevent blood clots.

d) Full Blood Count (FBC)
Used as a broad screening test to check for such disorders as anaemia, infection, and many other diseases. It is a panel of tests that examines different cells in the blood.

The Waitemata DHB POCT team is overseeing and managing the R-POCT service on behalf of both Auckland and Waitemata DHBs. This will ensure that all quality assurance and control measures are consistent across all general practices who are members of the Rural Alliance.

In December 2017, Kumeu Village Medical became the first test site for Waitemata DHB. Aotea Health on Great Barrier provided the test site for Auckland DHB. Learnings have now been included in the training and implementation processes. The service will be rolled out to all rural general practice sites in both Waitemata and Auckland DHBs before the end of April 2018.
Feedback from Kumeu Village Medical:
We used the d-dimer/FBC/Trop POCT on Friday to confirm a Deep Vein Thrombosis (DVT) post a total knee replacement. We have been able to very successfully diagnose and treat the patient acutely in the community and avoided hospital admission. We are rapidly getting very competent with the gear. Thank you!

Feedback from Aotea Health:
The GPs are finding it really helpful and believe that in fact just knowing it is an available modality has been reassuring for them. As you are no doubt aware when practising remotely there is a certain degree of risk that the health practitioners carry. When weighing up a clinical decision of whether to admit a patient or not there are multiple factors that need to be considered – does one risk wasting resources (helicopter/hospital) or risk making the wrong call and a patient is harmed.

An example using the d-Dimer POCT: A male presented with right calf pain and swelling, the diagnosis was complicated by his bilateral ankle oedema. His Wells score = 2. Unable to access an ultrasound without sending him off-island, the GP chose to perform a POCT d-Dimer which at 370 was within normal range. She was reassured that progressing to her second differential diagnosis would not put the patient at risk. The GP felt without the equipment she would have transferred the patient off-island.

Thank you to the Auckland DHB for providing the POCT machines, enabling the Barrier people to remain on-island and of course reducing expensive admissions to hospital.

3.2 National Health Targets
‘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 (NHT). Both Auckland and Waitemata DHBs did not achieve the primary care ‘Better Help for Smokers to Quit’ health target in quarter two, 2017/18. As shown in Figure 1, Auckland DHB’s performance is at 86.9% (↓ 1.2%) and Waitemata DHB’s performance is at 86.3% (↓ 1.3%). Furthermore, Auckland DHB ranked 15th and Waitemata DHB ranked 16th nationally for quarter two.
Auckland PHO, Alliance Health Plus (AH+) and ProCare were more successful at incorporating brief advice in business as usual activities during quarter two (Table 1). At a PHO level, only Auckland PHO and ProCare (Waitemata) successfully maintained the achievement of this health target. Performance of ProCare (Auckland) and AH+ decreased in quarter two compared with quarter one (↓ 0.9% and 0.6% respectively). A more significant decrease in performance was seen for National Hauora Coalition (NHC) and Comprehensive Care (↓ 4.7% and ↓ 2.9% respectively).

**Table 1: PHO Results for ‘Better Help for Smokers to Quit’ 90% Target (Q2, 2017/18)**

<table>
<thead>
<tr>
<th>Auckland DHB</th>
<th>90.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Health Plus</td>
<td>89.3%</td>
</tr>
<tr>
<td>National Hauora Coalition</td>
<td>72.1%</td>
</tr>
<tr>
<td>ProCare</td>
<td>88.7%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td></td>
</tr>
<tr>
<td>ProCare</td>
<td>89.6%</td>
</tr>
<tr>
<td>Comprehensive Care</td>
<td>82.7%</td>
</tr>
</tbody>
</table>

All PHOs are prioritising activities and events according to their smokefree plans to proactively reach more smokers and achieve the target. The Primary Care team is monitoring PHOs’ performance closely and have requested PHOs to provide weekly reports on activities. The weekly updates provide information related to the interventions and activities applied at a practice level by the PHOs.

### 3.3 Diabetes Management

**DHB Target:** A minimum of 75% of people with diabetes (aged 15 to 74 years) have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months.
Metro Auckland DHBs and PHOs are committed to improving population health outcomes for people with diabetes. Five prioritised diabetes and cardiovascular disease (CVD) clinical indicators are the basis of our measurement of performance. All metro Auckland PHOs now consistently report anonymised practice level data, related to these five clinical indicators, to the Metro Auckland Clinical Governance Forum (MACGF) (Table 2). This information is now the basis for the performance reporting to the committee.

Table 2: Auckland and Waitemata DHB performance against the MACGF Diabetes and CVD Clinical Indicators as of 31 December 2017.

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Goal</th>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>Pacific</td>
</tr>
<tr>
<td><strong>Clinical Indicators – Long Term Conditions Management - Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c Glycaemic control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months</td>
<td>80%</td>
<td>50.1% (↓2.0%)</td>
<td>49.9% (↓0.7%)</td>
</tr>
<tr>
<td>Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is &lt;140</td>
<td>80%</td>
<td>59.9% (↓1.2%)</td>
<td>53.9% (↓11.9%)</td>
</tr>
<tr>
<td>Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker</td>
<td>90%</td>
<td>71.9% (↑1.9%)</td>
<td>70.9% (↓1.6%)</td>
</tr>
<tr>
<td><strong>Clinical Indicators – Long Term Conditions Management – CVD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVD Secondary Prevention: Percentage of enrolled patients with known cardio-vascular disease who are prescribed triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)</td>
<td>70%</td>
<td>59.6% (↑0.7%)</td>
<td>60.7% (↓1.8%)</td>
</tr>
<tr>
<td>CVD Primary Prevention: Percentage of enrolled patients with cardio-vascular risk ever recorded &gt;20%, (aged 35 to 74 years, excluding those with a previous CVD event) who are prescribed dual therapy (statin + BP Lowering agent)</td>
<td>70%</td>
<td>44.3% (↑1.7%)</td>
<td>53.2% (↓0.4%)</td>
</tr>
</tbody>
</table>

Data Source: Numerator and denominator is extracted from the PHO enrolled data. The denominator is different than that for previous CPHAC reports and Ministry of Health reports.

3.1 Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 04/04/18
PHOs and metro Auckland DHBs established a consistent measurement system for the above five indicators in 2017 and have only been reporting on these indicators since June 2017. At the first upload historical 12 month data was provided. This allows a historical view of PHO performance against these clinical indicators. Reporting against these indicators is still in its infancy, therefore caution needs to be taken when interpreting the data as it contains coding and extraction errors, resulting in an incomplete dataset. This is highlighted by differences seen between the prescribing data reported below for secondary and primary CVD risk prevention and the dispensing data used to report against the Amendable mortality System Level Measure.

Due to this short reporting timeframe there has been minimal improvement in these indicators. This is in part due to the complex nature of diabetes management and ongoing data extraction issues. However, PHOs and DHBs are committed to improving diabetes outcomes with a specific focus on improving outcomes in our high need/risk populations (Māori, Pacific, Asian, those newly diagnosed with type 2 diabetes and those with poor glycaemic control). To achieve improved outcomes in the above clinical indicators a holistic system wide targeted approach is required and the first step are being undertaken as part of the Diabetes Service Level Alliance system redesign workplan.

There is variation in results by ethnicity (Figure 2). For example, the proportion of Māori and Pacific people with good or acceptable diabetes control is 8%-12% lower than other ethnicities.

**Figure 2: DHB performance, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (January 2017 – December 2017)**

Practice level data provided by the PHOs across both DHBs, highlighted that there were 5 out of 138 (3.6%) Auckland DHB practices and 4 out of 96 (4.2%) Waitemata DHB practices, that had achieved the glycaemic control target of 80% of their practice population with diabetes having an HbA1c <64mmol/mol in December 2017 (Figures 3 & 4). The practice level data also shows that there is a large variation in performance against this target between practices. The graphs show crude indicator performance (not adjusted for by practice population size or demographics).
Issues relating to overall data quality and completeness continue to improve with each quarterly data upload. However, the data continues to be affected by ongoing extraction and coding issues. PHOs are actively working to resolve these issues, to date these solutions include:

- A new and improved data warehouse was implemented by Alliance Health Plus PHO and this has enhanced their ability to report against these indicators.
- An upgrade to the Profile for Mac practice management system is expected in early 2018. This upgrade is expected to resolve the data extraction issues experienced by practices using this practice management system.

### 3.4 Cardiovascular Disease (CVD)

Auckland and Waitemata DHBs have achieved and sustained the 90% CVD risk assessment target at a total population level since September 2014 (Figure 5). However, both DHBs have yet to meet this target for the Māori population (this is an SLM contributory measure). To achieve the CVD risk assessment target in Māori the population least likely to receive a CVD risk assessment, Māori men aged 35-44 years, are being targeted.

The current screening rate for Māori men aged 35 to 44 years was 74.7% (↑0.3%) for Auckland DHB and 68.6% (↓0.5%) for Waitemata DHBs at the end of quarter two 2017/2018.
Team is working with the PHOs to ensure achievement of this target. The PHOs are undertaking the following activities to achieve the 90% target in Māori men:

- Placing cobas (portable machines that perform real time, on site HbA1c and lipid profile testing) in practices with large populations of Māori men
- Supporting practices to contact those who require CVD risk assessment to recall these patients for CVD risk assessment.

**Figure 5: ‘More Heart & Diabetes Checks’ performance for Auckland DHB and Waitemata (Q2, 2017/18)**

![Image of bar chart showing 'More Heart & Diabetes Checks' performance for Auckland DHB and Waitemata (Q2, 2017/18)]

*Note: More Heart and diabetes checks – 2017/18 Q2 – Preliminary Ministry of Health data*

**Blood Pressure Control in patients with diabetes:**

In quarter two, the percent of enrolled patients with diabetes (aged 15-74 years) whose latest systolic blood pressure recorded was <140mmHg in the last 15 months declined in Auckland DHB (Figure 6). This decline was due to a data extraction issue with Alliance Health Plus’s new data warehouse. Alliance Health Plus is working on extracting this data and will be able to provide retrospective data once this issue has been resolved.

**Figure 6: Blood pressure control of patients with diabetes – January 2017 - December 2017**
Management of microalbuminuria in patients with diabetes

Between January 2017 and December 2017 the number of people with diabetes and microalbuminuria, in the last 18 months, who are on an ACE inhibitor or Angiotensin Receptor Blocker (Figure 7), has remained relatively stable with very little ethnic variation in management rates. However, it is suspected that the presence of microalbuminuria may be underreported. Once a more complete data set is available this will need to be further analysed.

Figure 7: Management of microalbuminuria in patients with diabetes – January 2017 - December 2017

Secondary CVD risk prevention

The secondary CVD risk prevention clinical indicator is defined as the percentage of enrolled patients with known CVD who are prescribed triple therapy (Statin, BP lowering agent, Antiplatelet/Anticoagulant; Figure 8). The data source for this clinical indicator is PHO prescribing data. This is a different data set than that used for the Amendable Mortality System Level Measures which uses dispensing data.

Improving secondary CVD risk management rates is a focus area for PHOs and Auckland DHB and Waitemata DHB as this is an area where there can be significant and rapid improvements in population health by reducing the number of people experiencing a second or subsequent CVD event. Improving secondary CVD risk management rates will have the roll on benefit of improving blood pressure management in our diabetic populations as the prescribing of triple therapy will have a flow on effect on this clinical indicator.

This is the first time data is available to compare prescribing and dispensing data for those who require secondary or primary CVD risk prevention. This provides an opportunity to better understand the gaps between prescribing and dispensing rates. As a result of this, work can be undertaken to improve both prescribing practices within primary care and medication compliance within the targeted population to improve CVD health outcomes.

Based on the prescribing data received, secondary CVD risk prevention prescribing rates in the total population in Waitemata DHB during quarter two improved slightly across all ethnic groups. However, dispensing data for the same period indicates dispensing rates for those requiring secondary CVD risk prevention remain relatively unchanged.

Secondary CVD risk prevention prescribing rates in the total population in Waitemata DHB during quarter two improved across all ethnic groups. Across both Auckland and Waitemata DHB Pacific people have the highest rates of secondary CVD risk prevention management.
Secondary CVD risk management rates in patients with diabetes are higher than those seen in the total population (Figure 9). Dispensing data supports this finding.

**Figure 8: Secondary CVD risk prevention in the total enrolled population, by ethnicity, January 2017 - December 2017**

![Graph showing secondary CVD prevention by ethnicity in the total enrolled population from January 2017 to December 2017.](image)

**Figure 9: Secondary CVD prevention in patients with diabetes by ethnicity – January 2017 - December 2017**

![Graph showing secondary CVD prevention in patients with diabetes by ethnicity from January 2017 to December 2017.](image)

**Primary CVD risk prevention**

The primary CVD risk prevention clinical indicator is defined as the percentage of enrolled patients with CVD risk ever recorded >20% (aged 35 to 74 years) and who are on dual therapy (statin and BP lowering agent). This excludes those with a previous CVD event. The data source for this clinical indicator is PHO prescribing data. This is a different data set than that used for the Amendable Mortality System Level Measures which uses dispensing data.

Over quarter two, an improvement in primary CVD risk management was seen in Waitemata DHB across all ethnic groups in both the total population (Figure 10) and those with diabetes (Figure 11). However, the dispensing data for Waitemata DHB for the same period remains relatively unchanged.

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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 04/04/18
Auckland DHB primary CVD risk prevention rates remained relatively unchanged during January 2017 to December 2017.

Similar to secondary CVD risk prevention, primary CVD risk prevention management rates in those with diabetes is better than in the total population. Dispensing data supports this finding.

**Figure 10:** Primary CVD risk prevention in total enrolled population, by ethnicity, January 2017 - December 2017

**Figure 11:** Primary CVD risk prevention in those with diabetes, by ethnicity– January 2017 - December 2017

**Additional Commentary**
While we want to progress all five metro-clinical indicators there is a limit to discretionary effort by practice staff. A relentless focus to get rapid change will be required. Consequently, it is likely that the initial focus will be on a sub-set of the five indicators. Still to be confirmed a focus on Triple Therapy for secondary prevention of CVD and ACEi prescribing for those with Microalbuminuria maybe the first priority and once improving then consider primary prevention and glycaemic control as secondary considerations.
The recent release of a revised CVD risk assessment and management consensus statement indicates changes to recommendations and thresholds, the purpose of which is to improve CVD management and promote best practice with greater clarity than we have had previously. There is a sub-group of the MACGF that is meeting to consider the definitions and changes including age limits and the approach to implementing the new consensus statement in metro Auckland. This has considerable impact practically at a practice level and the change may have to be resourced to achieve implement. The Ministry of Health are developing an implementation plan for the new consensus statement, with primary care involvement, and this is expected towards the end of 2018.

3.5 Formation of the Northern Hospice Alliance
During the initial discussions in 2016 between the Hibiscus Hospice, North Shore Hospice Trust Boards and the Chief Executive (North Shore Hospice Trust and Warkworth Wellsford Hospice), the prospect of “sharing a Chief Executive” morphed to become a strengthened strategic partnership based on a common vision and long-term view of delivering services to better meet community needs. This resulted in a Strategic Alliance Agreement to establish a Northern Hospice Alliance (see Appendix 1). The overarching goal of this Alliance was to remove duplication of management roles and direct more funding back into clinical care.

Initially, a joint Chief Executive position and a shared Human Resources team were established. These changes were critical to facilitate subsequent change management and to support the sharing of resources.

The formation of the Northern Hospice Alliance has encouraged and enabled the hospices to work in collaboration and develop innovative solutions to ensure consistency of service delivery and sustainability of palliative care services in the north and eastern Waitemata DHB district. A number of significant changes have been successfully implemented by the Alliance and are listed below:

- Reinvestment of savings ($350,000) into clinical care and the creation of an Innovation Hub to focus on research and innovation
- Employment of a Clinical Development Specialist to upskill current and future clinical workforce
- Establishment of a Referral Specialist role to enable a single point of entry into the hospices and to ensure equitable access to care
- Development of a Day Group Coordinator and Community Volunteer Coordinator at Hibiscus Hospice and Warkworth Hospice
- Reduction in the number of executive leadership positions from 16 to 7.

Further details about the Northern Hospice Alliance initiative is provided in Appendix 1.

4. Children, Youth and Women

4.1 Better Public Service Targets and alignment of work programmes
The Ministry of Health has confirmed that the Better Public Service (BPS) targets are not being continued. The two areas this affects specifically are ‘early engagement with a Lead Maternity Carer’ and ‘Avoidable Hospitalisations 0 – 12 years’. These two measures had previously replaced targets for reducing Rheumatic Fever and increasing Immunisation. We are not yet aware of whether there will be changes to the Health targets including to the eight month immunisation health target. The Government has a focus on reducing child poverty, which may influence areas of activity associated with healthy housing. However, we do not yet have any clear direction on this. From the perspective of health gain priorities, immunisation, obesity reduction and early intervention from pregnancy remain important areas of focus for the health sector. Activities related to maternity and child health
priorities continue to be supported and monitored by a joint Auckland DHB and Waitemata DHB Service Alliance co-chaired by the Auckland DHB Chief Executive and a PHO CEO.

**4.2 National Sudden Unexplained Death in Infancy (SUDI) Prevention Programme.**
A draft Northern Region Plan for SUDI prevention was submitted to the MoH in November 2017. We are awaiting feedback from the MoH and the national SUDI prevention programme coordinator, Hapai, including from their Expert Advisory Group for SUDI prevention. The draft plan has also been circulated for feedback to the Child Health Steering Group and the Northern Region SUDI implementation group. Further development of regional planning will be undertaken towards achieving a clear plan of priorities for regional work in 2018/19, alongside local DHB priorities for SUDI prevention programme enhancement.

Jennifer Fletcher has recently begun working at Auckland and Waitemata DHB Planning, Funding and Outcomes unit as the SUDI prevention programme manager for Auckland and Waitemata regional work. Jennifer will work collaboratively with counterparts in Counties Manukau Health and Northland DHB to progress regional priorities.

The more intensive smoking cessation programmes for women in pregnancy are in the implementation phase, under the Primary Care Team. We expect this will have a significant positive impact on SUDI prevention. The SUDI prevention programme will work to promote and embed this and associated smoking cessation programmes alongside other SUDI prevention initiatives. Preparation for expanding the purchase and provision of safe sleep devices, wananga for hapu mama and health promotion resources is underway.

**4.3 Healthy Housing Initiative Kainga Ora**
The service is well established with 666 whanau and 1017 individual referrals (both DHBs).

The Ministry of Healthy have conducted a national evaluation of the healthy homes initiative services which indicates positive outcomes for whanau. Further evaluation is required to support the development of a service improvement framework locally and nationally.

**4.4 Immunisation Health Target**
After two consecutive quarters of achieving the Immunisation Health Target, Auckland DHB did not meet the target of 95% of 8 month old babies being fully immunised. In Q2, Auckland DHB achieved 93% overall. There was also drop in the Maori coverage rate to 78%. The National rate also decreased, but not to the same extent as in Auckland. A deep dive analysis is being undertaken to understand factors contributing to the number of babies who missed out on immunisation this quarter and we are meeting with the PHOs and Outreach Immunisation Service to discuss findings.

Achieving the target continues to be a challenge for Waitemata DHB. However, 93% of babies were fully immunised by eight months of age, up 1% from the same quarter last year and bucking the downward national trend. Importantly, the result for Maori was up 3% on the same quarter last year, although rates for Pacific dropped.

Efforts to achieve equity for Māori infants continue, including:
- the Māori case review group
- co-design work to improve immunisation promotion reach,
  - Particularly working with Te Whanau o Waipareira supporting the development of immunisation champions from the community and health support workers
- Quality improvement with primary care providers with larger number of Māori babies (to develop strategies for better engagement).
We are also working with Waipareira on an enhanced Well Child Tamariki Ora service providing in home vaccination. This will include communication channels with HealthWest in regards to the OIS service and we have already given OIS a heads up on the proposed extension of the Well Child Tamariki Ora service.

Immunisation was promoted at the Pacific and Māori Health League tournament, highlighting the importance of on time immunisation, particularly for MMR vaccination, for which we have developed a voucher to promote awareness.

4.5 Mumps catch-up programme
Since early 2017, metro Auckland has experienced an outbreak of Mumps. This outbreak started in West Auckland and has particularly affected those aged 10-29 years living in lower socio-economic areas, with Pacific peoples inequitably affected (see section 10.1 for the surveillance reporting for mumps).

As previously reported, most young people will have been given at least one dose of MMR in early childhood, however changes to the Immunisation Schedule in 2001 and less effective reminder systems before 2005 mean that many teenagers and young adults are not fully protected. Many Pacific children may not be protected against mumps as the majority of Pacific nations do not include mumps in their immunisation schedules.

In term 4 of 2017, Waitemata DHB implemented a MMR vaccine catch up programme in five low decile schools with existing Enhanced School Based Health Services which has resulted in positive uptake. Almost 700 year 9 and 10 students received a vaccination in the final weeks of term 4 2017. The programme is continuing in 2018 with the new Year 9 and Years 12 and 13 students, as well as any students that missed out last year.

Auckland DHB CEO has approved rolling out a similar MMR catch-up programme in 10 low decile high schools, 9 with existing Enhanced School Based Health Services and Avondale College, which has a large Pacific population. Principals of the 10 schools are all keen to engage in the programme. The focus is on the older students in Term two followed by the younger students in Term three. The PHOs are leading a focus on promotion of MMR in tertiary institutes (particularly Pacific student networks) and primary care.

The MoH have endorsed a local school based response and have indicated that there will be partial funding made available to support this, although the amount is yet to be confirmed.

Other schools are being asked to inform their communities and encourage students and whanau to go to their usual medical practice for MMR vaccination.

4.6 Pertussis Outbreak
As previously reported, the MoH declared a national outbreak of pertussis on 1 December 2017. ARPHS have reported an upswing in Pertussis notifications across all three Auckland DHBs. ARPHS is leading communications across the region; further information can be found in section 10.1.

An Auckland and Waitemata DHB response Plan is being developed, with particular focus on promoting antenatal immunisation. This activity is included under the SLM activity on special immunisations (antenatal and influenza vaccination for eligible children). A reminder card for the antenatal Boostrix has been developed and is in the process of being distributed to primary care, LMCs and pharmacies to give to women accessing their services.
4.7 Adult Vaccines

As previously advised, Zostavax, a vaccine to protect against herpes zoster (shingles) is being introduced to the National Immunisation Schedule. From 1 April 2018 Zostavax will be funded for adults aged 65 years. There is also a catch up programme for adults aged 66–80 years inclusively from 1 April 2018 to 31 March 2020 only. The Ministry has advised that Zostavax can be administered at the same time as funded influenza vaccine for the over 65 year olds and only one Immunisation Subsidy benefit can be claimed. This is likely to stretch the capacity of primary care practices.

The Northern hemisphere and Australia have suffered severed influenza seasons in 2017. In response, the 2018 influenza vaccines are broadly matched to include the “Australia Flu’ strain. The funded influenza vaccine is now quadravalent (protective of four types of influenza), because of the updated vaccine composition, supply has been delayed slightly. The vaccine for over 3 year olds is expected early April, whilst the vaccine for under 3 year olds will be mid-April. This delay may have an impact on our SLM activity of increased influenza vaccination of eligible children.

4.8 Obesity Health Target – ‘Raising Healthy Kids’

Auckland and Waitemata DHBs both continue to exceed the Raising Healthy Kids target for all ethnicities. Training for Primary Care providers and a brief intervention service continue following positive evaluations. A procurement process has begun to introduce a Positive Parenting and Active Lifestyle Programme for pre-school children and their families across both Auckland and Waitemata DHBs.

4.9 Oral Health

The Preschool Oral Health Action Plan for Metropolitan Auckland Region 2017-2019 is being used to focus actions to improve oral health. During 2017 there was a strong focus on ensuring children are enrolled with the service. This has included automatically enrolling babies at birth and reviewing and updating the Auckland Regional Dental Service (ARDS) registration form. The new registration form is being rolled out to Well Child Tamariki ora providers and primary care through a series of presentations.

ARDS clinics are now open on Saturdays in Wesley, Otara and Point England and there are plans to commence Saturday clinics in Kelston, Ranui, Kingsland, Mangere, Beach Haven and Onepoto. Saturday clinics are proving popular with the community.

A Fluoride Varnish programme has been developed and will begin in two Kohunga Reo and two Pacific Language nests in March. This programme will be evaluated and rolled out to other Early Childhood Centres around the region. Work is also underway to review the accuracy of the oral health data that is collected and reported.

4.10 National Child Health Information Platform (NCHIP)

The Northern region aims to ensure every child is enrolled at birth, and their access to the range of universal health services is tracked and supported through their early childhood years, with the goal of ‘Knowing Every Child’ and delivering equitable access to universal services.

To deliver on this goal, this project aims to provide three of the four Northern DHBs with a single, centralised system that identifies all the children living in the region and reports on enrolment and milestone data from service providers delivering the range of core universal child health services.

Auckland, Waitemata and Northland DHB Boards approved allocation of funding to implement the NCHIP over two years. A project manager has been appointed who will work across the Region. Four work streams have been identified for the current project initiation phase:
• Commercials and Agreements
• Technology and Development
• Provider Engagement
• Service Delivery and Governance.

4.11 Cervical Screening
Coverage targets for cervical screening of 80% have not been achieved. In particular, Māori coverage for both DHBs remains significantly lower than the target. Coverage trends are not reassuring.

The HPV Self-sampling Feasibility study for Māori women in West Auckland has been completed and results will be presented at the next CPHAC meeting. The Feasibility study has informed the design and materials for the larger randomised controlled trial, for Māori, Pacific and Asian women, which will begin recruitment in April 2018.

Education, practical support and promotion of the use of National Screening Unit data match lists for use by General Practices to recall women for screening continues to be provided. This supports more targeted recall efforts by primary care. We currently have a vacancy in the co-ordination service role and are planning for recruitment to fill this important role to support engagement with cervical screening.

We support and encourage PHOs and practices to promote screening and to utilise opportunistic screening strategies as well as broadening available clinic hours (such as weekend clinics). Funding for cervical screening to PHOs targeted to high priority women continues to be provided.

We continue to collaborate with Well Women and Family Trust (the nationally funded ‘independent service provider’) to promote outreach screening in community locations as well as support to services for screening for women who have proven difficult to recall for primary care. The Māori Health Gain team and Child, Youth and Women teams have been working collaboratively on a 90 day cancer screening plan to identify opportunities to provide greater support for engagement with the Māori provider organisations. This involves supporting the Independent Service Provider in building a stronger profile in the community and improved engagement with Māori organisations and communities.

5. Health of Older People

5.1 Age Residential Care (ARC)
Two key areas of work are underway at a national level:
• A21 Review
• ARC Funding Model Review

The A21 Review is the annual review of the national Age Related Residential Care (ARRC) Agreement; any revisions will be in place on 1 July 2018. This process will also include the price increase for the bed day rates. The ARC Sector is consistently raising concern about the increasing acuity and complexity of the residents they are caring for and the increasing costs associated with this care. A further complexity is how pay equity funding will be managed for 2018/19, this is yet to be agreed.

Ernst Young has the contract to review the ARC Funding Model. The purpose is: to review the existing funding model for ARC services in New Zealand, articulate the model(s) of care and outcomes that should be incentivised and driven, and then the funding model(s) required in support of such a...
model(s) of care and outcomes. A final report with a proposed funding model is due in December 2018.

5.2 Aged Residential Care Audits
We continue to see a downward trend in the number and risk rating of audit corrective action findings from ARC audits. The highest number of audit corrective actions relate to the Continuum of Service Delivery Standard. This standard covers the assessment, care planning and delivery of care services; weight monitoring; wound management; planned activities; medicine management; and nutrition, safe food and fluid management. The Quality Monitoring Managers have developed training tools on these findings to support ARC facilities, and have been discussing these through different provider forums.

<table>
<thead>
<tr>
<th>2017/18</th>
<th></th>
<th>Quarter 1</th>
<th></th>
<th></th>
<th>Quarter 2</th>
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<tbody>
<tr>
<td></td>
<td>ADHB</td>
<td>WDHB</td>
<td>ADHB</td>
<td>WDHB</td>
<td>ADHB</td>
<td>WDHB</td>
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<tr>
<td>Certification audits</td>
<td>9</td>
<td>6</td>
<td>14</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unannounced audits (surveillance)</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td>Average number of corrective action per audit</td>
<td>1.7</td>
<td>4.7</td>
<td>2.9</td>
<td>4.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>facilities &gt; 5 corrective actions</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective actions relating to health &amp; safety (% of total CAs)</td>
<td>9 (60%)</td>
<td>13 (46%)</td>
<td>17 (42.5%)</td>
<td>11 930%</td>
<td></td>
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<tr>
<td>Facilities with no corrective actions</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilities achieving a continuous improvement*</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td></td>
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<tr>
<td>Number of complaints the DHB received on ARRC</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>5</td>
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</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.

5.3 Home and Community Support Services (HCSS)
The Medication Guidelines for HCSS prepared by Waitemata DHB and the HCSS providers went out for national consultation in March. HealthCERT MoH has set up a Working Group to oversee this.

A Waitemata DHB Working Group has been set up to develop an HCSS model of care for the DHB, which will form the basis of a Procurement Plan. The Group is cognisant of the MoH DHB partnership programme, Future Models of Care, which has a deliverable of an HCSS framework by June. A Future Models of Care Stakeholder workshop is scheduled for the end of March in Auckland.

The Auckland DHB integration projects for HCSS are progressing well. A Stop and Watch Tool has been implemented to enable HCSS support workers to pick up early client deterioration and escalate appropriately. Stop and Watch events are being recorded and included in quarterly performance monitoring reports, which will also enable bench marking between providers.

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 04/04/18
Currently HCSS providers are receiving quarterly advance interim payments for pay equity with wash ups on actuals. The MoH has signalled an intention to incorporate pay equity funding into DHB contracts for the 1 July 2018, however the mechanism for this has not been decided. It is further complicated by the different funding models DHBs have in place for HCSS e.g. fee for service, bulk funding, case mix.

5.4 Other Health of Older People Activity
Notification and management of contract terminations for day activity programmes and supported living, previously approved by the Boards, are underway.

6. Mental Health and Addictions

6.1 Government Inquiry into Mental Health and Addiction 2018
The Government Inquiry into Mental Health and Addiction was established by the New Zealand Government in response to widespread concern about mental health and addiction services in the mental health sector and the broader community. The purpose is to identify unmet needs related to mental health and addiction, and develop recommendations for a cohesive approach for Aotearoa, New Zealand. The report from the inquiry is likely to relate to the mental health and addiction sector as well as other sectors, given the risk factors identified in the Terms of Reference (https://gazette.govt.nz/notice/id/2018-go318) including, but not limited to: poverty, unemployment, domestic violence, discrimination, access to affordable housing, and lack of education. The Minister of Health announced the Terms of Reference and membership of the Inquiry on 30 January 2018, with following appointments:

- Professor Ron Paterson, ONZM (Chair);
- Dr Barbara Disley, ONZM
- Sir Mason Durie, KNZM, CNZM
- Dr Jemaima Tiatia-Seath
- Josiah Tualamali‘i
- Dean Rangihuna

The inquiry must report back to the Government by 31 October 2018 and are committed to making recommendations that are pragmatic and implementable, with a focus on short and long-term solutions at the national and local level. The priority groups identified are Māori, youth, Pacific people, minority, immigrant and refugee groups, LGBTIQA+ communities, prison populations, the elderly and rural/farming communities. The inquiry wants to build on the good work already being done, while looking to system-level change that will improve both promotion of good mental health and support for people with mental health challenges and/or addictions. In short, the inquiry report aims to generate hope and set a clear direction for the next five to ten years that Government, the mental health and addiction sectors, and the broader community can pick up and implement, to make real, positive change.

Mental Health and Addictions Inquiry, Opportunities to Connect
The Inquiry members are committed to wide and ongoing engagement throughout the Inquiry. They expect to release a consultation document and receive submissions as well as:

- Meet with sector groups, consumer groups, Māori health providers and representatives of diverse other sectors, e.g. housing, corrections and police
- Hold public (and potentially private) hui, fono and hearings around the country
- Engage through social media and online (opportunities will be advised).
The Inquiry estimated timing for engagement is:
- Consultation document release: end March/early April
- Submissions open: April – May 2018
- Hearings: May – June 2018
- Direct engagement with interested parties: March – August / September 2018.

The process is designed to allow engagement throughout the Inquiry, and have flexibility to respond and adapt if necessary. The Inquiry will always be contactable through the team email address mentalhealthinquiry@dia.govt.nz

### 6.2 Auckland DHB Mental Health and Addiction Programme Board Work Plan

The Mental Health and Addiction Programme Board will be a key leadership, accountability and advisory group reporting to the Auckland DHB Board (via the Executive Sponsor Group). Its purpose is provide leadership for the development and monitoring of the Mental Health and Addictions programme which aims to transform mental health and addictions services funded or delivered by Auckland DHB for the purpose of supporting our population to live well, stay well, get well. This programme aligns with Auckland DHB’s strategic themes including: community, whānau and person-centred model of care; emphasis and investment on both treatment and keeping people healthy; service integration and/or consolidation; outward focus and flexible, service orientation. Below is a table of high level work plan for Mental Health and Addiction Board established January 2018.

<table>
<thead>
<tr>
<th>Mental Health and Addiction Programme Board Progress Report</th>
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<tbody>
<tr>
<td><strong>Project Title</strong></td>
</tr>
<tr>
<td>1. Zero Suicide*</td>
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<tr>
<td>2. Improving the physical health of people who have severe and enduring mental illness - How might we improve the long term physical health of people who are presenting with psychosis for the first time?</td>
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### Mental Health and Addiction Programme Board Progress Report

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Outcomes or measures</th>
<th>Linkage</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Objective clinical markers</td>
<td>• Improving the physical health of people who have severe and enduring mental illness</td>
<td></td>
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<tr>
<td></td>
<td>• Balanced physical and mental health support</td>
<td>• Review of Effective Interventions, Healing Practices and alternatives to medication Project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Zero weight gain</td>
<td>• NRA Mental Health and Addictions Project to implement PREDICT tool across adult Mental Health Services and Forensic Services</td>
<td></td>
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<tr>
<td>3. Supporting effective and safe prescribing in Mental Health Services</td>
<td>In scope: • Audit current prescribing practices • Establish recommended doses • Offer taper off option to people currently on medication in specialist services • screening and monitoring side effects and putting in place intervention and treatment of risks and to address risks</td>
<td>• NRA Mental Health and Addictions Project to reduce the number of audit corrective actions that relate to medication</td>
<td></td>
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<tr>
<td></td>
<td>Benefits of Project: • Reduce inadvertent high-dose prescribing • Providing Choice • Quality improvement of clinical practice standards for prescribing • Education and information about medication for all parties • Screening, Monitoring side-effects and implementing strategies to address risk factors • Wrap around service approach for new people to anti-psychotic medication – prescribing, screening and monitoring side effects and putting in place intervention and treatment of risks and to address risks</td>
<td>• NRA Acute IPU Working Group Electronic Discharge Summary Project and Barriers to Discharge including safe and affordable accommodation.</td>
<td></td>
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<tr>
<td>4. Review of Effective Interventions, Healing Practices and alternatives to medication Project</td>
<td>In scope: • Evidence based interventions; identify and deliver interventions that demonstrate effectiveness improving mental health; evidence that such interventions will provide good value for health system resources • Early intervention in psychosis, for example, are highly cost saving, even within a relatively short two year timeframe • Provide good examples of interventions for which empirical evidence is strongest • Continuum of services and interventions • Changing workforce and training and education</td>
<td>• Supporting effective and safe prescribing in MH Services Project</td>
<td></td>
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</table>

Project scope to be reviewed and developed by Medical Director, Service Clinical Directors and Pharmacy Consultants/Advisors (March-April 2018). Project Resource competencies identified and level required March 2018 Data Analyst resource identified and clinical audit framework established (March-April 2018).

Workshop set up to further define project scope and resource to be held on Tuesday 17 April 2018.
### Mental Health and Addiction Programme Board Progress Report

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Outcomes or measures</th>
<th>Linkage</th>
<th>Actions Update 28/2/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. IT project to identify within Primary Care GP reporting system ability to flag priority groups</td>
<td>Service and intervention mapping of current for effectiveness and continuance.</td>
<td>Supporting effective and safe prescribing in MH Services Project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scope of project: Develop flag within IT GP Reporting system for priority populations including those people prescribed anti-psychotic medication.</td>
<td>NRA MHA Health Pathways adapted to Northern Region from Canterbury for Primary Care providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outcome of Project: Flag active GP engagement with people for annual physical reviews and management/support of side effects of medication; routine metabolic screening is completed with active care planning in Primary Care and referral to right support services.</td>
<td>NRA Acute IPU Working Group Electronic Discharge Summary Project and Barriers to Discharge including safe and affordable accommodation.</td>
<td></td>
</tr>
<tr>
<td>6. Housing Project to increase and improve range of accommodation options for people with enduring and serious mental illness and/or addiction, working with other services and Government agencies to achieve this.</td>
<td>There is a negative relationship between poor-quality housing and Mental Health and Addictions problems, it is important that key stakeholders in the sector understand the living situation of service users and work with other agencies to influence change in this area.</td>
<td>NRA Mental Health and Addictions Projects: Improve Mental Health and Addictions Service Capacity for people with high and complex needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quick accommodation status from ADHB NGO PRIMHD data estimated to be:</td>
<td>NRA Mental Health and Addictions Factors that Impact on high use of acute IPU services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 2016: 7% of people accessing NGO services have “homeless accommodation status”</td>
<td>NRA Workforce Development Module on Behavioural and Risk Management for non-clinical support workers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 2017 still at 7%</td>
<td></td>
<td>March-April 2018 develop project scope with identified Project Manager and Funding and Planning Lead</td>
</tr>
</tbody>
</table>

*Zero Suicide update from workshops held across Auckland and Waitemata DHBs on 1 December 2017 with Dr Kathryn Turner talking about their journey to Zero Suicide over the last three years in Gold Coast Health is presented below in the CPHAC report.

### 6.3 Zero Suicide Framework

Suicide rates in New Zealand are a national tragedy, with over 500 people each year taking their own life and a large number of people harming themselves; and/or reporting suicidal thoughts. NZ also has high rates of youth suicide (second highest in OECD Countries), statistics have shown.
approximately 40% of people who suicide have accessed specialist mental health services at some point in their life journey.

Waitemata and Auckland DHB supported the visit of Dr Kathryn Turner, from Gold Coast Health, to present at two workshops on 1 December 2017, providing an overview of her organisations three-year journey progressing to Zero Suicide through Leadership, support and continuous improvement. The workshops introduced DHB staff to the idea that we could follow, be supported and mentored by Dr Turner and her team, learning from their implementation to start our own journey to Zero Suicide.

The critical attributes identified by Dr Turner for their in implementing Zero Suicide are:

1. Core values: the belief and commitment that suicide can be eliminated in a population under care (boundaried population) by improving service access and quality and through continuous improvement
2. System Management: systematic steps take in organisation and systems of care aimed at creating a safety culture where suicide is unacceptable and that sufficient support is available for the clinical personnel who do this difficult work
3. Evidence-based and Clinical Best practices: using methods, interventions and practices that are research validated and/or consistent with research evidence and based on expert judgment, delivered through a care system that emphasises productive (healing) patient and staff interactions.

Auckland DHB Mental Health and Addiction programme board has a Zero Suicide project charter with project resource approved for the next three years. Dr Turner reported that dedicated project management from the start would have hastened their journey, with the first year spent having conversations with senior clinicians, Board, clinicians, consumers, carers, senior management staff, developing strategy and pathways and developing the training packages based on clinical best practices.

The elements of Zero Suicide:

- Lead – engagement with staff, executive, Board, about concepts of Zero Suicide Model and Just Culture, development of the Suicide Prevention Strategy and subsequent pathways and establish working groups
- Train – develop online and face to face training to all medical and all community staff, commence Suicide Prevention Pathway and onsite support of staff
- Identify – systematically identify and assess suicide risk among people receiving care
- Engage – ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means
- Treat – using effective, evidence-based treatments that directly target suicidal thoughts and behaviours
- Transition – provide continuous contact and support especially after acute care
- Improve – service improvement through data collection and feedback and survey staff (culture, confidence and safety) and repeat surveys, review data on suicide attempts and representations and gain consumer experience and feedback (Turner, 2017; Rafferty, 2017).

The perception of adopting the zero suicide frameworks is about setting targets, if zero is not achieved there will be arguments that it is deemed a failure. However, the framework identifies zero suicide not only as an inspirational goal but one that will change DHB culture and mindset to create an appropriate system response and a no blame culture (Table 1 below). Zero suicide is a commitment to suicide prevention in health and behavioural health care systems and a specific set of strategies and tools, it presents both a bold goal and an aspirational challenge. “Knowing is not
enough; we must apply. Willing is not enough; we must do” stated by Joe Rafferty, CEO of Mersey Care, UK at seminar in Auckland in November 2017.

Table 1: Culture change/Change in mind-set (Turner, 2017)

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeing suicide as inevitable</td>
<td>Suicide is preventable with a systems approach</td>
</tr>
<tr>
<td>A culture of blame or outcome severity bias</td>
<td>Just Culture and system that supports staff; continue working toward goal of high reliability health care and increase fidelity to the pathway</td>
</tr>
<tr>
<td>Risk assessment and containment</td>
<td>Collaborative safety, treatment and recovery</td>
</tr>
<tr>
<td>Standalone training and tools</td>
<td>Overall systems and culture change</td>
</tr>
<tr>
<td>Individualised clinicians judgment and actions</td>
<td>Standardised screening, assessment and interventions</td>
</tr>
<tr>
<td>Hospitalisation during episodes of crisis</td>
<td>Productive interactions throughout ongoing continuity of care</td>
</tr>
</tbody>
</table>

The Zero Suicide Framework includes providing a number of interventions that all health professionals within the hospital settings can easily learn, adopt and implement to significantly respond to suicidal ideation or attempts with a subsequent reduction in deliberate further self-harm and mortality (Erlangsen, A. 2015). If every health professional systematically applied the following five zero suicide strategies, it is highly likely we could bend the curve of our rising suicide rate in the right direction:

1. review suicide risk systematically
2. address suicide directly
3. make a safety plan with at-risk patients
4. manage means by which people plan to suicide with
5. follow up with high-risk individuals immediately.

The interventions that make up the elements of Zero Suicide are known to work. A number of Health providers around the world have successfully adopted these frameworks, including Michigan (US), Mersey Side NHS (Liverpool, England) and Gold Coast Health (Australia). They have all evaluated the framework and produced evidence of the efficacy and effectiveness of this approach.

6.4 Substance Addiction Compulsory Assessment and Treatment Act (SACAT) Update

The SACAT legislation came into effect on 21 February 2018. To date one person from the Northern Region has been assessed, with a certificate issued under the legislation. Once the person is detoxed, medically stable and it has been determined they have not regained cognitive capacity; they will be transferred to the National facility located in Christchurch. There have been a number of enquires (less than 10) relating to eligibility for people residing in the Northern Region. Nationally, there have been no other people placed under the legislation to date, a very small number of enquires/referrals have been recorded.

A business case seeking a financial contribution from the Ministry of Health to an innovative Northern Region initiative to co-locate specialist addictions services has been submitted. The intent is to co-locate social and medical detoxification services within integrated primary and secondary health, housing, and social services: Mission HomeGround (Auckland City Mission). The request is to construct an additional floor at Mission HomeGround to accommodate a 10-15 bed medical detoxification service. Funding the construction of this additional floor has potential to increase detoxification bed capacity by 50% and will allow metropolitan Auckland Detoxification services to manage the existing high demand for treatment. There is also provision within this build for future proofing for a Northern Region SACAT facility. The Ministry have made no commitment to fund a
Northern Region SACAT facility. If this funding proposal is approved, the intention is for the purpose built medical detox facility to be fully operational by June 2020. This initiative has the potential to achieve substantial health and social benefits including a reduction in unnecessary emergency department presentations and hospital admissions as a result of greater collaboration between primary and secondary health, housing and social services. The outcome of this funding bid to the MoH is expected in March 2018.

6.5 Equally Well Initiatives
In 2017 the Health Gain Team conducted a Health Needs Assessment (HNA) focussed on the Physical Health Status of people with chronic serious mental illness in Auckland and Waitemata DHBs. In New Zealand and overseas, people with mental health and addiction problems have worse physical health than their counterparts in the general population, and a significantly shorter life expectancy. Diabetes, cardiovascular disease, metabolic syndrome, cancer and oral health issues are more common for this population group particularly for those prescribed antipsychotic medication.

The HNA was undertaken to establish what was known in our system (across primary and specialist care) about the basic physical health status for a cohort of people who had been engaged with Mental Health Services for greater than one year. This provided a baseline indication about the current state of the system and to determine priorities for action. It is tied into Equally Well work and is an issue that primary and specialist care needs to tackle together.

The first phase of HNA analysis has been completed (only ProCare and Auckland PHOs were able to contribute data so far) and is currently being presented to local governance groups. One of the key findings is 92-94% of people with serious mental illness were enrolled with primary care (which is better than the population average for Auckland DHB and about the same as the Waitemata DHB population average). Drilling into Procare data enabled us to see people are also regularly attending primary care (on average about six visits per year compared to an average of three visits for general population).

Regional Health Pathways adapted to local services and agreed optimal assessment and management guidelines will support Primary Care in their support of people with serious mental illness. More work needs to be done at a population level to recognise people with serious mental illness as a priority group for physical health monitoring and support within primary care and in partnership with specialist mental health services.

The HNA work has prompted a number of initiatives on the Auckland DHB Mental Health and Addictions Programme Board work plan described briefly above and specifically includes:

- Improving the physical health of people who have severe and enduring mental illness - How might we improve the long term physical health of people presenting with psychosis for the first time?
- Develop a wrap around service approach for new people to anti-psychotic medication – prescribing, screening and monitoring side effects and putting in place intervention and treatment of risks and to address risks (as part of Supporting effective and safe prescribing in Mental Health Services).

6.6 Infant, Child, Adolescent and Youth Mental Health and Alcohol and Other Drug issues
continuum of care review and project plan
Auckland and Waitemata DHBs are working jointly to fund and sponsor a project lead to review and update an Infant, Child and Youth Continuum of care to address existing gaps, effectively respond to demand and ensure the right level of care is provided at the right time, in the right place. Auckland and Waitemata Child and Adolescent Mental Health Services are under increasing pressure, the closure of the Richmond Youth residential respite service, increased demand for Child and Family
Unit beds, increasing levels of acuity and complexity, demand from Child Youth and Family Services, and the need to address multiple co-morbidities has highlighted the need for more cohesive and targeted interventions to meet the needs of children and young people across the developmental spectrum.

Infancy, childhood and adolescence represents the period with the greatest opportunity to reduce the impact of mental health and addiction issues through effective and focussed early interventions and targeted therapeutic work. Development of a comprehensive Auckland and Waitemata Infant, Child and Youth continuum of care across the whole developmental age range is required to ensure cohesive, effective and sustainable service responses from primary prevention to acute care. This project will identify existing resources, ascertain if there are gaps in service provision, determine what interventions are most effective and should be up-scaled, as well as those which do not meet the current need and may be rationalised or integrated to make more efficient use of the existing investment. A project manager, supported by a Technical Advisory Group will run a series of workshops with key experts and community stakeholders, where the scope of the continuum will be defined and further developed. The key deliverable will be a finalised continuum of care for Auckland and Waitemata DHBs, with recommendations for investment and/or disinvestment.

The following key areas of work have been identified to be addressed:

- Development of a service map of existing Infant, Child and Youth mental health and addiction services available across the developmental continuum in NGO, primary and secondary services
- Review the epidemiology to identify the estimated demand for different service types ranging from primary to acute care and addressing the range of presenting issues from attachment and behavioural issues, suicide and self-harm along with other comorbidities including foetal alcohol spectrum disorder and neonatal abstinence syndrome
- Build on strengths within our child and youth mental health and addiction services
- Identify existing resources, service gaps and the capacity of existing services across Auckland and Waitemata DHBs to manage the demand for the range of therapeutic interventions required
- Support the development of a comprehensive continuum of care with an emphasis on stepped care
- Identify areas for disinvestment and reinvestment in services to best meet the need
- Estimate the funding required to support establishment of any new services or service changes required
- Identify any workforce development issues or gaps
- Help guide preparation of a business case to commission evidence based services to meet the identified need.

This project has a 10 month timeframe and is due for completion at the end of November 2018.

6.7 Paired Up – Youth Peer Support Service Pilot and Evaluation
Auckland DHB has contracted Connect Supporting Recovery in partnership with other NGO and services to pilot and evaluate “Paired Up – Youth Peer Support Services” initially within the Tamaki College population group. Paired Up service will support Tamaki College, Auckland DHB and the wider Tamaki community in achieving their suicide prevention and youth resiliency goals. Connect Supporting Recovery and Paired Up are committed to working alongside Tamaki College, their student support team and the teaching faculty, as well as Tamaki’s community agencies, primary care providers, secondary mental health services, social enterprise Rakau Tautoko, and most importantly the young people of Tamaki College.

Paired Up creates a network of connected young people sharing guidance about positive wellbeing while taking purposeful action through groups, events and activities called ‘Pop Ups’. It was co-created by a team of youth designers with a lived experience of mental and emotional distress,
alongside the support of industry leaders from mental health and addictions services. Paired up is grounded in the principals of manaakitanga, mauri ora, whanaungatanga, diversity, ‘tell it like it is’, and ‘we don’t do for people we do with people’. Like Māhutonga, the Southern Cross, these values guide us in the way we connect with people. Youth peer support is a valued and complementary addition to any service provision.

This pilot is to be implemented and evaluated over a 12 month term with an evaluation report due to Auckland DHB by 31 January 2019.

6.8 Review of Primary Mental Health Initiatives
The implementation and priority actions for 2017/2018 are:

- Development of a co-designed model of care across both Auckland and Waitemata DHBs
- Alignment of any actions/activity with the Fit For the Future Project and the evaluation framework being completed, hence work is progressing on developing a meaningful outcomes and data framework, with the appointment of project lead to manage this action for the next 15 months
- Three forums planned for 2018 to occur in February, May and August across three Metro DHBs and PHOs to share priority areas of focus and key projects and initiatives, as well as exploring the feasibility of a joined up “Metro” approach to Primary Mental Health Initiatives service planning, delivery and evaluation, noting that the majority of Primary Mental Health Initiative providers span all three metro Auckland DHBs.

6.9 Fit for the Future
Waitemata DHB Fit for the Future (FFtF) Evaluation of Our Health in Mind
Waitemata DHB received funding for the 2017/18 financial year to:

1. Support community based initiatives that meet the needs of people with moderate mental health issues. This consists of the upscaling and development of existing initiatives (a-d) and implementation of new and new initiatives as follows:
   a. Direct phone access to specialist advice for GPs
   b. Enhanced specialist support for primary care
   c. Packages of Care
   d. Improved navigation resources
   e. Awhi Ora Supporting Wellbeing.
2. To evaluate these interventions and support to build an evidence base of effective interventions for people with moderate mental health needs. This will be achieved by a robust process and outcome evaluation.

Waitemata DHB has contracted Synergia to complete the evaluation between September 2017 and September 2018. This update is for the period of 14 November 2017 to 2 February 2018.

The Waitemata DHB FFtF evaluation is currently in the data collection phase as illustrated in Figure 1 (An overview of our evaluation approach). The current focus has been on conducting interviews to understand progress and implementation to date, as well as engaging with key stakeholders to prepare for the extraction of existing service data and client outcome measures. Analysis of existing data and staff interviews are planned for later in the evaluation to allow for greater reflection on the outcomes achieved. This progress is on track to meet the current timelines for the evaluation deliverables.
Figure 1: Evaluation status

Enhanced specialist support
- Currently delivered in four practices by two Psychiatrists employed by Waitemata DHB
- Logs are used to track the support provided to the general practice teams
- Key themes to date include:
  - Specialists use different consult liaison models that respond to the different contexts of the individual practices which they support
  - The enhanced specialist support model and credentialed mental health nurses within practices appear to be complementary
  - The mental health needs of patients seen within primary care covers a wider spectrum of cases than those that typically reach the level of severity for specialist mental health
  - The key intended outcome of this intervention is to develop capability and empower practices to confidently manage patients in primary care. There is a perception this is occurring but it will need to be explored in data collection from staff.

Direct telephone access to specialist support
- Direct telephone support from a psychiatrist is available to general practice teams across Waitemata DHB
- Call log data will be provided by the psychiatrist to track the utilisation and outputs
- Analysis was completed in September 2017 on the first 50 calls by Waitemata DHB as part of the evaluation and quality improvement approach:
  - The psychiatrist answering the phone had received a lot of very positive feedback from callers. Over 90% of the time she was able to provide what the caller needed. Around 25% of the time faxed information was also sent to the caller (more precise information to be collected on this next round)
  - On average one to two calls were received a day (a maximum of six calls per day), at least 35 practices had utilised the line in the first 50 calls
  - Most of the calls involve medication and clinical management questions (40 out 50 or 80%), almost half of the time the response back also included service navigation advice
  - Often calls were about people also known to mental health services. There were a number whereby the GP was seeing the person for the first time which was a trigger
- Key conclusions from the first analysis round:
  - Many calls were typical queries that would otherwise have had to come in on referrals with the associated time delay
  - The availability of direct telephone access to specialist support allows timely exchange of information (vs asynchronous) to support better clinical decision making
and for specialist services avoids the inefficiencies of trying to contact people/referrer to verify information a few days later
  o The psychiatrist is also providing clinical education when it is most relevant for a practitioner (so likely to be highly effective)
  o Direct telephone access to specialist support provides a positive communication conduit

- Feedback from this preliminary review has been shared with the Our Health in Mind Governance Group, Waitemata DHB PHOs, Waitemata DHB Specialist Mental Health Services, other DHBs and the Ministry of Health
- The results of this review informed the data collection and questions to answer moving forward (further analysis of calls received late last year is underway now)

Additional funding for primary mental health initiatives
- ProCare has used this funding for the 2017/18 financial year to develop enhanced practice teams at two practices in the Waitemata DHB region. This includes the employment of a Health Improvement Practitioner and a Health Coach. These roles have recently been deployed (December 2017 and January 2017). Subsequently, this intervention is in its early stages of implementation
- Comprehensive Care has used this funding for the 2017/18 financial year to pilot an eTherapy version of their Managing Mood group therapy for patients who cannot or do not wish access face-to-face group sessions. This includes the purchase of online packages of care and the employment of a psychologist to provide the weekly 1:1 video contact included as part of the eTherapy option. This 13-week course was available from September and currently five patients have completed all 13 modules
- Hearts and Minds have used this funding to provide additional Primary Mental Health Initiatives groups.

Awhi Ora Supporting Wellbeing Waitemata DHB
- Awhi Ora Supporting Wellbeing is at its set-up and initial implementation stage at Waitemata DHB
- Four NGO providers have received additional funding to deliver Awhi Ora with another six able to reprioritise 10% of their existing support hours from 1 October 2017 to deliver to the Awhi Ora model
- The early implementation of Awhi Ora Supporting Wellbeing has been challenging, particularly in terms of engagement with general practices that was initially described as uncoordinated. To address this challenge, there has been a focus on slowing down implementation to allow space for project management to engage practices via PHOs and formalise relationships between practices and NGOs
- The project manager has been engaging with NGOs to support the understanding of the principles of Awhi Ora Supporting Wellbeing, and the linkage of NGOs to local practices. Delivery to patients can only occur once these have been established; subsequently Awhi Ora Supporting Wellbeing is still in its set-up phase in Waitemata DHB. In March 2018 additional project management support is being established to hasten and enhance Awhi Ora reach across the district.

Auckland DHB Fit for the Future Update
Auckland DHB received funding for the 2017/18 financial year to:
- Support the upscaling and development of existing community based initiatives that meet the needs of people with moderate mental health issues. This consists of:
  o An expansion of the Awhi Ora - Supporting Wellbeing service (Awhi Ora)
Co-designing a framework to guide the prototype of a person-centred primary and community mental health model of care through integrated practice teams (Framework).

To evaluate these services and support to build an evidence base of effective interventions for people with moderate mental health needs. This will be achieved by a robust process and outcome evaluation.

Auckland DHB also contracted Synergia to complete the evaluation between September 2017 and September 2018. An update for the period of 14 November 2017 to 2 February 2018 is provided.

The evaluation is on track and currently focussed on data collection. Overall, data collection regarding Awhi Ora providers (service data plus interviews) is as intended. The initial data collection with the Framework is approximately four weeks later than anticipated due to the changes in the timeframe for the set up and initial delivery of the Framework.

The engagement and review of existing data collection systems and processes has been completed with the NGOs delivering Awhi Ora Supporting Wellbeing and with ProCare and the East Tamaki Healthcare PHOs.

**Awhi Ora Supporting Wellbeing Auckland DHB**

Awhi Ora Supporting Wellbeing is designed to enable primary care practices and cross sector agencies to have a lead NGO they can introduce people to who would benefit from wellbeing or social support. Following an introduction, people are seen by a Support Worker. This may be in the GP clinic, their home or in the community. A plan to address the person’s presenting need is developed with the Support Worker. Support is usually brief – typically weekly for up to three months – but varies according to need. Sometimes one-off support is all that is required (for example providing navigation support to connect people to resources). Other people, with multiple or more complex issues, may require support for a longer period.

Awhi Ora responds to a range of needs that most commonly relate to:

- Physical health and supporting healthy lifestyles
- Emotional health and mental wellbeing
- Managing problem drinking, drug use or gambling
- Family/whānau issues
- Money issues
- Housing issues

NGOs draw on their mental health expertise, knowledge of community resources and the Awhi Ora network to support people as effectively as possible so they can reduce the stressors in their life.

**Current status:** Awhi Ora Supporting Wellbeing was being implemented at Auckland DHB prior to the FftF funding. Seven NGOs with contracts to provide community support hours were delivering Awhi Ora following referrals (called introductions) from 13 primary care practices (introduction partners).

In terms of the Awhi Ora Supporting Wellbeing expansion:

- The seven NGOs are now connected to an additional 10 primary care introduction partners, bringing the total number to 23
- Three of the NGOs will receive introductions from seven other agencies or networks across the health, social and education sectors that they are partnered with
- All providers are delivering services and have indicated they have capacity for more introductions. The evaluation will explore this and the opportunities to support this across the network with NGOs

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*Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 04/04/18*
• Shared learning sessions are in place. The last was in October 2017, the next in March 2018.

**The framework for enhanced integrated practice teams**
The Framework presents key principles and insights to promote enhanced integrated practice teams in Primary Care. The model draws on and recognises existing work and ideas happening in the sector prior to the FfTF funding. The Framework is being delivered by ProCare and East Tamaki Health Care with leadership from Sue Hallwright, Director of Mental Health Development at ProCare and David Codyre, Mental Health Lead and Consultant Psychiatrist at East Tamaki Health Care. There are currently three practices involved in prototyping the Framework:

- Glenn Innes (East Tamaki Health Care), University of Auckland and Turuki (ProCare),
- Framework practices have used FfTF funding to contribute to the provision of Health Improvement Practitioners and new or extended peer or non-peer Health Coaches. This was supported by the development of job descriptions and an extensive recruitment process.
- Training for the Health Improvement Practitioner role (based on the Behavioural Health Consultant US model) took place late November through to early December 2017. Additional training for Health Coaches was also provided at this time. Staff from both PHOs attended training. ProCare teams also had additional on-site support and there is further training planned for March 2017.

The roles are not all full time, as the different practices are trialling a different mix and level of support to understand the best way to meet the needs of their local populations alongside their current practice teams. Specifically:

- Glen Innes started with the new Health Improvement Practitioner working with the existing Peer Health Coach for one or two half days before Christmas and is building up to longer regular sessions (two or more afternoons per week) following the holiday period
- Auckland University has 0.8FTE of a Health Improvement Practitioner and 0.3FTE from a Health Coach now in place
- Turuki has a 0.3FTE from a Health Coach now in place.

There has been recent indication that Orakei (from Auckland PHO) will come on board as a Framework practice. This would not be until late March or April 2018, when training for new roles is completed. Grey Lynn (from ProCare) is not going ahead with implementing prototype or pilot.

7. **Māori Health Gain**

7.1 **Whānau House Needs Assessment**
The Whānau House Health Needs Assessment outlined areas of disproportionate need for their enrolled population. In response to this data, Waitemata DHB is developing business cases to support enhancing current service delivery models combined with new service delivery to support improved health outcomes. To date Business Case One has been signed-off and implementation has begun. Business Case Two is being developed. A summary of progress is provided below:

- **Business Case One - intervention to enhance Well Child Tamariki Ora service and Antenatal and Newborn Health Navigator Service:**

<table>
<thead>
<tr>
<th>Action</th>
<th>By</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Te Whanau O Waipareira develop a remedial action plan to improve provision of Well Child Tamariki Ora services, with the intention of providing at least 85% of core visits</td>
<td>30 January 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>Action</td>
<td>By</td>
<td>Progress</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>---------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Evaluation scope, logic model drafted</td>
<td>14 February 2018</td>
<td>The Māori Health Gain Team in collaboration with the Health Gain Team will develop an evaluation plan and logic model. This has been initiated and will be completed before the first phase of the service is evaluated</td>
</tr>
<tr>
<td>Waitemata DHB to approve the remedial action plan</td>
<td>28 February 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>Waitemata DHB develop contract documentation and release $15,000 for establishment of cold chain, training and process development</td>
<td>28 February 2018</td>
<td>• Service specifications have been drafted and are nearly completed&lt;br&gt;• Waipareira will purchase the cold chain resources before contract sorted to ensure service is implemented on time</td>
</tr>
<tr>
<td>Service alignment discussions and planning to occur</td>
<td>28 February 2018</td>
<td>These discussions have been initiated</td>
</tr>
</tbody>
</table>

- **Business Case Two – Taitamariki Programme**

**Purpose:** Fund a preventative programme which aims to positively impact on the wellbeing of whānau by engaging with Taitamariki to strengthen protective factors and reduce the risks of developing substance misuse problems.

**Target audience:** Taitamariki/Rangatahi aged 10-16 years of age and who are at risk of developing substance misuse problems.

**Progress:** The draft business case has been reviewed and updated to reflect internal feedback. The proposed service delivery model has also been reviewed by senior members of the Community Alcohol and Drug Service Youth Team. Their suggested changes will also be incorporated.

The Business Case will also follow a stage-gated approach as was used with Business Case One. The final draft of the business case will be presented to Planning, Funding and Outcomes Senior Management for endorsement with a view to present the Business Case to the Board in due course.

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### 7.2 Cardiac Rehabilitation

The pilot for the Cardiac Rehabilitation Programme is due to start in April, with key stakeholders having met through December 2017 and January 2018 to agree service level arrangements. A partnership agreement is in place with Te Whānau O Waipareira who will host the service at their Whānau House facility in Henderson, with AUT University providing Clinical Exercise Physiologists and fitness programming, yet to sign a formal agreement with us. All services have agreed in principle to use the Whānau Tahi Care Connect patient management system to manage clients through the pilot programme. This system allows a greater level of sharing client and care information between services, as well as hosting virtual multi-disciplinary team meetings.

The model of care has been confirmed, and will encompass cardiac nurse led clinics, exercise assessments and programmes, culturally competent education classes, and community nursing services provided by Waipareira.
Confirmation of clinic days at Whānau House, nurse clinic protocols, and engagement protocols with other co-located Whānau House services are to be confirmed in February and March. We are also working with evaluators to confirm an evaluation framework that will be used to inform the eventual roll out of the new model following the successful completion of the pilot phase.

7.3 Māori AAA Screening Update
The extended AAA and AF Screening Project for Māori re-commenced screening on 15 January 2018. We are now screening at the University of Auckland Tamaki site and Greenlane Clinical Centre in order to increase access for patients living in Central and East Auckland. Patient feedback has been very positive. The extension project is drawing to a close, with the last clinics scheduled for mid-April. There has also been positive media coverage around both this project and the Precision Driven AAA Screening (non-Māori).

More than 1,800 people have been screened, with approximately 63% participation to date. Of those screened, more than 90 people have had an aneurysm detected and been referred to the vascular service. This includes eight people with large aneurysms over 50mm, six of these people have already been operated on. The parallel Precision Driven Health AAA Screening project (non-Māori), now complete, screened 637 people with three large aneurysms and 94 small aneurysms detected, and the predictive algorithm performed exceptionally well.

8. Pacific Health Gain

Note, 2017/2018 Quarter 3 reports from providers are not due until 20 March, specific information from some contracted services are not yet available.

8.1 PHAP Priority 1 – Children are safe and well and families are free of violence
We continue to be involved with the Child Health Team to implement the Positive Parenting and Active Lifestyle programme for children identified as overweight or obese in the Before Schools programme.

Whilst the Living without Violence programme is continuing with Todd Foundation funding, we have not been able to find funding to continue to implement the Triple P parenting education programme with Healthy Village Action Zones (HVAZ) churches. A further meeting was held with Foundation North and the nine churches that had applied for funding for implementation of their parenting programmes and Foundation North, who had initially declined the applications. We have suggested to the churches they re-submit their applications, however, there is no certainty that they will be successful this time.

We intend to make contact with the Parenting Place to explore the possibility of them working with HVAZ churches.

The Healthy Babies Healthy Futures programme is continuing well. The Ministry of Health has confirmed that the programme will continue to be funded for the next financial year, 2018/19.

8.2 PHAP Priority 2 – Pacific People are smoke-free
A draft business case for implementation of the co-design work done with Tongan male smokers has been completed. We would like to compare the cost effectiveness of the proposed model with the current MoH funded model, in terms of the current engagement of Pacific smokers with the service as well as their quit rates. We are awaiting information from the Ministry and the providers.
8.3 Priority 3 – Pacific people are active and eat healthy
Fitbit Corporate Wellness in New Zealand donated 300 Fitbits to the DHB to be used by community groups who promote healthy lifestyles. Three more groups have been allocated Fitbits this month, in addition to the three groups that received them last month. One of the groups is a group of mental health consumers receiving services from Lotofale, Auckland DHB’s Pacific mental health service.

Weekly exercise programmes in the Healthy Village Action Zones churches continue.

8.4 PHAP Priority 4 – People seek medical and other help early
Alliance Health Plus PHO facilitated a meeting with the three providers of the Fanu Ola Integrated Health services. It was useful to hear from these providers directly, they were strongly in support of the model and identified key areas needing further work, including:

- Further refinement of the real cost of the service to show how other sources of funding are contributing to fanau results
- Further investigation of the use of technology such as the use of tablets by front-line workers to reduce double handling of information as well as the use of voice-activated technology
- Closer inter-sectoral work, in policy, funding and front-line work

We agreed to progress these issues jointly by Auckland DHB, Alliance Health Plus and the providers.

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
The Asian, Migrant & Refugee Health Plan (Waitemata and Auckland DHBs) (see Appendix 2) and metro Auckland Asian and Middle Eastern, Latin American and African (MELAA) Primary Care Action Plan have both been developed and are rolling out over a two year (2017-2019) period to allow greater time for implementation of the actions. The priorities of the Plans were determined with focus on the findings from the International Benchmarking of Asian Health Outcome Waitemata and Auckland DHBs report. Key areas of focus include:

- Granular ethnicity data monitoring to level 4. Making sure our data tells us about the subgroups we’re interested in. We are working on a national level to get systems solutions
- Access to and utilisation of healthcare services e.g. PHO enrolment; better management of long term conditions; smoking cessation; youth mental and sexual and reproductive health; cervical screening; immunisations (over 65 years); and preschool oral health
- Health promotion/prevention including tailored and/or targeted preventive healthy lifestyle activities
- Adopting a partnerships approach to engage segments of the population i.e. new migrants, students, former refugees, asylum seekers in awareness raising of health services.

9.2 Increase Access and Utilisation to Health Services Indicators:

- Increase by 2% the proportion of Asians who enrol with a PHO to meet 87% (Waitemata DHB) and 71% (Auckland DHB) target by 30 June, 2018 (current rate 86% (Waitemata DHB); 69% (Auckland DHB) as at Q3 2017/18)

The Waitemata DHB Asian PHO enrolment rate has increased by 1% to 86% with 2,256 new enrolees from Q2 to Q3. In Auckland DHB the rate continues to remain unchanged at 69% with 1,491 new enrolees.
In Auckland DHB, an analysis by Age standardised PHO enrolment rates for Asians by gender using Waitemata DHB as the reference population was conducted using Q1 2017/18 data. The intentions were two-fold: 1) profile PHO enrollees by age and gender to better understand the gaps in population segments and factors that appear to continue to dilute the Asian PHO enrolment for Auckland, and 2) use the findings to effectively target promotion of primary care and enrolment to Asian subgroups in the Auckland area.

The findings highlight that the lower PHO enrolment rate of Asians in Auckland DHB is a joint effect of relatively higher younger population and lower age specific PHO enrolment rates, in particular among the younger age groups there is an approximate 5% difference in the two age groups 20-24 and 25-29 years domiciled in Auckland than in Waitemata for males and females combined (less than 50%; only 27% among Auckland residents aged 20-24 years) as compared to Waitemata Asians which was at least 10% higher among the residents aged 15-19, 20-24, 25-29 and 30-34 years.

This effect appears to dilute the Asian PHO enrolment rate overall for Auckland as compared to Waitemata who has a higher younger population eligible to enrol and considerably less international students living in the catchment. Further work is required to:

1. Analyse students’ adjusted age-standardised PHO enrolment rate with Statistics NZ
2. Continue engagement and messaging about the NZ health system and role of the family doctor with Universities/Private Training Establishments at Orientation days, ethnic community events, newsletters, online platforms etc.
3. Target enrolment messaging specifically to domestic students
4. Explore proxy measures for international student engagement with a family doctor (GP) in the absence of PHO enrolment data.

An Asian Health & Wellbeing Day (Waitemata DHB) ran on 27 February at Netball North Harbour Stadium in partnership with Asian Health Services (Waitemata DHB), The Asian Network Inc. and PHOs (ProCare and Comprehensive Care) aimed at promoting information to new Asian migrants about participating in the Census 2018, and New Zealand health system, Healthcare – where should I go?, local health services and PHO enrolment messaging - including the role of a family doctor (GP). A similar Auckland DHB event ran last year in September 2017. Over 100 Asian community members participated at each event.

**10. Auckland Regional Public Health Service (ARPHS)**

**10.1 Disease Management**

**Mumps outbreak update**

ARPHS has been managing a mumps outbreak in the Auckland region since January 2017. The community spread of mumps is established both in the Auckland region and other parts of New Zealand. As at 5 March 2018, 1184 confirmed and probable cases have been notified to ARPHS and there are currently 17 cases under investigation. However, volumes are decreasing as the below epi curve shows.
ARPHS continues to undertake our ‘manage it’ approach.

**Pertussis update**
Since 1 September 2017 Auckland has been in the midst of a pertussis outbreak with 501 confirmed and probable cases (to 5 March 2018). The Ministry of Health declared a national outbreak on 1 December 2017.

The focus of the pertussis strategy is to protect children under the age of one. There have been eight cases (8% of all cases) in under one year olds in the last four weeks – the proportion of cases in this age group has remained constant since the start of the outbreak. This is consistent with the proportion of cases under one seen nationally in this outbreak. Overall case numbers have held steady, averaging 20-25 cases per week since the start of the year. There has not been a big increase in cases following the start of the first school term, as ARPHS continues to work closely with nine schools and two ECECs to support containment efforts in these key settings.

Other activities to support management of the outbreak have included:
- Prepared article for Manukau Courier that encouraged immunisation in pregnancy and primary series
- Media interviews about pertussis and mumps outbreaks, with focus on back to school preparedness and maternal boosting for pertussis
- Distribution of Health Professional Advice to primary care, which recommended using PMS systems to recall pregnant patients for maternal boosting
- Gave oral submission to the Health Select Committee in support of the proposed Newborn Enrollment to General Practice Bill. We asked for consideration of systemic measures to better link maternity and primary care services to improve the delivery of maternal boosting for pertussis.

**Measles Contact Tracing**
ARPHS has undertaken a large contact trace for measles. On 22 February 2018 a six month old New Zealand born infant returned to New Zealand from India and was subsequently diagnosed with measles. Contact tracing included 121 travellers on flight SQ285 from Singapore who were deemed to have been in close contact with the case. 40 of these were forwarded to other public health units.
The six month old baby was seen at a medical centre in West Auckland. Contact tracing has been completed for all those in the waiting room and who were deemed at risk (n=71). All staff (n=16) were followed up to assess their immunity.

Media messages were released to support this work.

On 8 March a secondary case of a person on the flight was confirmed. Contact tracing associated with this case is underway.

**Dengue Fever**

From 1 August 2017 to 6 March 2018, 181 confirmed and probable dengue cases have been notified to ARPHS. 130 cases have been hospitalised, and the ethnic groups commonly affected identified as Samoan (n=118) and Tongan (n=19). 90% of the cases have reported recent travel to Pacific Island countries, including Samoa (n=121), Tonga (n=23) and Fiji (n=18).

The number of dengue notifications is declining, from a peak of 84 in January 2018, to 39 in February 2018.

On 21 December 2017 ARPHS released a media statement advising travellers to the Pacific Islands to take steps to avoid mosquito bites. Messaging from this media statement was picked up by several media outlets. A Health Professional’s Advisory notice was also sent to health providers on 16 January 2018.

**10.2 Auckland Plan Refresh and Long Term Plan (10 year budget)**

In February 2018 an Auckland Council representative attended the Auckland Intersectoral Public Health Group (AIPHG) meeting to discuss the Long Term Plan. The Plan sets out Council’s priorities over the medium to long term and outlines how Council intends to achieve its purpose. This is Council’s primary strategic planning document and the main opportunity for the public to participate in local decision making. Council is publically consulting on the Plan from 28 February to 28 March 2018.

At the same time, Council is consulting on the refresh of its 30 year spatial plan for the city, the Auckland Plan. The AIPHG has had pre-consultation input into this plan and has been working with the Auckland Plan refresh team over the past year to ensure the visibility of health and wellbeing for Aucklanders’ in the Plan.

The AIPHG noted the importance of providing a submission on these two plans and highlighted the contribution of the health sector in resolving complex challenges across Auckland. ARPHS is working collaboratively with key DHB staff to provide input into the submission. The submission on both planning documents is to be signed and endorsed by ARPHS and the three Auckland DHB CEOs.

**10.3 Emergency Management Workshop**

On 15 November 2017 ARPHS hosted a Public Health Emergency Management Training Workshop for public health medicine specialists in the Auckland region, including those working at Auckland University and the Ministry of Health. This collaboration between the Auckland metro DHBs and ARPHS aimed to increase attendees’ awareness of emergency management so they could contribute to a future public health emergency response.

The focus of this workshop was to provide information on the Coordinated Incident Management System and apply this information during several facilitated scenarios designed around public health events. Following presentations on outbreak management and communications during emergencies, attendees were also given an orientation about relevant ARPHS systems and processes, including
public health surveillance, the assessment and management team, and notifiable disease information management.

Throughout the workshop attendees were encouraged to identify their skill set and their role during a public health emergency, and how their organisation could assist with the response and management.

10.4 International Accreditation New Zealand accreditation drinking water
The Auckland Drinking Water Assessment Unit had its International Accreditation New Zealand (IANZ) unit accreditation assessment in November 2017. IANZ provided an audit report of their findings for the Auckland Drinking Water Assessment Unit to respond to by 24 January 2018, which was subsequently done. Annual accreditation was maintained for the unit.

10.5 Healthy Auckland Together (HAT) update and ASA complaint
Healthy Auckland Together (HAT) partners have identified that marketing and sponsorship of high fat and sugar products helps contribute to the establishment and maintenance of obesogenic environments. In April 2016 HAT made a submission to the review of the Code for Advertising to Children, and also commented on the resulting recommendations and Code adopted by the Advertising Standards Authority in 2017. HAT partners have agreed to both monitor the effectiveness of the voluntary ASA system, while simultaneously building public awareness of the impact of marketing and sponsorship on population health.

A series of meetings with HAT partners have been held to develop an action plan for marketing to children. Areas for action across four streams have been developed, including:

- Advocacy
- Environments
- Regulation of marketing to children
- Sponsorship.

In support of this HAT lodged a complaint with the Advertising Standards Authority in December 2017. The complaint maintained that an advertisement for Youthline, which included an image of Santa holding bottles of Coca-Cola Classic and Coca-Cola No Sugar, was a sponsorship advertisement, which showed an occasional beverage, and therefore was in breach of the Code.

HAT argued the advertisement targeted children and young people as it was placed at a bus stop opposite local shops where many children and young people stop on their way to and from school.

The complaint was upheld in part. The Advertising Standards Complaint Board agreed the advertisement was in breach of the Code after determining it was a sponsorship advertisement, and was targeting children and young people. Under the Code sponsorship advertisements must not show an occasional food or beverage product.

Two relevant rules in the Code were found not to have been breached. The Advertising Standards Complaint Board did not think the advertiser had used Santa (a proprietary/celebrity character) in an irresponsible way, and it did not believe children or young people would have made up a significant proportion of the audience walking or driving past the bus shelter.

The decision was released on February 23 2018, and HAT put out a media statement that received wide coverage that was mostly positive. HAT also received positive online comment. Several HAT partners have received OIA requests in relation to the complaint.
HAT has also been undertaking the following:

- All data has been received for the 2017 monitoring report. A meeting is being held with stakeholders to discuss the initial findings.
- ARPHS’ senior dietician has been working with ATEED to influence the food and drink provided at Auckland events. This has resulted in the National Food and Drink Policy being part of the contract with vendors for the Tamaki Herenga Waka Festival over Auckland Anniversary weekend https://www.aucklandnz.com/tamaki-herenga-waka-festival.

10.6 Submissions

ARPHS completed and submitted two formal submissions between January and March 2018.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 February</td>
<td><strong>Newborn Enrolment with General Practice Bill</strong></td>
<td>The aim of the Bill is to improve health and social results for infants and children by requiring that newborns are enrolled with a general practice and primary health organisation before the newborn is due for their first immunisation at six weeks of age. ARPHS’ submission supported the Bill in principle but considered there was an opportunity to strengthen it by widening its scope to encourage greater communication between LMCs and primary care, with the principal aim of improving maternal immunisation rates. Comments were also sought from Auckland’s three metro DHBs, and feedback received was included in ARPHS’ final submission.</td>
</tr>
</tbody>
</table>
| 15 March    | **Auckland Stormwater Network Discharge Consent** | Auckland Council (Healthy Waters, Infrastructure and Environmental Services) seeks to obtain resource consent for:  
- The diversion of stormwater from both existing and future urban land uses within the Rural Urban Boundary, coastal and rural settlements, and urban-zoned land outside of these areas that enters or will enter Council’s stormwater network  
- Discharges of stormwater from the Council’s stormwater network to land, rivers/streams, lakes, groundwater aquifers and the Coastal Marine Area. Contaminants in stormwater discharges can have public health implications for recreational water quality, wild food gathering (i.e. shellfish) and potable water extraction. Poor management of stormwater flows can also exacerbate flood risks. |
<p>| 20 March    | <strong>Alteration to Auckland Airport’s Designation 1100 – proposed northern runway</strong> | Auckland Airport estimates that a second runway that is capable of accommodating long haul international flights will be required by 2028. It is seeking to extend the proposed northern runway from the existing designated length of 2150 metres to 2,983 metres, and shift it 72 metres north of its designated location. The introduction of the proposed northern runway will result in |</p>
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|            | adverse noise effects for residents in specific areas of Papatoetoe, Otara, Ormiston and Mangere. ARPHS intends to comment on the Auckland Airport’s proposed measures to mitigate noise effects, including its proposed noise mitigation package for activities sensitive to aircraft noise. | 28 March  *Auckland Plan refresh and Long Term Plan*  
See earlier comments for item two. |
Appendix 1

Formation of the Northern Hospice Alliance

Northern Hospice Alliance’ report

_Celebrating and uniting Hibiscus, North Shore and Warkworth Wellsford Hospices_

(Prepared by: Jan Nichols, CEO, Hibiscus, North Shore & Warkworth Wellsford Hospices)

During 2016 initial discussions between the Hibiscus Hospice and the North Shore Hospice Trust Boards and the Chief Executive morphed from the prospect of “sharing a Chief Executive” to full Board consideration of a more strategic partnership based on a common vision and long term view of community needs. A **Strategic Alliance Agreement** established the Northern Hospice Alliance and a new way of working together (see Appendix A). The Agreement included an immediate interim 6 month programme to begin resource sharing across the three sites – Hibiscus, North Shore and Warkworth Wellsford Hospices, to be overseen by an **Alliance Committee** of representatives from the respective Boards.

**Early Learnings**

With a joint Chief Executive in place, HR - critical to facilitating subsequent change - were the first group to restructure and become “Alliance” resources. From the outset it was clear that early adopters needed to be self starters, able to work without a blueprint. Not everyone could work this way. Whilst the jobs were there, over time a few who disagreed with changes to established practice self selected.

During 2017 significant effort was put into two separate review processes which represented the bulk of the Hospice workforce: clinical management (medical, nursing and family support, quality, clinical and general administration) and fundraising, marketing, communications and retail.

**The Process of Change**

It’s fair to say Hospice were not particularly “change ready” so having a clearly defined process was very important to manage expectations and fears.

1. **Review** — a clear Terms of Reference was established for an in depth discovery of current and desired state for each function with a wide range of staff involved in the functions under review. This was led by two HR Leaders and informed the next stage of the process. This was led by HR because all the leaders in the functions under review were themselves under review.

2. **Proposal for Change Consultation Process** — drawing on the principles of approach from the Strategic Alliance Agreement, we set out to establish a bold new approach for the combined service. Themes common to both reviews included the ability to use scale to move away from roles that were made up of many different parts to **consolidate and deepen** the expertise and spread that expertise across a **wider span**.

The feedback process for the Clinical Review was extended to accommodate issues raised by the Nurses Union and it’s fair to say that in both reviews there was **genuine listening** and **changes made**, based on the feedback.

3. **Communicating the Final Decision** —

By the time the final decisions were communicated we were confident that leaders were on board and could articulate the changes to their teams. The Chief Executive played a key role in communicating the decision to teams undergoing the most significant change.
4. Selection Processes
The vast majority of existing staff had options for new roles. In some instances expectations for the new roles were increased so placement was not automatic. Some hard decisions were made where skills and/or fit were an issue.

Significant Changes
The overarching goal was to remove duplication of management and direct more money back into clinical care. The Executive Leadership Teams began at 16 and ended at 7. $350k was reinvested into Clinical Care and allowed us to create an Innovation Hub to focus on research and innovation, a Clinical Development Specialist to upskill the current and future clinical workforce, a Referral Specialist established to enable a single point of entry to the Alliance and to ensure equitable access to care, Day Group Coordinator and Community Volunteer Coordinator (Hibiscus and Warkworth) and to increase counselling and cultural hours across the service.

Are We There Yet?
The spirit of cooperation and trust at Board level has allowed the respective Boards to move more quickly towards a fully merged entity than was ever anticipated. By 1 July 2018 there will be a new legal entity with one Operating Trust.
The clinical teams have embraced the changes and value the increased support they get through the Alliance. There are pockets of non clinical staff who are struggling with loss and the reality that their manager is not always on site. It’s a work in progress to create a stable leadership base at each site.

Appendix A  ALLIANCE GOALS
- There is a clear vision, purpose and common set of values to guide the Alliance
- The Alliance provides a single voice to WDHB
- More revenue is directed into patient care
- There is an efficient and effective coordination of services and resources and lower overhead costs
- The Alliance attracts, develops and retains the skills and talent required to deliver quality specialist palliative care to our communities

HOW WE WORK TOGETHER - Guiding Principles
- We will support clinical governance and leadership and, in particular, clinically led service development
- We will adopt a patient-centred, whole of system approach, and make decisions on a Best for System basis
- We will promote an environment of high quality, performance and accountability, and low bureaucracy
- We will seek to make the best use of finite resources in planning and delivering health services to achieve improved health outcomes for our populations
- We will adopt and foster an open and transparent approach to sharing information
- We will remain flexible and responsive to support an evolving health environment
- We will develop, encourage and reward innovation and challenge our status quo

We commit to sustainable care for all our communities and acknowledge the importance of local “ownership” of each Hospice through the retention of donations within each Hospice community
Asian, Migrant & Refugee Health Plan 2017-2019
Waitemata and Auckland District Health Boards
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Foreword

Auckland’s population is growing and changing incredibly rapidly. We have more than 180 different ethnicities living in the city, and almost 40% of Aucklanders were not born in New Zealand.

In the last 15 years the greatest increase of any ethnic group has been in those of Asian origin, principally from China, India, Korea and more recently the Philippines. In 1991, 5.5% of Auckland’s population identified themselves as Asian. By 2001 this had risen to 14% and in 2017 it had reached 26%.\(^1\)

The overall health outcomes achieved by our Asian populations are very good. The *International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHBs is report (2017)*\(^2\) highlights that the two District Health Boards (DHB) are national and international leaders in Asian health, with Asian peoples experiencing excellent health outcomes and health status compared to the rest of the population and when benchmarked internationally. Our Asian peoples enjoy very high life expectancy at birth, lower rates of infant mortality and lower mortality from cardiovascular disease (CVD), diabetes and cancer when compared to other population groups.

Importantly, migrants are less likely to experience barriers to social integration in New Zealand. Our Asian population score very highly in terms of personal rights, personal freedom and choice, tolerance and inclusion. The Asian population in both DHBs have attained high levels of educational achievement with the proportion of the population having a bachelor degree/level 7 qualification or above, higher than the New Zealand average.

Our challenge is to maintain these outstanding results and to address those areas where issues are emerging particularly for some ‘high-risk’ Asian sub groups. While many Asian migrants enjoy good health, we need to be mindful that the ‘healthy migrant effect’ will diminish over time and the rapidly growing population will create unique challenges for maximising health outcomes into the future.

For 2017-2019, we will progress specific areas of focus outlined in the recommendations of the Benchmarking Report that will help us maintain world class health status for our Asian population. These include the future burden of lifestyle-associated risk factors such as smoking and obesity, youth mental health, preschool oral health, and the ability of the Asian and migrant populations to get timely information on the health and disability system, and access and utilise culturally appropriate health services in a timely manner. Refugee and asylum seeker background health will continue to be a focus to ensure equity of access to healthcare. Waitemata and Auckland DHBs cannot achieve this without the support and advice of our Asian and migrant communities and regional Asian and Middle Eastern, Latin American and African (MELAA) health leaders. This plan includes a commitment to enhance our regional collaboration in Asian, migrant and refugee health gain planning, reporting and monitoring to make best possible use of our collective knowledge and resources.

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Introduction

‘Asian’ as defined in New Zealand

The New Zealand health and disability sector classifies ethnicity data according to the Ministry of Health protocols. The term ‘Asian’ used in the New Zealand Census and related data sets, refers to people with origins in the Asian continent, from China in the north to Indonesia in the south and from Afghanistan in the West to Japan in the East. This differs from the definition used in other countries such as the United Kingdom or the United States of America.

This definition includes over 40 sub-ethnicities and these communities have very different cultures and health needs. Reviewing health data using this broad ‘Asian’ classification is problematic if the health status of Chinese, Indian and Other Asian communities is averaged. The risk is that averaged results can appear ‘healthy’, but potentially masks true health disparities such as cardiovascular disease and diabetes in sub-ethnicity groups. Furthermore, many people classified as being ‘Asian’ do not identify with the term which may lead to under-utilisation of ‘Asian’ targeted services.

‘MELAA’ as defined in New Zealand

The Middle Eastern, Latin American and African (MELAA) populations ethnicity grouping consists of extremely diverse cultural, linguistic and religious groups. There are two key challenges for planners and funders of services to MELAA groups with respect to collecting and reporting ethnicity, 1. Reports only capture MELAA at level 1 ‘Other’ category, and 2. Reports capture MELAA as a single aggregated ethnic group output at level 2 category which is problematic to inform, plan, and monitor services that target the unique needs of the Middle Eastern, Latin American and African ethnic groups separately.

Our Partners

Waitemata and Auckland DHBs acknowledge that maintaining national and international leadership in Asian health requires strong collaborative partnerships. This means a commitment to working with with and alongside communities, government agencies, Primary Health Organisations (PHO), Non-Governmental Organisations (NGO), health and social service providers, academia, institutes, associations, and settlement agencies; and learning from our regional Asian health colleagues across the Auckland region and nationally.

The Asian, migrant and refugee health gain team are actively working with Counties Manukau Health and other regional Asian health leaders to learn and share best practice and collaborate where we can to achieve health gain collectively. This includes coordinating and leading governance platforms such as the Asian & MELAA Health Governance Group (Waitemata and Auckland DHBs); Metro Auckland Asian & MELAA Primary Care Working Group; and collegial contribution to the Northern Region Health Plan. We also lead and coordinate other key professional groups such as the Metro Auckland Refugee Health Network Executive Group; Metro Auckland PHO Refugee Services Operational Group; and Multi-Ethnic Health Network.
The Asian Health Service (Waitemata DHB) continues to be an important local partner to support the health of Asian patients and their families within the Waitemata district provider arm services.

A significant national service is the eCALD 3(Culturally and Linguistically Diverse) programme of courses and resources to support the health workforce to develop their cultural competence for working with CALD patients, clients, families and colleagues.

The metropolitan Auckland DHBs each respectively have their own interpreting service and provide essential language support to CALD patients who use DHB funded health services and primary health services.

**Te Tiriti o Waitangi**

Waitemata and Auckland DHBs recognise and respect Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and iwi. The four Articles of Te Tiriti o Waitangi provide a framework for Māori development, health and wellbeing by guaranteeing Māori a leading role in health sector decision making in a national, regional, and whānau/individual context. The New Zealand Public Health and Disability Act 2000 furthers this commitment to Māori health advancement by requiring DHBs to establish and maintain a responsiveness to Māori while developing, planning, managing and investing in services that do and could have a beneficial impact on Māori communicates.

Te Tiriti o Waitangi provides four domains under which Māori health priorities for Waitemata and Auckland DHBs can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

**Article 1 – Kawanatanga (governance)** is equated to health systems performance. That is, measures that provide some gauge of the DHBs’ provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with mana whenua at a governance level.

**Article 2 – Tino Rangatiratanga (self-determination)** is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHBs’ activities.

**Article 3 – Oritetanga (equity)** is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

**Article 4 – Te Ritenga (right to beliefs and values)** guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHBs have a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

These guiding principles are applicable to our diverse Asian and MELAA communities as they contribute to cultural safety and in particular, their contribution to positive health outcomes and experience of care.

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3 Accessible online from [http://www.ecald.com/](http://www.ecald.com/)
National Context
This Plan aligns to the following key national strategies that are important linkages to our Asian, new migrant, former refugee and student health aspirations:

The *New Zealand Health Strategy*
- **Value and High Performance** - striving for *equitable health outcomes* for our populations
- **People Powered** - enabling our populations to *make choices* about their care or support they receive
- **Closer to Home** - providing *care closer* to where our populations live and study
- **Smart System** - having *data* that improves *evidence informed decisions* and management reporting.

The *Migrant and Integration Strategy*\(^4\) identifies five measurable settlement and integration outcomes to focus on, with particular alignment to outcome 5: ‘Health and Wellbeing’. Success indicator: *Increased proportion of recent migrants enrolled with primary health organisations*.

The *Refugee Resettlement Strategy*\(^5\) focuses on refugees’ goals for settling here. The strategy has five goals, with particular alignment to goal 3 ‘Health and Wellbeing’. Success indicators: Refugees’ utilisation of general practitioner services; Refugees’ access to mental health services; and Proportion of refugee children receiving age-appropriate immunisations.

The *New Zealand International Student Wellbeing Strategy*\(^6\) sets out focus areas for government agencies that work to support international students. The strategy has four outcome areas with outcome 3: ‘Health and Wellbeing’ significant to alignment of efforts in this Asian & MELAA Health Plan. Success indicator: *International students are aware of and can access effective healthcare that is culturally appropriate*.

Our Decision Making Kaupapa
*Waitemata DHB strategic direction*

Best care for everyone
Our promise, purpose, priorities and values are the foundation for all we do as an organisation.

- **Our promise** is that we will deliver the *‘best care for everyone’*\(^7\). This means we strive to provide the best care possible to every single person and their family engaged with our services. We put patients first and are relentless in the pursuit of fundamental standards of care and ongoing improvements enhanced by clinical leadership.
- **Our purpose** defines what we strive to achieve, which is to:

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\(^4\) Accessible online from https://www.immigration.govt.nz
\(^5\) Accessible online from https://www.immigration.govt.nz
o Promote wellness
o Prevent, cure and ameliorate ill health
o Relieve suffering of those entrusted to our care.

- We have two priorities:
  o Better outcomes
  o Patient experience.

The way we plan and make decisions and deliver services on a daily basis is based on our values – everyone matters; with compassion; better, best, brilliant and connected. Our values shape our behaviour, how we measure and continue to improve.

To realise our promise of providing ‘best care for everyone’ we have identified seven strategic themes. These provide an overarching framework for the way our services will be planned, developed and delivered.

Waitemata DHB Strategic Themes

**Community, family/whānau and patient-centred model of care**

Patients, whānau and our community are at the centre of our health system. The quality of patient and whānau experience and their outcomes should be the starting point for the way we think, act and invest. Our focus is on empowering people to achieve the health outcomes they want.

**Emphasis and investment on treatment and keeping people healthy**

We are investing in our people, services and facilities across the spectrum of care, with increasing focus on preventing ill health. Lifestyle and preventative programmes and primary and community-based services will increase wellness and reduce the need for hospital admission. We will direct resources at high needs communities.

**Service integration and/or consolidation**

We need to work collaboratively to ensure that services are delivered by the best provider in the right place. We will focus on what we do best deliver higher standards of care through dedicated centres of excellence, and more local health care.

**Intelligence and insight**

The dynamic use of data, information and technology will improve clinical decision making and develop our health insights. Data will be used to support quality improvement, population health management and innovation. Patients will have greater access to information via new technologies.

**Consistent evidence-informed decision making practice**

Delivering safe and high quality care is an integral part of our culture. Evidence from research, clinical expertise, patients and whānau, and other resources will drive our decisions.

**Outward focus and flexible service orientation**

We put patients first and strive for fundamental standards of care. We must have an openness to change, improve and learn and be outward focused and flexible. Strong clinical leadership is embedded at all levels of the organisation. We are an advocate for the health of our population.
Emphasis on operational and financial sustainability

Operational and financial sustainability is critical to our ability to deliver on our organisational promise and purpose. We need a longer-term view. To achieve more with the funding we have we will work with others to develop the best service configuration and optimise models of care for efficiency and the best health outcomes. Our workforce must have the highest standard of expertise.

Auckland DHB strategic direction

Our vision is Healthy Communities, World-class Healthcare, Achieved Together. This means we are working to achieve the best outcomes for the populations we serve, people have rapid access to healthcare that is high quality and safe, and that we work as active partners across the whole system with staff, patients, whānau, iwi, communities, and other providers and agencies.

Our strategic themes outlined below provide an overarching framework for the way our services will be planned, delivered, and developed to deliver our vision. Our values shape our behaviour and describe the internal culture that we strive for.
Auckland DHB Strategic Themes

**Community, whānau and patient-centric model of care**
Our job is to support people to live well and stay well, making sure that people are well informed about health and able to determine the health outcomes they want. What matters to communities, patients and whānau should guide how the DHB thinks, acts and invests.

**Emphasis and investment on treatment and keeping people healthy**
We deliver ‘world-class healthcare’ but also work to prevent ill health. We support people to stay healthy and independent as they age. Our resources are directed to the areas and communities of high need.

**Service integration and/or consolidation**
Services need to be conveniently located and easy to access. By collaborating around the needs of the patient, we can deliver the right services in the right place and by the best person. The DHB can create a seamless experience of care as people move between services.

**Intelligence and insight**
The dynamic use of data, information and technology will improve clinical decision making and develop health insights. Data will be used to support quality improvement, population health management and innovation. Patients will have greater access to information via new technologies.

**Consistent evidence-informed decision making practice**
We aspire to have our practices and decisions based on the best available evidence. Our academic partnerships allow access to world-class training, research and evidence help us to deliver safe, effective, world-class care. Co-design work provides vital information about health.

**Outward focus and flexible, service orientation**
A focus on long-term population health outcomes is required to reduce inequalities. We need to work efficiently with other agencies to achieve this. We have a statutory accountability for the health of Aucklanders and will speak out on important issues.

**Emphasis on operational and financial sustainability**
We will shift the focus of planning from the volume of work to the value of work, from outputs to outcomes. Our savings strategy ensures we keep searching for value and efficiency and look for opportunities to increase revenue. We are working to reduce clinical and financial risk through collaborative cost-effective services between the four regional DHBs.
The People We Serve

Auckland Region
Asian populations

Across New Zealand our diverse Asian and migrant communities are growing faster than any other population group. Auckland’s population is growing and changing with more than 180 ethnicities living in the city, almost 40% of Aucklanders were not born in New Zealand. In the last 15 years the greatest increase of any ethnic group has been in those of Asian origin, principally from China, India, Korea and more recently the Philippines.

While there was an increase in the proportion of Asians living in every region, the biggest growth occurred in the Auckland region. In 2006, 1 in 5 people (19 percent) living in the Auckland region identified with one or more Asian ethnic groups. By 2013 it was almost 1 in 4 people (23 percent) and by 2036 it is forecast to be about 1 in 3 people (34 percent). Socio-demographic and health status information tells us that life in New Zealand is changing for these communities.

![Figure 1: Estimated population by prioritised ethnicity, Auckland Region (Auckland metropolitan DHBs), 2006 and 2013](image)


Figure 1: Estimated population by prioritised ethnicity, Auckland Region (Auckland metropolitan DHBs), 2006 and 2013

We know that New Zealand and Auckland are the destination of choice for many new migrants both permanent and temporary. In 2016, the top five source countries for work were from non-Asian countries such as United Kingdom, Germany, Australia, South Africa and the United States of America. The top three Asian source countries for work were India (21%), China (19%) and the Philippines (9%). Over 50 percent of Skilled Migrant Visa Holders settled in the Auckland region.

Other than ethnic origins, the people grouped under the generic label of ‘Asian’ are very diverse in health status, health beliefs and practices, housing, geographical distribution, migration history, English language proficiency and socioeconomic status.

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8 Accessible online from [https://www.enz.org/migrants.html](https://www.enz.org/migrants.html)
These factors alongside available services and community networks impact how we monitor population health, design and deliver supporting health services. While the three metropolitan Auckland DHBs are committed to collaboration, each will need to complement these activities with a focus on specific health improvement actions that are specific to local population needs.

**Former refugees and asylum seekers**

Conversely, although some Asian ethnic groups may have arrived on these shores as a new migrant by ‘choice’, refugees and asylum seekers (and their families) have come to New Zealand asking for refuge and protection. Quota refugees who resettle in the metropolitan Auckland DHBs in the last 10 ten years have come from Asian, Middle Eastern and African countries with an increasing number who are Myanmarese (Rakhine, Chin, Kachin, Burmese, Karen, Mon, Karenni, Shan) who have/are resettling in the Auckland region.

Immigration New Zealand are receiving an increasing number of asylum seeker claims for refugee and protection status from Asian and Middle Eastern countries. Top five countries are, 1. China, 2. Turkey, 3. India, 4. Sri Lanka, and 5. Iraq (Figure 1). The majority of asylum seekers who are processing claims are living in the Auckland region.

![Main Refugee Status Branch Claims by Nationality, 2016-17](image)

**Figure 1: Main Refugee Status Branch Claims by Nationality, 2016-17**

Source: Immigration New Zealand, 2017

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11 A person who has entered New Zealand under the United Nations High Commissioner for Refugees mandated quota system.

12 An asylum-seeker is someone whose request for sanctuary has yet to be processed.


14 Ministry of Business Innovation and Employment Asylum Forum 2017
From what is available, we know that former refugees and asylum seekers arrive with unique health care needs including: musculoskeletal and pain issues; poor oral health; longstanding undiagnosed chronic conditions; infectious diseases; neglected injuries; and mental health problems including Post-Traumatic Stress Disorder (PTSD); depression; and anxiety. Many conditions often require long term management and support at a primary or secondary care level. Although, the health profile of an asylum seeker may vary from that of a former refugee individual, language support is a key enabler to positive health outcomes for these vulnerable groups.

**International students**

Our International student numbers continue to increase with over 125,000 international students now choose New Zealand to study at our schools and tertiary education organisations. In 2016, over 63 percent were studying in the Auckland region with the vast concentration living in the Auckland district close to city based institutes. A key outcome indicator within the International Student Wellbeing Strategy aims to ensure that International students are aware of and can access effective and culturally appropriate healthcare. Areas of concern for students include timely access to health services; mental health and wellbeing; and sexual and reproductive health.

**Middle Eastern, Latin American and African populations**

According to Census 2013 (Census Usually Residents population, CUR) in the Auckland region, the MELAA populations made up 1.7 percent of the Auckland region total. This population increased by 34 percent from Census 2006 to Census 2013 (acknowledging the growth percentage was based on the relatively small size of the population). The Middle Eastern population made up half of the MELAA group in the Auckland region and the African and Latin American groups made up about a quarter each.

**Table 1: MELAA Population by Ethnic Group, Auckland Region, Census 2013 (total response ethnicity, CUR)**

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<thead>
<tr>
<th>MELAA Ethnic Group</th>
<th>Total</th>
<th>%</th>
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<tr>
<td>Middle Eastern</td>
<td>12,888</td>
<td>52.0%</td>
</tr>
<tr>
<td>African</td>
<td>6,321</td>
<td>25.0%</td>
</tr>
<tr>
<td>Latin American</td>
<td>5,835</td>
<td>23.0%</td>
</tr>
<tr>
<td>Total L2 MELAA Responses</td>
<td>24,996</td>
<td>100.0%</td>
</tr>
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20.6 percent of the MELAA population in the Auckland region were born in New Zealand. The younger age brackets had a much higher proportion born in New Zealand. 39.7 percent were under the age of 25 years; 4.0 percent were aged 65+. The top three languages spoken other than English were Arabic, Spanish, and Persian. 8.3 percent of the MELAA population spoke

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17 Walker R. Auckland Region DHBs Asian & MELAA: 2013 Census Demographic and Health Profile. Auckland: Northern Regional Alliance (NRA), 2014
no English. This group is one of the fastest growing population groups and has unique health needs not entirely met by mainstream health services.\textsuperscript{19}

Auckland and Waitemata DHBs

Asian populations

Overall, the findings of the *International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHBs report* (2017) highlight that the two DHBs are national and international leaders in Asian health with Asian peoples experiencing excellent health outcomes and health status compared to the rest of the population and when benchmarked internationally. This includes high life expectancy at birth, lower rates of infant mortality, lowest rate of years of life lost from CVD and lowest rate of YLLs from cancer.\textsuperscript{20} The impact from diabetes for both DHBs was also low when considered internationally. These results are consistent with the well-established phenomenon of the ‘healthy migrant effect’.\textsuperscript{21}

The report also identifies that migrants in New Zealand experience the most equitable entitlement (Migrant Integration Policy Index report 2014) when compared to the


\textsuperscript{20} ‘Cancer’ to refer to all neoplasms that may be benign (not cancer), or malignant (cancer)

comparator countries. Asian peoples in both DHBs are highly educated with the proportion of the population having a bachelor degree/level 7 qualification or above higher than the New Zealand average (Appendix 1 & Appendix 2).

If we are to maintain or improve Asian health status we must address the disparities within Asian ‘high-risk’ subgroups associated with access to and utilisation of health and disability services for newcomers, distribution of health determinants and risk factors, and a diminishing protective ‘healthy migrant effect’. We know that socioeconomic status, language, and awareness and familiarity with the New Zealand health system can affect access to health services when they are needed. At the forefront of our efforts to support newcomers - both temporary and permanent to our districts is to increase awareness of the New Zealand health & disability system, and role and benefits of a regular family doctor (GP) and pathways to primary care.

Other disparities highlighted in the report include a greater risk of CVD for our South Asian population, higher Chinese risk of diabetes, youth mental health and childhood obesity.

**Middle Eastern, Latin American and African populations**

The MELAA populations are one of the fastest growing population groups in Auckland. Similar to Asians, MELAA face significant barriers to accessing health care. In addition, areas of focus to improve health outcomes are long term conditions e.g. CVD/Diabetes; oral health; women’s health screening; prevention; and management programmes.

Table 2: MELAA Population by Ethnic Group, Waitemata DHB, Census 2013 (total response ethnicity, CUR)

<table>
<thead>
<tr>
<th>MELAA Ethnic Group</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle Eastern</td>
<td>4,551</td>
<td>51.0%</td>
</tr>
<tr>
<td>African</td>
<td>2,181</td>
<td>25.0%</td>
</tr>
<tr>
<td>Latin American</td>
<td>2,142</td>
<td>24.0%</td>
</tr>
<tr>
<td>Total L2 MELAA Responses</td>
<td>8,862</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 3: MELAA Population by Ethnic Group, Auckland DHB, Census 2013 (total response ethnicity, CUR)

<table>
<thead>
<tr>
<th>MELAA Ethnic Group</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle Eastern</td>
<td>4,203</td>
<td>43.0%</td>
</tr>
<tr>
<td>African</td>
<td>2,802</td>
<td>29.0%</td>
</tr>
<tr>
<td>Latin American</td>
<td>2,721</td>
<td>28.0%</td>
</tr>
<tr>
<td>Total L2 MELAA Responses</td>
<td>9,705</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

22 These are: Australia, being a neighbouring country of New Zealand and with a high immigrant population; Canada, the UK and Singapore who all have high immigrant populations and China, Korea and India where the highest volumes of Asian immigrants originate from.
**Key Achievements**

In 2016/17 the high level findings of the *International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHBs report* (2017) were:

### Health Outcomes

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life expectancy</strong></td>
<td>Both DHBs experience a higher life expectancy at birth (90 years, Waitemata; 89 years, Auckland; 92.9 years for Chinese in Waitemata) when compared to the comparator countries and to the Asian population of New Zealand.</td>
</tr>
<tr>
<td><strong>Cardiovascular diseases</strong></td>
<td>Both DHBs had the lowest rate of years of life lost (per 100,000 population) from cardiovascular disease (Waitemata women 897, men 1,147; Auckland women 894, men 1,617).</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>Both DHBs had among the lowest rates of years of life lost from cancer (Waitemata women 1,330, men 2,265; Auckland women 1,633, men 2,020).</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td>Both DHBs had lower overall years of life lost from Alzheimer’s disease and other dementias than the total population of New Zealand (Waitemata women 118 per 100,000, men 129 per 100,000; Auckland 103 per 100,000, for both women and men).</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>Both DHBs had among the lowest rates of years of life lost from diabetes (Waitemata women 154, men 204; Auckland women 174, men 212).</td>
</tr>
<tr>
<td><strong>Infant health</strong></td>
<td>Both DHBs had a combined infant mortality rate which was amongst the lowest (2.2 per 1,000 live births).</td>
</tr>
</tbody>
</table>

### Risk Factors & Prevention

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco smoking</strong></td>
<td>Both DHBs had slightly lower smoking prevalence among the Asian population (9.9%, Waitemata; 8.8%, Auckland) than the New Zealand average (19%) (New Zealand Healthy survey)</td>
</tr>
<tr>
<td><strong>Obesity</strong></td>
<td>The rates of obesity in both DHBs (14.1%, Waitemata; 11.6%, Auckland) are lower than New Zealand as a whole.</td>
</tr>
</tbody>
</table>
| **Physical activity** | Both DHBs had a lower prevalence for adults meeting the New Zealand guidelines for physical activity (30.5%, Waitemata; 45.2%, Auckland) than the New Zealand average (54.0%)  
Both DHBs had the lowest prevalence of sufficient physical activity when compared to the comparator countries. |
| **Health service use** | **Immunisation**  
Both 8-month and 2 year old immunisation rates are above the 95% coverage target. Rates are similar to the best performing comparator country (China).  
**Cancer screening**  
Asian breast screening rate was lower in Waitemata (66.3%) than the New Zealand average (71.4%) and lower when compared to the comparator countries. |
Te Rōpu Whānui o Waitematā me Auckland


- Increased awareness of the New Zealand health & disability system to Asian, students and former refugee subgroups by developing and delivering a suite of multilingual interventions, such as podcast videos (English, Mandarin, Hindi); Healthcare – where should I go? campaigns; health literate materials; Your Local Doctor websites (English, Simplified Chinese, Korean); and health & wellbeing seminars (21).

- Enhancing Asian health leader regional relationships and collaboration. This included regional advice and support for the new Counties Manukau Health Asian Health Gain Advisor recruitment and streamlining regional Asian efforts; and collegial contribution to the Northern Region Health Plan 2017/18.

- Completed an evaluation of implementation fidelity of the metropolitan Auckland Refugee Primary Care Wrap Around Service Agreements 2013-2017.

- Delivered regional professional development on refugee health to the primary health workforce, such as regional refugee health forums (3) and cross-cultural training to frontline staff (2).
Performance Expectations for 2017-2019

To identify key health inequities as a focus for health planning, we require a comparator population group that shows the true story of inequities, i.e. what is the gap in health outcomes and scale of health gain we plan for? Waitemata and Auckland DHBs along with Counties Manukau Health have chosen the New Zealand ‘European/Other’ population as our health equity comparator group. For this reason, our baseline measures and related trend graphs in this Plan reflects this as our “local health equity target” in addition to the national targets reflecting government performance expectations.

<table>
<thead>
<tr>
<th>Health Priority Area</th>
<th>Indicators</th>
<th>ADHB Baseline Data Total</th>
<th>ADHB Baseline Data European/Other</th>
<th>ADHB Baseline Data Asian</th>
<th>WDHB Baseline Data Total</th>
<th>WDHB Baseline Data European/Other</th>
<th>WDHB Baseline Data Asian</th>
<th>Target 2017-2019 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mātua, Pēpi me Tamariki</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Health</td>
<td>Percentage of babies exclusively or fully breastfed at 3 months.</td>
<td>61%</td>
<td>64%</td>
<td>63%</td>
<td>61%</td>
<td>64%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Percentage of eligible girls fully immunised with HPV vaccine.</td>
<td>81%</td>
<td>84%</td>
<td>73%</td>
<td>60%</td>
<td>54%</td>
<td>63%</td>
<td>75%</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Percentage of children aged birth – 4 years enrolled in DHB-funded Community Oral Health Services.</td>
<td>83%</td>
<td>92%</td>
<td>80%</td>
<td>91%</td>
<td>100%</td>
<td>81%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Percentage of children aged 5 years who are caries free – Asian Ethnicity.</td>
<td>60% (European) 45% (MELAA) 58% (African) 54% (Latin American) 35% (Mid-Eastern)</td>
<td>60% (Asian Overall) 60% (Chinese) 63% (Indian) 55% (SE Asian) 60% (Other Asian)</td>
<td>66% (European) 63% (MELAA) 81% (African) 67% (Latin American) 44% (Mid-Eastern)</td>
<td>79% (European) 63% (MELAA) 81% (African) 67% (Latin American) 44% (Mid-Eastern)</td>
<td>56% (Asian Overall) 52% (Chinese) 69% (Indian) 51% (SE Asian) 55% (Other Asian)</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Average number of DMFT at age of 5 years – L1 and L2 Asian and MELAA Ethnicity.</td>
<td>0.72</td>
<td>0.58 (European) 2.45 (MELAA Overall) 1.25 (African) 2.15 (Latin American) 3.31 (Mid-)</td>
<td>2.00 (Asian Overall) 2.07 (Chinese) 1.74 (Indian) 2.51 (Southeast Asian) 2.05 (Other)</td>
<td>0.68</td>
<td>0.63 (European) 1.64 (MELAA Overall) 1.11 (African) 1.10 (Latin American) 2.37 (Mid-)</td>
<td>2.10 (Asian Overall) 2.24 (Chinese) 1.52 (Indian) 2.57 (Southeast Asian) 2.13 (Other)</td>
<td>-</td>
</tr>
</tbody>
</table>

23 Data is Q4 2016/17 unless otherwise stated.
24 5 Year Olds between 01-Jan-2016 and 31-Dec-2016.
<table>
<thead>
<tr>
<th>Health Priority Area</th>
<th>Indicators&lt;sup&gt;23&lt;/sup&gt;</th>
<th>ADHB Baseline Data Total</th>
<th>ADHB Baseline Data European/Other</th>
<th>ADHB Baseline Data Asian</th>
<th>WDHB Baseline Data Total</th>
<th>WDHB Baseline Data European/Other</th>
<th>WDHB Baseline Data Asian</th>
<th>Target 2017-2019 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rangatahi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth Health</td>
<td>Percentage of pregnant women aged 15–24 years who are screened for chlamydia during pregnancy.</td>
<td>44.7%</td>
<td>40.9%</td>
<td>22.6%</td>
<td>31.6%</td>
<td>27.7%</td>
<td>23.5%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Self-harm hospitalisations (10-24 years) (Rate per 100,000 population).</td>
<td>425</td>
<td>838</td>
<td>114</td>
<td>534</td>
<td>768</td>
<td>112</td>
<td>-</td>
</tr>
<tr>
<td>Mātua me Whānau</td>
<td>Cardiovascular Disease Percentage of eligible population who have had their cardiovascular risk assessed in the last five years.</td>
<td>92%</td>
<td>92%</td>
<td>91% (Asian)</td>
<td>91% (Indian)</td>
<td>92%</td>
<td>92%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Percentage of patients who are eligible for primary CVD risk prevention on dual therapy (prescribed).</td>
<td>47.3%</td>
<td>41.9%</td>
<td>48.2% (Other Asian)</td>
<td>51.2% (Indian)</td>
<td>45.7%</td>
<td>43.9%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Percentage of patients with prior CVD who are prescribed triple therapy (prescribed).</td>
<td>55.4%</td>
<td>52.7%</td>
<td>56.5% (Other Asian)</td>
<td>67.8% (Indian)</td>
<td>54.6%</td>
<td>54.2%</td>
<td>-</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Percentage of eligible population with HbA1c ≤ 64mmol/mol recorded in the last 12-15 months (based on PHO enrolled numerator and denominator).</td>
<td>62%</td>
<td>66.2%</td>
<td>73.1% (Other Asian)</td>
<td>64.7% (Indian)</td>
<td>64.1%</td>
<td>67.6%</td>
<td>69.8%</td>
</tr>
<tr>
<td>Cancer</td>
<td>Percentage of women aged 25–69 years who have had a cervical screening event in the past 36 months (Statistics NZ Census projection adjusted for prevalence of hysterectomies).</td>
<td>69%</td>
<td>79%</td>
<td>56%</td>
<td>74%</td>
<td>79%</td>
<td>69%</td>
<td>80%</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Percentage of PHO enrolled patients who smoke have been</td>
<td>The baseline and target is in development as part of a regional collaboration.</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>23</sup> To align with 2018 Ministry of Health Cardiovascular Disease Risk Assessment and Management for Primary Care Guidelines, South-Asians include: Indian, including Fijian Indian, Sri Lankan, Afghani, Bangladeshi, Nepalese, Pakistani and Tibetan.

<sup>24</sup> NRA CVD Medicine Adherence Report, September 2017.
<table>
<thead>
<tr>
<th>Health Priority Area</th>
<th>Indicators</th>
<th>ADHB Baseline Data Total</th>
<th>ADHB Baseline Data European/Other</th>
<th>ADHB Baseline Data Asian</th>
<th>WDHB Baseline Data Total</th>
<th>WDHB Baseline Data European/Other</th>
<th>WDHB Baseline Data Asian</th>
<th>Target 2017-2019 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>offered help to quit smoking by a health care practitioner in the last 15 months.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.</td>
<td>94.7</td>
<td>-</td>
<td>-</td>
<td>98.4</td>
<td>-</td>
<td>-</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Immunisation</td>
<td>Percentage of people aged over 65 years receive free flu vaccinations.</td>
<td>51%</td>
<td>51%</td>
<td>51%</td>
<td>46%</td>
<td>46%</td>
<td>47%</td>
<td>75%</td>
</tr>
<tr>
<td>Hospitalisation rates for respiratory illness over 65 years (Rate per 100,000).</td>
<td>3,704</td>
<td>3,243</td>
<td>2,413</td>
<td>4,001</td>
<td>3948</td>
<td>1942</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Self harm and suicide</td>
<td>Decrease in Asian deaths coded as suicides (Ministry of Health) and provisional suicides (Ministry of Justice), by age.</td>
<td>44</td>
<td>33</td>
<td>3</td>
<td>49</td>
<td>36</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Self-harm hospitalisations 65 years and over by ethnicity (Rate per 100,000 population).</td>
<td>90</td>
<td>91</td>
<td>92</td>
<td>38</td>
<td>43</td>
<td>24</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Rōhe o Waitematā me Auckland</td>
<td>Access To Care</td>
<td>Percentage of the population enrolled in a PHO.</td>
<td>84%</td>
<td>91%</td>
<td>69%</td>
<td>92%</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Percentage English proficient Asians and MELAA, rating overall care as ‘Very Good’ or ‘Excellent’ in the ADHB Inpatient and Outpatient surveys.</td>
<td>Inpatient 84.6%</td>
<td>Inpatient 86% (European/Other)</td>
<td>82% (MELAA Overall)</td>
<td>80% (African)</td>
<td>82.8% (Latin American)</td>
<td>Inpatient 77% (Asian)</td>
<td>79% (Chinese)</td>
</tr>
</tbody>
</table>

27 Annual data from the National Mortality Collection 2014. Numbers may differ from preliminary Coroner reports.
28 Annual data 2016/17.
<table>
<thead>
<tr>
<th>Health Priority Area</th>
<th>Indicators&lt;sup&gt;23&lt;/sup&gt;</th>
<th>ADHB Baseline Data Total</th>
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<th>ADHB Baseline Data Asian</th>
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<th>WDHB Baseline Data European/Other</th>
<th>WDHB Baseline Data Asian</th>
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<tbody>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>89%</td>
<td>(European/Other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84.1%</td>
<td>(MELAA Overall)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84.6%</td>
<td>(African)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85.3%</td>
<td>(Latian American)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85.3%</td>
<td>(Mid-Eastern)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net promoter score on WDHB Friends and Family Test for Asians rating ‘extremely likely’ to ‘recommend our ward to friends and family if they need similar care or treatment’.</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>72</td>
<td>80</td>
<td>84</td>
<td>65</td>
<td></td>
</tr>
</tbody>
</table>

- (Chinese) 88.2% (Indian)
Asian, Migrant and Refugee Health Gain Focus for 2017-2019

This Health Plan summarises collective business as usual initiatives across the “Funder” (Waitemata and Auckland DHBs) and Waitemata DHB’s Asian Health Service (AHS) provider arm that represents existing work specific to Asian, new migrant, former refugee, asylum seeker and/or student health. The focus of the Plan is on action now, protecting and sustaining the excellent health outcomes that the Asian population experience, increasing access to and utilisation of health services, and continuing to support equitable access to healthcare for former refugee and asylum seeker background populations.

The recommendations of the International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHBs report (2017); consultation with the Asian & MELAA Health Governance Group (Waitemata and Auckland DHBs) members; Metro Auckland Asian & MELAA Primary Care Working group, and aligning to common Counties Manukau Health’s population priorities for health equity define the top four higher level areas for action in this Plan which are:

i. **Granular data monitoring to level 4.** Making sure our data tells us about the subgroups we’re interested in. We are working on a national level to get a systems solutions

ii. **Access to and utilisation of healthcare services** e.g. PHO enrolment; better management of long term conditions; smoking cessation; youth mental and sexual and reproductive health; cervical screening; immunisations (over 65 years); and preschool oral health.

iii. **Health promotion/prevention** including tailored and/or targeted preventive healthy lifestyle activities.

iv. **Adopting a partnerships approach** to engage segments of the population i.e. students, former refugees and asylum seekers in awareness raising of health services and health education; and co-design work with Asian & MELAA ethnic consumers.

**Strategic Approach**

We will align our efforts in this Plan to the following:

- New Zealand Health Strategy: Future direction
- New Zealand Migrant Settlement and Integration Strategy’s - Outcome 5: Health and Wellbeing
- New Zealand Refugee Resettlement Strategy - Health Outcome
- New Zealand International Student Wellbeing Strategy Outcomes Framework - Outcome 3: Health & Wellbeing
- Plunket Asian Peoples Strategy
- All of Government (AoG) contracting
- Northern Region Health Plan
- Counties Manukau Health Asian Health Plan 2017/18
- Auckland, Waitemata & Counties Manukau Health Alliance, System Level Measures Improvement Plan 2017/18
- Preschool Oral Health Action Plan for Metropolitan Auckland Region
- Metro-Auckland Healthy Weight Action Plan for Children 2017-2020
This Asian and Middle Eastern, Latin American and African Health Plan 2017-2019 will be overseen by the Asian & MELAA Health Governance Group (Waitemata and Auckland DHBs). A quarterly Asian scorecard (Appendix 3) will guide monitoring on progress of the key areas of focus where data is available. Successful implementation of the Plan will require collaboration across the three metropolitan DHBs, and the health and community sectors.
Where do we want to get to?

- 60% of Asian babies are fully or exclusively breastfed at 3 months.

<table>
<thead>
<tr>
<th>DHB</th>
<th>European/Other</th>
<th>Asian*</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
<td>64%</td>
<td>63%</td>
<td>60%</td>
</tr>
<tr>
<td>WDHB</td>
<td>64%</td>
<td>60%</td>
<td>60%</td>
</tr>
</tbody>
</table>

*Q4 2016/17. Plunket data only.

Good child health is important not only for children and family now, but also for good health later in adulthood. A number of the risk factors for many adult diseases such as diabetes, heart disease and some mental health conditions such as depression arise in childhood. In addition, child health, development and wellbeing have broader effects on educational achievement, violence, crime and unemployment. In 2017-2019, our action focus for Asian & MELAA infants, children and family is on breastfeeding, immunisation (human papillomavirus), healthy weight and good oral health.

Breastfeeding

Why is this a priority?
Research shows that children who are exclusively breastfed for the early months of life are less likely to suffer adverse effects from childhood illnesses such as respiratory tract infections, gastroenteritis, otitis media, etc. Breastfeeding benefits the health of mother and baby, as well as reducing the risk of Sudden Unexpected Death in Infancy (SUDI), asthma, diabetes and obesity.

What are we trying to do?
Maintain the number of exclusively or fully breastfed Asian & MELAA babies at 3 months of age.

To achieve this we will focus on:
Continue to promote breastfeeding information and support for Asian & MELAA women.

Who will we work with?
Women, Child and Youth team, Well Child Tamariki Ora (WCTO) Providers, Health Babies Healthy Futures (Asian providers), Asian NGOs, midwives, and ethnic partners/communities.

<table>
<thead>
<tr>
<th>DHB</th>
<th>What are we going to do?</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland/ Waitemata</td>
<td>YR 1-YR 2 (Q1-Q4): Continue to support the Healthy Babies Healthy Futures programme which targets Asian mothers to support them to exclusively breastfeed their babies for the first six months: - Promote the benefits of breastfeeding to 6 months and beyond.</td>
<td>Coverage rates for Asian are equal to European/Other. 95% of Asian and MELAA infants receive all core WCTO contacts in the first year of life.</td>
</tr>
<tr>
<td>Auckland/ Waitemata</td>
<td>Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian &amp; MELAA Health Governance Group.</td>
<td></td>
</tr>
</tbody>
</table>
**Immunisation - Children**

**What are we trying to do?**
We want Asian & MELAA girls and women to be protected against cervical cancer. Screening and immunisation together will offer the most effective protection.

**Why is this a priority?**
Cervical cancer is caused by certain types of HPV. There is no treatment for persistent HPV infections but immunisation is now available to help protect young women against the two common types of high-risk HPV that cause up to 70 percent of cervical cancer.

**To achieve this we will focus on:**
Ensure Asian & MELAA girls and their families are aware of availability of the HPV vaccine to support improved uptake of the vaccine.

**Who will we work with?**
Women, Child and Youth team, Metro Auckland Asian & MELAA Primary Care Working Group, WCTO Providers, schools, Asian NGOs, and ethnic partners/communities.

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<tr>
<th>DHB</th>
<th>What are we going to do?</th>
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<tbody>
<tr>
<td>Auckland/ Waitemata</td>
<td>YR 1-YR 2 (Q1-Q4): Ensure promotional materials (in priority Asian &amp; MELAA languages) developed by the Ministry of Health are available for the Asian &amp; MELAA communities and promoted in localities where high number of Asian &amp; MELAA peoples reside.</td>
<td>75% of eligible Asian &amp; Other girls are fully immunised with HPV vaccine</td>
</tr>
<tr>
<td>Auckland/ Waitemata</td>
<td>YR 1 (Q3-Q4): Explore parent attitudes towards the HPV vaccination for boys and girls amongst African and Middle Eastern groups.</td>
<td>1 report</td>
</tr>
<tr>
<td>Auckland/ Waitemata/ Counties Manukau</td>
<td>YR 1-YR 2 (Q1-Q4): Leverage off learnings from Counties Manukau Health’s interviews with parents/families of Asian girls who declined receiving three doses of HPV vaccine to identify the reasons and opportunities to improve.</td>
<td>1 report</td>
</tr>
<tr>
<td>Auckland/ Waitemata</td>
<td>Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian &amp; MELAA Health Governance Group.</td>
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</tbody>
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29 HPV stands for human papillomavirus, a group of very common viruses that infect about four out of five people at some time in their lives. HPV causes cells to grow abnormally, and over time, these abnormalities can lead to cancer.
Oral Health

Why is this a priority?

Good oral health practices in the first five years of a child’s life are critical for lifelong oral health. Early childhood caries or dental decay remains the most prevalent chronic and irreversible disease in the western world.

In New Zealand, disparities still exist in oral health by ethnicity, deprivation level, and age group. This is evident where South East Asian e.g. Filipino and Chinese children have higher rates of caries and decayed, missing and filled teeth (DMFT) at age of 5 years among Asian in both districts. Indian dental caries and DMFT was lowest of the Asian subgroups in both districts.

For MELAA groups, African children had the best oral health outcomes for DMFT and caries free compared with Latin American and Middle Eastern children. Middle Eastern children had the worst oral health outcomes for DMFT and caries free across the three groups in both districts.

Prevention of oral disease in infants and pre-schoolers reduces the risk of dental, gingival and periodontal disease in permanent teeth and will have positive impact on their long term oral health, general health and well-being.

What are we trying to do?

Enable access to health care to reduce inequalities in oral health status for Filipino, Chinese, and Middle Eastern children. This work will also contribute to the Metro-Auckland Healthy Weight Action Plan for Children 2017-2020.

To achieve this we will focus on:

Support the Preschool Oral Health Action Plan for Metropolitan Auckland region, and promote oral health messaging to targeted ethnic communities.
**Who will we work with?**
Auckland Regional Dental Services (ARDS), Women, Child and Youth team, WCTO providers, midwives, Asian NGOs, and ethnic partners/communities.

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**Average number of DMFT at age of 5 years, 2016 – L2 Asian Ethnicity**
*All coverage as at December 2016*

![Graph showing average number of DMFT at age of 5 years, 2016 – L2 Asian Ethnicity]

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<tr>
<th>DHB</th>
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</table>
| Auckland/ Waitemata| YR 1-YR 2 (Q1-4): Support Asian & MELAA inputs to the:  
- Preschool Oral Health Action Plan for Metropolitan Auckland region  
- Metro-Auckland Healthy Weight Action Plan for Children 2017-2020                                                                                       | Percentage of 0-4 year old children enrolled with pre-school oral health services                                                                                                                                                                                                                              |
| Auckland/ Waitemata| YR 1-YR 2 (Q1-Q4): Ensure ARDS promotional materials are translated in various languages.                                                                                                                                | Percentage of children caries free at age of 5 years – L2 Asian and Other Ethnicity                                                                                                                                                                                                                                              |
| Auckland/ Waitemata| YR 1-YR 2 (Q1-Q4): Engage with ethnic partners and communities to promote culturally appropriate oral health messaging to Filipino, Chinese and Middle Eastern parents and children:  
- Explore parents’ attitudes towards healthy eating & oral health amongst Filipino, Chinese and Middle Eastern groups.                                                                                      | Average number of DMFT at age of 5 years, – L2 Asian and Other Ethnicity  
1 report                                                                                                                                                                                                                                                                                                                      |
| Auckland/ Waitemata| Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.                                                                   |                                                                                                                                                                                                                                                                                                                                 |

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26
Rangatahi – Young People

Good health enables young people to succeed in their studies, opportunities to achieve their dreams and aspirations, and to make meaningful contributions to their families and communities. We are committed to supporting young people living in Waitemata and Auckland DHBs to be healthy, feeling safe and supported. In 2017-2019, our action focus for Asian & MELAA young peoples is on supporting youth access to - and utilisation of - youth appropriate health services as part of the System Level Measures Improvement Plan 2017/18.

Mental Health & Addictions

Why is this priority?
Data from the New Zealand Health Survey (2011-2013) for adults (15+ years) indicate that Asians had a higher rate for psychological distress in Auckland (8.4%) but not in Waitemata DHB (3.6%) compared to European/Other (4.9% Auckland; 4.6% Waitemata). Those Asian youth experiencing high rates of mental distress and often present later for treatment due to stigma, shame, not knowing how to access services, and cultural barriers. Edgewalking, substance abuse and family pressures about education/study are cited by former refugee youth as reasons for their mental health concerns. Accessing services later can be attributed to level of acculturation and years lived in New Zealand.

Asian and former refugee peoples have disproportionately lower access rates to mental health and addictions services compared to other ethnic groups. Of all young people (12 – 19 years) who accessed primary mental health interventions in 2016/17 Asian was lower (15% Auckland; 5% Waitemata) compared to European/Other (47% Auckland; 59% Waitemata).

What are we trying to do?
Reduce self-harm and interpersonal violence amongst Asian & former refugee youth (15-24 years old), and improve their wellbeing through earlier intervention and access to integrated culturally appropriate mental health and addictions (MH&A) care.

To achieve this we will focus on:
Supporting the System Level Measures Improvement Plan 2017/18 so that young people experience less mental distress and disorder, and are supported in times of need.

Who will we work with?
Northern Regional Alliance, Mental Health & Addictions team, Primary Care team, Asian Health Services (Waitemata DHB), Asian Mental Health Services teams (Waitemata and Auckland DHBs), Metro Auckland Asian & MELAA Primary Care Working Group, NGO Mental Health Providers, Refugees As Survivors New Zealand, Asian NGOs, Auckland Agency Group, institutes, student associations, youth agencies, and ethnic partners/communities.

30 Age standardised rate of psychological distress (high or very high probability of anxiety or depressive disorder K10 score >=12), adults (15+ yrs), by DHB and Ethnicity, NZHS 2011-13
31 Auckland Regional Refugee Network Health Youth Mental Health Forum, 24 August, 2016.
32 Primary mental health interventions includes package of care, or extended consult, or group therapy.
### Sexual and Reproductive Health

**Why is this priority?**
Chlamydia is the most common sexually transmitted infection in New Zealand. International modelling suggests annual chlamydia testing of 30-40% of young people reduces disease prevalence. In 2016, 11% of 15-24 year olds living in Metro Auckland were tested for chlamydia; 19% of women, 5% of men. There was significant variation across the region by gender, ethnicity, enrolled PHO, and family doctor (GP) practice. Chlamydia testing is a Youth System Level Measure introduced in 2017.

Sexual and reproductive health is a taboo subject among many Asian cultures. Embarrassment, stigma, shame and confidentiality issues are often barriers preventing Asian young peoples accessing sexual and reproductive health services.

Travel and medical insurance products to international students varies in terms of coverage for sexually transmitted infections (STI) and medication in general practice, resulting in underutilisation and late access for screening and treatment in general practice.

**What are we trying to do?**
Young people are less likely to see a family doctor (GP) each year than older adults. Opportunistic preventive care should occur at every family doctor (GP) visit and chlamydia testing in sexually active young people, irrespective of symptoms in settings such as universities.

**To achieve this we will focus on:**
Supporting the System Level Measure Improvement Plan 2017/18, and engage with medical and travel insurers to influence their review cycles for student plans and coverage in general practice for STIs and contraception.

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<tr>
<th>DHB</th>
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<tbody>
<tr>
<td>Auckland/ Waitemata</td>
<td>YR 1-YR 2 (Q1-Q4): Work with the Metro Auckland Asian &amp; MELAA Primary Care Working Group to support the Youth System Level Measure (youth are healthy, safe and supported) for mental health &amp; wellbeing.</td>
<td>Self-harm hospitalisations (10-24 years)</td>
</tr>
<tr>
<td>Auckland/ Waitemata</td>
<td>YR 1 (Q3-Q4): Develop and deliver two workshops for youth and parents in Asian, refugee and migrant communities, focused on available mental health services, including evaluation.</td>
<td>2 workshops delivered</td>
</tr>
<tr>
<td>Auckland/ Waitemata</td>
<td>YR1-YR 2 (Q1-Q4): Support the recommendations from the ‘Improving sexual health provision to international students in general practice - a corporate responsibility of travel and medical insurers in New Zealand’ paper: - Engage with medical and travel insurance companies to influence policy review cycles on mental health products available to international students in general practice.</td>
<td>All international student health insurance plans include mental health coverage in general practice</td>
</tr>
<tr>
<td>Auckland/ Counties Manukau</td>
<td>Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian &amp; MELAA Health Governance Group.</td>
<td></td>
</tr>
</tbody>
</table>
**Who will we work with?**
Northern Regional Alliance, Primary Care, sexual health services, Metro Auckland Asian & MELAA Primary Care Working Group, Auckland Agency Group, Asian NGOs, student associations, institutes, youth agencies, and ethnic partners/communities.

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<tbody>
<tr>
<td>Auckland/ Waitemata</td>
<td>YR 1-YR 2 (Q1-4): Work with the Metro Auckland Asian &amp; MELAA Primary Care Working Group and Primary Care to support the Youth System Level Measure (youth are healthy, safe and supported).</td>
<td>Percentage of pregnant women aged 15–24 years are screened for chlamydia during pregnancy.</td>
</tr>
</tbody>
</table>
| Auckland/ Waitemata/Counties Manukau | YR1-YR 2 (Q1-Q4): Support the recommendations from the 'Improving sexual health provision to international students in general practice - a corporate responsibility of travel and medical insurers in New Zealand' paper:  
- Engage with medical and travel insurance companies to influence policy review cycles on sexual health products available to international students in general practice. | All international student health insurance plans include STI coverage in general practice.          |
| Auckland/ Waitemata     | Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.                                                                 |                                                                                                |
Mātua me Whānau– Adults and Family Group

Adults and older people face different health issues than younger people. Diabetes, heart disease, cancer, smoking and mental health and addictions are some of the conditions adults experienced. We are committed to supporting adults and older people living in our districts to be healthy, and managing their health conditions. This supports them to look after their loved ones, enjoy lives with them, succeed in careers, and see their grandchildren grow up. In 2017-2019, our action focus for Asian & MELAA adults and their families is on cardiovascular disease management, diabetes management, cervical screening, smoking cessation, immunisation (over 65 years) and mental health and addictions.

Long Term Conditions – Cardiovascular Disease and Diabetes

Why is this a priority?
Cardiovascular disease is one of the leading causes of death among Asian peoples. In particular, Indian people have a higher prevalence of risk factors associated with CVD, and Indian aged 35 to 74 years had higher CVD hospitalisation rates as compared to the European/Other group in Auckland and Waitemata DHBs.

Maintaining the number of eligible Indians who receive a CVDRA and improving management for Indian with CVD is also an amenable mortality contributory measure as part of the System Level Measures Improvement Plan 2017/18.

What are we trying to do?
Reduce cardiovascular disease related morbidity and mortality among Indian people via improved access to quality cardiovascular and diabetes care.

To achieve this we will focus on:
The Auckland and Waitemata DHBs have entered into an Alliance agreement with the PHOs across both districts and the two Memorandum of Understanding partners. Diabetes and cardiovascular disease have been identified by the Alliance Leadership Team as the priority areas in the Alliance.

Where are we at and where do we want to get to?

CVD Primary Prevention: Percentage of enrolled patients with cardiovascular risk ever recorded >20%, (aged 35 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)

CVD Secondary Prevention: Percentage of enrolled patients with known cardiovascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)

*All coverage as at September 2017 (prescribed)

Work Plan. Cardiovascular disease management includes both secondary prevention (risk factor management) and tertiary prevention (reducing the mortality and morbidity from disease).

Who will we work with?
Northern Regional Alliance, Primary Care team, Metro Auckland Asian & MELAA Primary Care Working Group, Asian Health Services (Waitemata DHB), Asian NGOs, Green Prescription providers, Healthy Families Waitakere, and ethnic partners/communities.

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<tbody>
<tr>
<td>Auckland/Waitemata</td>
<td>YR 1-YR 2 (Q1-4): Improve the CVD health outcomes of our population through maintaining CVD risk assessment rates at 90% and improving CVD risk management: - Continue to perform More Heart and Diabetes Checks with eligible South-Asian and Asian groups.</td>
<td>90% CVDRA coverage for South-Asian and Asian</td>
</tr>
<tr>
<td>Auckland/Waitemata</td>
<td>YR 1-YR 2 (Q1-4): Support the Diabetes Care Improvement Plan.</td>
<td>80%</td>
</tr>
<tr>
<td>Auckland/Waitemata</td>
<td>YR 1-YR 2 (Q1-4): Support the recommendations from the retinal screening review consistently across Auckland and Waitemata DHBs.</td>
<td></td>
</tr>
<tr>
<td>Auckland/Waitemata</td>
<td>YR 1-YR 2 (Q1-4): Support the recommendations from the podiatry review consistently across Auckland and Waitemata DHBs.</td>
<td></td>
</tr>
<tr>
<td>Auckland/Waitemata</td>
<td>YR 1-YR 2 (Q1-4): Ensure Asian peoples are accessing podiatry, dietetics and health psychology at the same rates as other ethnicities by providing these services in community based settings.</td>
<td>Percentage of Asian peoples accessing podiatry, dietetics and health psychology</td>
</tr>
<tr>
<td>Auckland/Waitemata</td>
<td>YR 1-YR 2 (Q1-4): Increase the proportion of South Asian participants enrolled with Green Prescription services.</td>
<td>South Asian adults enrolled in Green Prescription - 9% Waitemata - 18% Auckland</td>
</tr>
<tr>
<td>Auckland/Waitemata/Counties Manukau</td>
<td>YR 1-YR 2 (Q1-4): Support CVD research for example AUT’s ‘Primary Prevention of Stroke in the Community (PreventS)’ study</td>
<td></td>
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<tr>
<td>Auckland/Waitemata</td>
<td>Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian &amp; MELAA Health Governance Group.</td>
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Cervical Screening

Why is this a priority?
Asian women continue to have persistent and unacceptable lower participation in the cervical screening programme. The cervical screening coverage rates for Asian women of both DHBs (69% Waitemata; 56% Auckland) were lower that European/Other (79% Waitemata; 79% Auckland).

We intend for the HPV self-sampling research project to provide policy relevant evidence as the National Cervical Screening Programme transitions to a HPV primary screening programme.

34 To align with 2018 Ministry of Health Cardiovascular Disease Risk Assessment and Management for Primary Care Guidelines, South-Asians include: Indian, including Fijian Indian, Sri Lankan, Afgani, Bangladeshi, Nepalese, Pakistani and Tibetan.
Where are we at and where do we want to get to?

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

80% of eligible Asian women received a three yearly cervical screen

Percentage of eligible women receiving a cervical screen in the past three years.

**As at June 2017**

![Cervical Screening Rates](chart.png)

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<tr>
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<tbody>
<tr>
<td>Auckland/</td>
<td>YR 1 (Q2): Complete the HPV self-sampling feasibility study for Asian (Chinese and Indian) women.</td>
<td>Cervical screening rate (25-69 years: 3 year coverage)</td>
</tr>
<tr>
<td>Waitemata</td>
<td>YR 1 (Q3-4); YR 2 (Q1): Plan and support the larger randomised control trial of the Massey University HPV self-sampling research project for priority Asian women to September, 2019.</td>
<td>80% coverage across all ethnic groups</td>
</tr>
<tr>
<td>Auckland/</td>
<td>YR 1-YR 2 (Q1-4): Continue to promote and support the National Cervical Screening Programme for Asian &amp; MELAA women in general practice.</td>
<td></td>
</tr>
<tr>
<td>Waitemata</td>
<td>YR 1-YR 2 (Q1-4): Awareness raising of culturally appropriate screening messaging to ethnic communities and students.</td>
<td></td>
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<tr>
<td>Auckland/</td>
<td>Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian &amp; MELAA Health Governance Group.</td>
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<tr>
<td>Waitemata</td>
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Smoking

Why is this a priority?

Cigarette smoking is a well-recognised risk factor for many health conditions and is a major cause of preventable death in OECD countries. This associated with health conditions such as cardiovascular disease, respiratory conditions and many cancers.

The age standardised prevalence rate of regular smokers in Chinese men is among the highest in the Asian sub-groups (15.2%, Waitemata; 13.8%, Auckland) and higher than that of the...
European/Other population (12.8%, Waitemata; 11.3%, Auckland).  

There is a large inequality in smoking prevalence between sexes, with Asian males having a smoking prevalence five to seven times higher than females.

**What are we trying to do?**
Asian & MELAA peoples who smoke received smoking cessation advice and support; increase in smokers who successfully quit, and a reduction in smoking prevalence.

**To achieve this we will focus on:**
Connect communities to targeted Stop Smoking Services and utilise language appropriate resources to support smoking cessation, as well as promotion and education in Asian & MELAA communities.

**Who will we work with?**
Primary Care team, Metro Auckland Asian & MELAA Primary Care Working Group, ProCare, Asian NGOs, institutes, and ethnic partners/communities.

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</table>
| Auckland/ Waitemata/ Counties Manukau | YR 1-YR 2 (Q1-4): Work with ProCare’s Stop Smoking Services to identify targeted promotional plans to Chinese men:  
- Collaborate with Counties Manukau Health to leverage on learnings from their Promotion Plan to Chinese men in the Eastern Locality. | 95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking  
90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months |
| Auckland/ Waitemata | Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group. | |

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35 Lifeng Zhou and Samantha Bennett, Asian Benchmarking Technical Report for Waitemata DHB and Auckland DHB.  
Immunisation against Influenza

Why is this a priority?
Asian & MELAA elderly peoples may not be aware they are eligible for free Seasonal Influenza vaccines. They often are staying at home looking after infants and children, thus may increase the chances of spreading the flu with family members.

What are we trying to do?
Improve the number of Asian & MELAA elderly peoples who received Seasonal Influenza vaccines.

To achieve this we will focus on:
Promotion of Seasonal Influenza vaccines.

Who will we work with?
Primary Care team, Metro Auckland Asian & MELAA Primary Care Working Group, WCTO providers, Asian NGOs, and ethnic partners/communities.

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<tr>
<td>Auckland/ Waitemata</td>
<td>YR1-YR 2 (Q1-Q4): Work with PHO Immunisation Coordinators to ensure general practices are recalling and providing the Influenza vaccine for those eligible.</td>
<td>Coverage rates for Asian are equal to European/Other. Hospitalisation rates for respiratory illness over 65 years.</td>
</tr>
<tr>
<td>Auckland/ Waitemata</td>
<td>YR1-YR 2 (Q1-Q4): During flu season ensure that PHOs (via the Metro Auckland Asian &amp; MELAA Primary Care Working Group) are actively promoting flu vaccinations and are targeting culturally appropriate communications to the eligible 65+ Asian &amp; MELAA populations at the practice level.</td>
<td></td>
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<tr>
<td>Auckland/ Waitemata</td>
<td>YR1-YR 2 (Q1-Q4): During flu season leverage on the national promotional campaign messaging to promote the funded influenza vaccination to Asian &amp; MELAA communities.</td>
<td></td>
</tr>
<tr>
<td>Auckland/ Waitemata/</td>
<td>YR1-YR 2 (Q1-Q4): Leverage off CMH learnings from interviews with Asian elderly people and pregnant women to identify the reasons they didn’t receive Seasonal Influenza vaccines and Boostrix.</td>
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<tr>
<td>Counties Manukau</td>
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<tr>
<td>Auckland/ Waitemata</td>
<td>Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian &amp; MELAA Health Governance Group.</td>
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</table>
Mental Health & Addictions

Why is this a priority?
Asian peoples in Auckland have significantly lower rates of access to Perinatal Maternal Mental Health services (PMMH), and Mental Health & Addiction services compared to other ethnic groups, despite a high and increasing burden of mental health issue. There have been a number of completed suicides and self-harm cases in Aged Care Facilities (ARC) for older Chinese adults that warrants further investigation and coordinated effort, in terms of screening and prevention in primary care and ARC.

What are we trying to do?
Improve early access rates to PMMH services, and MH & A services.

In Waitemata DHB, there is an Asian Mental Health Work Stream Plan 2015-2020 which has been developed in alignment to the Waitemata Stakeholder Network Mental Health and Addiction Strategic Plan 2015-2020.

The Asian Mental Health Work Stream Plan includes initiatives that enable Waitemata DHB mental health services to demonstrate cultural capability and improve the equity and wellbeing of Asian peoples through better access to MH & A Services.

To achieve this we will focus on
Supporting the Regional Perinatal and Maternal Mental Health Group, Waitemata Stakeholder Network Mental Health and Addiction Strategic Plan, and Auckland DHB’s Mental Health and Addictions Programme Board.

Who will we work with?
Northern Regional Alliance, DHBs, Mental Health & Addictions team, Primary Care team, Asian Health Services (Waitemata DHB), Asian Mental Health Services teams (Waitemata and Auckland DHBs), Metro Auckland Asian & MELAA Primary Care Working Group, NGO Mental Health Providers, Refugee As Survivors New Zealand, Asian NGOs, eCALD services, and ethnic partners/communities.

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<tr>
<td>Auckland/ Waitemata/ Counties Manukau</td>
<td>YR1-YR 2 (Q1-Q4): Support the Regional Perinatal and Maternal Mental Health Group to review and advise on equity and access to Perinatal and Maternal Mental Health services.</td>
<td>Decrease in Asian deaths coded as suicides (Ministry of Health) and provisional suicides (Ministry of Justice), by age</td>
</tr>
<tr>
<td>Auckland/ Waitemata</td>
<td>YR1-YR 2 (Q1-Q4): Work via the Metro Auckland Asian &amp; MELAA Primary Care Working Group to: - Identify high Asian enrolled practices screening processes for depression - Promote assertive screening for depression in general practice - Promote cultural competency of the primary health workforce who work with mental health clients in general practice - Promote use of the Primary Health Interpreting services in general practice to older adults.</td>
<td>Self-harm hospitalisations 65 years and over by ethnicity</td>
</tr>
<tr>
<td>Auckland/</td>
<td>YR 1-YR 2 (Q1-Q4): Increase the quality of service provision to Asian</td>
<td>Number of</td>
</tr>
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<td>DHB</td>
<td>What are we going to do?</td>
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| Waitemata                  | residents in Aged Residential Care:  
- Coordinate the Facility Owners Group meeting (including Chinese and Korean) run bi-monthly  
- Work with Dr. Gary Cheung to support the ARC facilities in this Group with screening approaches for depression, suicide prevention and best practice interventions  
- Review the effectiveness of the PHQ-9 screening tool in this Group for ARC. | meetings convened  
Decrease in number of completed suicides and self-harm within ARC facilities of this Group  
Best practice screening tools recommended for ARC                                               |
| Auckland/ Waitemata        | YR 1-YR 2 (Q1-Q4): Continue to support the Maungakiekie/Tāmaki locality – Mental Health and Wellbeing project with focus on the new service, ‘Awhi Ora’ – supporting wellbeing, which provides holistic early engagement and prevention for people who experience social challenges and mental health issues. | Tāmaki locality – Mental Health and Wellbeing principles of practice developed with peoples from Asian, former refugee and CALD migrant backgrounds and implemented |
| Auckland/ Waitemata        | Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; and Asian Mental Health & Addictions Stakeholder Network Group (Waitemata DHB). |                                                                                                                                                       |

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36 The service was co-designed with the community from the outset (including with people from Asian, refugee and CALD migrant backgrounds). Informed by a set of 3 core principles; that support be person-centred, relational and collaborative, the service is now embedded in 13 general practices working with seven NGOs in Tāmaki and beyond. The approach is being rolled out in stages throughout Auckland and Waitemata DHBs.
Rōhe o Waitematā me Auckland

There are health systems that are potential barriers to health gain for Asian and MELAA peoples in our districts. In 2017-2019, our action focus is on regional planning and reporting, data quality, primary care enrolment, former refugee health, patient experience and community engagement.

Regional Asian Health Gain Planning and Reporting

Why is this a priority?
In order to maintain or improve Asian health status we must address the disparities within Asian ‘high-risk’ subgroups associated with access to and utilisation of health and disability services for newcomers, distribution of health determinants and risk factors, and a diminishing protective ‘healthy migrant effect’.

Former refugee communities continue to resettle across the metropolitan districts under the quota, family support and refugee convention category pathways.

A regional response is necessary to achieve best value from available resources, experience and skills by working collaboratively (where possible) to make a positive change in health outcomes for Asian, migrant, former refugee and asylum seeker populations.

What are we trying to do?
The metropolitan Auckland DHBs have a common goal to improve or accelerate health gain in their respective Asian populations. Together, we aim to review and learn from our health gain activities, insights and outcomes so we can benefit from our collective knowledge and relationships with community and health leaders.

What will we focus on?
Collectively work towards the areas of focus in the Metropolitan Auckland Asian & MELAA Primary Care Action Plan 2017-2019, share available Asian health status data, and leverage respective Asian health oversight, advisory and governance forums.

Where do we want to get to?
We will aim to develop an Asian regional scorecard to apply an equity lens across the three metro DHBs.

Who will we work with?
Northern Regional Alliance, and Counties Manukau Health.

<table>
<thead>
<tr>
<th>DHB</th>
<th>What are we going to do?</th>
<th>Measures</th>
</tr>
</thead>
</table>
| Auckland/ Waitemata/ Counties Manukau | YR 1 (Q3-Q4): Develop a metropolitan Auckland Asian health equity picture for DHB respective planning, monitoring and governance processes:  
- Align to the Northern Region Health Plan (Health Equity section) for Asian & MELAA (where possible). | Metro Auckland Asian Health Scorecard |
**What are we going to do?**

**Measures**

**Auckland/Waitemata/Counties Manukau**

YR 1-YR 2 (Q1-Q4): Explore potential opportunities to work regionally to raise Asian and former refugee health equity awareness.

Auckland Regional Asian Health planning approach

YR 1-YR 2 (Q1-Q4): Continue to streamline the Refugee Primary Care Wrap Around Service Agreements across the metropolitan Auckland region.

PHO Refugee Services Operational Group

Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; Metro Auckland Asian & MELAA Primary Care Working Group; Metro Auckland PHO Refugee Services Operational Group; and Counties Manukau’s Asian Advisor.

**Data Quality**

**Why is this a priority?**

Accurate data is imperative for policy, planning and monitoring of many indicators important for Asian Health. A key area of interest is to establish complete and accurate breakdown data on level 2 Asian subgroups to identify ‘at risk’ subgroup population health outcomes.

**What are we trying to do?**

Improve the quality of ethnicity data collected by Auckland and Waitemata DHBs.

**To achieve this we will focus on:**

Implement the Standard of Ethnicity Data Protocols and action plans to improve ethnicity data collection.

**Who will we work with?**

Primary Care team, Health Intelligence team, Metro Auckland Asian & MELAA Primary Care Working Group, and Waitemata and Auckland DHBs provider arm services.

**DHB** | **What are we going to do?** | **Measures** |
---|---|---|
Auckland/Waitemata | YR 1-YR 2 (Q1-Q4): Continue to develop a quarterly Asian performance scorecard to monitor trends in health outcomes. | Quarterly Asian Health Outcome Scorecards |
Auckland/Waitemata | YR 1-YR 2 (Q1-Q4): Accuracy of ethnicity reporting in PHO registers as measured by Primary Care Ethnicity Data Audit Toolkit. | Standard of Ethnicity Data Protocols implemented. |
Auckland/Waitemata | YR 1-YR 2 (Q1-Q4): Identify services where there are gaps in collecting and reporting of level 1 ‘Asian’ and ‘Other’ and level 2 categories subgroups (‘Other Asian’, ‘Chinese’, ‘Indian’, ‘South East Asian’ and ‘Asian NFD’). | |
Auckland/Waitemata | YR 1-YR 2 (Q1-Q4): Work with identified services to ensure accurate collecting and reporting of level 2 ‘Asian’ ethnicity subgroups. | |
Auckland/Waitemata | Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group. | |

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Primary Healthcare Enrolment

Why is this a priority?
Asian peoples have disproportionately lower PHO enrolment rates compared to European/Other in both districts (85% (Asian), 95% (European/Other), Waitemata; 69% (Asian), 91% (European/Other)).

The Auckland DHB’s Asian PHO enrolment rate continues to remain significantly lower than the other metropolitan Auckland DHBs largely due to the high number of international students and transient temporary migrant population living in the Auckland district.  

Equitable access to timely primary care services and language support for newly arrived refugee and asylum background individuals in general practice is imperative to resettlement experiences.

What are we trying to do?
Deliver a suite of initiatives to increase newcomers’ awareness of the New Zealand health & disability system; role and commensurate benefits of enrolling with or seeing a regular family doctor (GP) for holistic care including timely health checks, immunisations, family health services, integrated wrap around services; and knowing where to go for healthcare to get help when you’re fee – for urgent, less serious conditions, injury and when it’s an emergency.

To achieve this we will focus on:
Implement the Metropolitan Auckland Asian & MELAA Primary Care Action Plan 2017-2019, and support the health & wellbeing outcome areas for the: New Zealand Refugee Resettlement Strategy; New Zealand Migrant Settlement and Integration Strategy; and New Zealand International Student Wellbeing Strategy.

Who will we work with?
Ministry of Health, Ministry of Business, Innovation and Employment, Primary Care team, Metro Auckland Asian & MELAA Primary Care Working Group, Auckland Agency Group, Homecare Medical, New Zealand Red Cross, WCTO Providers, ARDS, institutes, settlement agencies, student associations, and ethnic partners/communities.

<table>
<thead>
<tr>
<th>DHB</th>
<th>What are we going to do?</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland/Waitemata YR 1-YR 2 (Q1-Q4): Work with the Metro Auckland Asian &amp; MELAA Primary Care Working Group and Primary Care to implement the Action Plan 2017-2019.</td>
<td>2% increase in the proportion of Asians enrolled with a PHO.</td>
<td></td>
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</tbody>
</table>

38 International students and temporary migrants domiciled in a district for 1 year are included in the denominator when calculating a DHB’s PHO enrolment rate even though they are ineligible to enrol with a PHO. The Auckland DHB’s PHO enrolment rate appears to be diluted as a result of a high ineligible healthcare population unable to enrol with a family doctor (PHO) yet included in the denominator.
## Former Refugee Health

### Why is this a priority?
Available evidence suggest that both former refugee and asylum seekers face significant barriers to accessing health, mental health, pharmacy, oral health and maternity services. Key barriers to accessing health services (including maternity services), include varied levels of settlement support, difficulty accessing language services, financial and transport stressors, lack of knowledge of the health system, cultural competence of the health workforce, and lack of awareness within health services of refugee and asylum seeker unique needs and experiences. Financial constraints mean individuals are generally not able to access private services and depend on public or community-based services.39

Former refugee and/or asylum seeker families have low access to and utilisation of primary health services in New Zealand.40

### What are we trying to do?
Enable equitable access to mainstream primary care (affordable or no-cost options) for former refugee and asylum seeker patients in general practice, and monitor health service access and utilisation (and long-term outcomes).

### To achieve this we will focus on:
Work with PHOs to manage the Refugee Primary Care Wrap Around Service Agreements with their participating general practices in the metropolitan Auckland region, promote the Service among former refugee and/or asylum seeker communities, improve cultural competency among primary caregivers.

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<table>
<thead>
<tr>
<th>DHB</th>
<th>What are we going to do?</th>
<th>Measures to meet targets</th>
</tr>
</thead>
</table>
| Auckland/Waitemata   | **YR 1-YR 2 (Q1-Q4):** Promote a suite of multilingual interventions, such as podcast videos (English, Mandarin, Hindi), Healthcare – where should I go? campaign, health literate materials, and the Your Local Doctor websites (English, Simplified Chinese, Korean):   - Deliver the NZ Health & Disability System presentations to universities, Private Training Establishments (PTE), settlement partners, ethnic associations/communities and libraries. | -87% Waitemata  
-71% Auckland  
No. of hits to Your Local Doctor websites  
2 seminars /month |
| Auckland/Waitemata   | **YR 1-YR 2 (Q1-Q4):** Promote PHO enrolment messaging to Asian & MELAA newcomers to increase the proportion of Asian newborn infants enrolled with PHO at 3 months of age:   - Leverage on the National Child Health Information Platform (NCHIP)   - Work with the PHO Newborn Enrolment Coordinators to support access to Under 5 services and culturally responsive service provision. | 98% of newborns are enrolled with a PHO, general practice, WCTO provider and ARDS |
| Auckland/Waitemata   | Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group. |                                                                                         |

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care practices, promote the use of the DHBs’ Primary Health Interpreting services, and deliver professional development to the primary health workforce.

**Who will we work with?**
Primary Care team, DHBs, Metro Auckland PHO Refugee Services Operational Group, Metro Auckland Asian & MELAA Primary Care Working Group, PHOs, community health workers, New Zealand Red Cross, Mangere Refugee Resettlement Centre, Immigration New Zealand, Asylum Seeker Support Trust, asylum seeker lawyers/barristers, settlement agencies, and ethnic partners/communities.

<table>
<thead>
<tr>
<th>DHB</th>
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<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland/ Waitemata/ Counties Manukau</td>
<td>YR 1-YR 2 (Q1-Q4): Fund and manage the Refugee Primary Care Wrap Around Service Agreements.</td>
<td>Increase in number of former refugees enrolled with the Refugee Primary Care Services.</td>
</tr>
</tbody>
</table>
| Auckland/ Waitemata/ Counties Manukau | YR 1 (Q2): Conduct an evaluation of the Refugee Primary Care Wrap Around Service Agreements:  
- Support the recommendations of the report to guide ongoing funding and quality service delivery across both Waitemata and Auckland DHBs. | 1 report |
| Auckland/ Waitemata/ Counties Manukau | YR 1-YR 2 (Q1-Q4): Coordinate bimonthly meetings with the Metro Auckland PHO Refugee Services Operational Group:  
- Minimum data sets to enable monitoring of service access and health outcomes. | 6 meetings  
6 monthly reporting |
| Auckland/ Waitemata/ Counties Manukau | YR 1-YR 2 (Q1-Q4): Strengthen pathways to PHO enrolment for quota refugees through integrated pathways with Mangere Refugee Resettlement Centre, NZ Red Cross and general practices. | Increase in number of former refugees enrolled with the Refugee Primary Care Services |
| Auckland/ Waitemata | YR 1-YR 2 (Q1-Q4): Raise awareness within former refugee and asylum seeker communities of Service availability:  
- Work with our stakeholders, outreach services and community leaders to increase awareness, access to and uptake of the Services. | 

| Auckland/ Waitemata | YR 1-YR 2 (Q1-Q4): Q4: Lead and coordinate professional development to the primary health workforce:  
- Metro Auckland Refugee Health Network Executive Group  
- Metro Auckland Refugee Health Network (ARRHN) Forums  
- Cross Cultural Frontline Training. | 4 Executive Group meetings  
4 ARRHN Forums  
1 Frontline training |
| Auckland/ Waitemata | YR 1-YR 2 (Q1-Q4): Encourage and promote CALD training with the participating practices of this Service. | Increase the number of practice staff attending CALD3 ‘Working with Refugees’ training module |
| Auckland/ Waitemata | YR 1-YR 2 (Q1-Q4): Encourage and promote the use of the DHBs’ Primary Health Interpreting services in participating general practices of this Service. | Increase the number of Practices offering this service |
| Auckland/ Waitemata/ Counties Manukau | Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; and Metro Auckland PHO Refugee Services Operational Group. | |
Patient Experience

Why is this a priority?
Patient experience is an important indicator in assessing the quality of care provided and is strongly linked to overall health outcomes. An enhanced patient experience leads to better emotional health, symptom resolution, less reported pain and more effective self-management.

Asian patients of Auckland DHB are less likely to rate their overall care and treatment as ‘very good to excellent’ (81%), compared to non-Asians (NZ European 84%, Māori 84% and Pacific 84%).

58.7% of Chinese patients of Waitemata DHB were ‘extremely likely’ to ‘recommend our ward to friends and family if they need similar care or treatment’, compared to non-Asians (NZ European 70%, Māori 69.2%, Samoan 65.2% and Tongan 58.8%).

What are we trying to do?
Our focus is to improve the care our population receives, and to engage people as partners in their care and providing services that are responsive to the individual needs of patients and their whānau.

Increase opportunities for Waitemata and Auckland communities to access, understand and act on health-related information.

To achieve this we will focus on:
Work in partnership with our communities which results in services, activities and programmes that reflect the strengths, needs and resources of our patients, families and the wider community, and outcomes that are understandable and reflect their values and expectations.

Who will we work with?
Primary Care team, Chief of Strategy Participation & Improvement (Auckland DHB), Director of Participation and Insight (Auckland DHB), Online Participation Manager (Auckland DHB), Director of Patient Experience (Waitemata DHB), PHOs, Asian Health Services (Waitemata DHB), Community Engagement Manager (Waitemata DHB), Health Links, Asian NGOs, and ethnic partners/communities.

<table>
<thead>
<tr>
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</table>
| Waitemata | YR 1-YR 2 (Q1-Q4): Monitor patient experience for Asian, Indian, Chinese and Korean reporting ‘extremely likely’ to ‘recommend our ward to friends and family if they need similar care or treatment’, compared to European/Other:  
- Quarterly Asian scorecard to report Net Promoter Score in Friends Family Test (FFT)  
- Administer the translated FFT survey versions on the Patient Experience Survey System. | 65 score on FFT for Asians rating ‘extremely likely’ to ‘recommend our ward to friends and family if they need similar care or treatment’ |
| Auckland  | YR 1-YR 2 (Q1-Q4): Explore inequities for Asian subgroup patient experience applying the Patient and Whānau Centred Care Framework:  
- Quarterly Asian scorecard to report % ‘very good’ or ‘excellent’ rating for overall care and treatment in the inpatient survey  
- Complete a report identifying differences in overall scores for Percentage of English proficient Asians and MELAA rating overall care as ‘Very Good’ or |                                                                                       |

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What are we going to do? Measures

Asian subgroups compared to Auckland DHB average ratings in the Inpatient and Outpatient surveys
- Pilot within key directorates/clinical programmes analysis of reasons for unplanned readmissions and increased length of stay for Asian subgroups compared to European/Other.

‘Excellent’ in the Inpatient and Outpatient surveys
2 reports

Auckland/Waitemata/Counties Manukau

YR 1 (Q3-Q4): Monitor inequities in Asian patient experience of care in primary care:
  - Establish a list of high enrolled Asian practices to level 3 ethnicity
  - Establish a baseline from the Primary Care Patient Experience Survey (PES) of Asian patient satisfaction rates in the identified high Asian enrolled practices.

1 list
Baseline of Asian level 3 ethnicity patient satisfaction rates in high Asian enrolled general practices

Auckland/Waitemata

YR 1-YR 2 (Q1-Q4): Advocate for and capture Asian & MELAA health needs in the higher level planning of the Health Literacy Framework:
  - Support those services that have integrated a health literacy lens into service design, celebrate those services and share best practice
  - Encourage standardisation of successful health literacy initiatives across both organisations
  - Develop and distribute guidelines that outline the information needs of Asian & MELAA populations e.g. preferred channels, accessibility and language
  - Ensure health literacy consumer groups include Asian, former refugee and migrant representation (where appropriate).

Annual Plan patient information benchmark includes specific targets for Asian and MELAA communities
Health Links Contracts include targets for ethnic specific groups

Auckland/Waitemata

YR 1-YR 2 (Q1-Q4): Investigate the barriers to inclusion of disabled people from Asian and MELAA backgrounds within service provision
  - Work with Asian health networks and CALD disability projects.

Auckland/Waitemata

Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; Health Literacy Steering Group; and Director of Participation and Insight (Auckland DHB).

Community Engagement

Why is this a priority?
To increase health system capacity to address the growing needs of Asian & MELAA peoples and to contribute to achieving the Waitemata and Auckland DHBs’ strategic goal of achieving health equity for populations with health disparities.

What are we trying to do?
Asian and MELAA consumer voices are included in service co-design planning cycles.

To achieve this we will focus on:
Develop a range of approaches to improve communication and engagement with Asian and MELAA communities to enable them to participate in, or provide feedback on planning, policies and services so that DHB activities are reflective of the community’s ethnically and culturally diverse population.
**Who will we work with?**
Director of Participation and Insight (Auckland DHB), Community Participation Manager (Auckland DHB), Online Participation Manager (Auckland DHB), Community Engagement Manager (Waitemata DHB), Health Links, Asian NGOs; and ethnic partners/communities.

<table>
<thead>
<tr>
<th>DHB</th>
<th>What are we going to do?</th>
<th>Measures</th>
</tr>
</thead>
</table>
| Auckland/ Waitemata  | YR 1-YR 2 (Q1-Q4): Recruit participants to join Reo Ora Health Voice to provide an ongoing opportunity for engagement with Asian and MELAA communities on a range of topics:  
- Identify enablers to uptake to online community panels  
- Consider different language needs and target information where possible to encourage participation  
- Use Asian and MELAA social media sites to recruit participants. | At least 5% of Reo Ora Health Voice members are from Asian and MELAA communities  
Meet or exceed Asian (30%) & MELAA (2%) Reo Ora Health Voice membership based on general Asian population numbers (Auckland DHB)  
Targeted recruitment is carried out at Asian and MELAA events and activities to grow overall Asian and MELAA Reo Ora Health Voice membership by 50% |
| Auckland/ Waitemata  | YR 1-YR 2 (Q1-Q4): Link with Asian and MELAA leaders in the communities to grow mutually reciprocal relationships.                                                                                                   |                                                                                                                                                                                                                             |
| Auckland/ Waitemata  | YR 1-YR 2 (Q1-Q4): Leverage on ethnic specific platforms and events to improve communication messaging, and to invite them to provide feedback on planning, policies and services.                                           |                                                                                                                                                                                                                             |
| Auckland/ Waitemata  | Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; Community Engagement Group (Waitemata DHB); and Director of Participation and Insight (Auckland DHB). |                                                                                                                                                                                                                             |
**Glossary**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARC</td>
<td>Aged residential care</td>
</tr>
<tr>
<td>ASH</td>
<td>Ambulatory sensitive hospitalisations</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse</td>
</tr>
<tr>
<td>CBD</td>
<td>Central business district</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>CVDRA</td>
<td>Cardiovascular disease/cardiovascular disease risk assessment</td>
</tr>
<tr>
<td>DHB</td>
<td>District health board</td>
</tr>
<tr>
<td>DMFT</td>
<td>Measure of oral health (Decayed/Missing/Filled/Teeth)</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends and family test</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papilloma virus</td>
</tr>
<tr>
<td>MELAA</td>
<td>Middle Eastern, Latin American or African</td>
</tr>
<tr>
<td>MH&amp;A</td>
<td>Mental health and addictions services</td>
</tr>
<tr>
<td>NCHIP</td>
<td>National child health information platform</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for economic co-operation and development</td>
</tr>
<tr>
<td>PES</td>
<td>Primary care patient experience survey</td>
</tr>
<tr>
<td>PHIS</td>
<td>Primary health interpreting services</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary health organisation</td>
</tr>
<tr>
<td>PMMH</td>
<td>Perinatal maternal mental health</td>
</tr>
<tr>
<td>PTE</td>
<td>Private training establishment</td>
</tr>
<tr>
<td>SLM</td>
<td>System level measure (national set of six health indicators)</td>
</tr>
<tr>
<td>YLL</td>
<td>Years of life lost</td>
</tr>
</tbody>
</table>
Appendices

Appendix 1: Benchmarking of Asian Health in Waitemata District Health Board

Benchmarking of Asian Health in Waitemata District Health Board

The Auckland region is becoming more diverse in ethnicity and culture with one in four of the population Asian.

40% of the Asian population are Chinese
50% aged 15-44 and 9% aged 65+

Waitemata District Health Board (DHB) has the fastest growing Asian population in New Zealand, expected to reach nearly 215,000 by 2033

Health Status

Waitemata DHB are leaders in health outcomes among the Asian population however there are some areas for improvement

90 Years
Higher life expectancy compared with all other ethnicities (Chinese 92.9 years)

Less likely to die prematurely from cancer
Less likely to die prematurely from diabetes

Less likely to die prematurely from cardiovascular disease
The Indian population are more likely to die prematurely from diabetes

Prevention

Doing well:

Adults are less likely to smoke (10% vs 19% NZ)
Adults are less likely to be obese (14% vs 25% NZ)
Children are more likely to be fully immunised (98% vs 93% NZ)

Smoking rates are highest in Chinese men (15%)
Adults are less likely to meet physical activity guidelines (31% vs 60% NZ)
Fewer women are screened for cervical cancer (66% vs 77% NZ)

Health Services

8 out of 10 are enrolled with a doctor (less enrolled compared with other ethnicities)
Asian International students access Emergency Departments less than other ethnicities

Social progress

2 out of 5 have a bachelors degree or higher qualification (1 out of 5 NZ)
New Zealand has the most equitable entitlement policies for new migrants when compared with other countries

“Asian” as used in New Zealand refers to very diverse communities with origins in the Asian continent, from Afghanistan in the west to Japan in the east, and from China in the north to Indonesia in the south. This infographic summarises some of the high level findings from the report “International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHB” It should be read in the context of the report. It is not an assessment of health need within the Asian population but a comparison of Asian Health against other ethnicities and other Asian countries.

Appendix 2: Benchmarking of Asian Health in Auckland District
Health Board

Benchmarking of Asian Health in Auckland District Health Board

The Auckland region is becoming more diverse in ethnicity and culture with one in four of the population Asian*

40% of the Asian population are Chinese

50% aged 15-44 and 9% aged 65+

Auckland District Health Board (DHB) has the largest Asian population in New Zealand with 154,370 or nearly one in three of the population Asian

Health Status
Asian peoples in Auckland DHB have good health compared to Asians living in most other DHBs however there are some areas for improvement

89 Years

Higher life expectancy compared with all other ethnicities

Less likely to die prematurely from cancer

Less likely to die prematurely from diabetes

Less likely to die prematurely from cardiovascular disease

The Indian population are more likely to die prematurely from diabetes

Prevention
Doing well:

Adults are less likely to smoke (9% vs 19% NZ)

Adults are less likely to be obese (12% vs 29% NZ)

Children are more likely to be fully immunised (97% vs 93% NZ)

Not doing so well:

Smoking rates are highest in Chinese men (14%)

Adults are less likely to meet physical activity guidelines (45% vs 60% NZ)

Fewer women are screened for cervical cancer (59% vs 77% NZ)

Health Services

7 out of 10 are enrolled with a doctor (less enrolled compared with other ethnicities)

Asian International students access Emergency Departments less than other ethnicities

Social progress

2 out of 5 have a bachelors degree or higher qualification (1 out of 5 NZ)

New Zealand has the most equitable entitlement policies for new migrants when compared with other countries

* Asian as used in New Zealand refers to very diverse communities with origins in the Asian continent from Afghanistan in the west to Japan in the east and from China in the north to Indonesia in the south. This infographic summarises some of the high level findings from the report ‘International Benchmarking of Asian Health Outcomes for Waiata and Auckland DHB’. It should be read in the context of the report. It is not an assessment of health need within the Asian population but a comparison of Asian Health against other ethnicities and other Asian countries.

### Appendix 3: Auckland and Waitemata DHBs Asian Performance Scorecard (Dec 2017)

#### Health Targets - Auckland DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Euro/other</th>
<th>Asian</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better help for smokers - Primary Care</td>
<td>68%</td>
<td>85%</td>
<td>90%</td>
<td></td>
<td>▲</td>
</tr>
<tr>
<td>Faster cancer treatment (62 days)</td>
<td>99%</td>
<td>100%</td>
<td>90%</td>
<td></td>
<td>▲</td>
</tr>
<tr>
<td>Increased immunisation (8-month old)</td>
<td>92%</td>
<td>97%</td>
<td>95%</td>
<td></td>
<td>▼</td>
</tr>
<tr>
<td>Raising Healthy kids</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td></td>
<td>--</td>
</tr>
</tbody>
</table>

#### Health Targets - Waitemata DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Euro/other</th>
<th>Asian</th>
<th>Actual</th>
<th>Target</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Better help for smokers - Primary Care</td>
<td>85%</td>
<td>82%</td>
<td>90%</td>
<td></td>
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<td>Faster cancer treatment (62 days)</td>
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<td>95%</td>
<td></td>
<td>▼</td>
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<tr>
<td>Raising Healthy kids</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
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</table>

#### Access - Auckland DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Euro/other</th>
<th>Asian</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better help for smokers - Hospital</td>
<td>94%</td>
<td>90%</td>
<td>95%</td>
<td></td>
<td>▼</td>
</tr>
<tr>
<td>Breast screening</td>
<td>63%</td>
<td>74%</td>
<td>70%</td>
<td></td>
<td>▲</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>77%</td>
<td>54%</td>
<td>80%</td>
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</tbody>
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#### Access - Waitemata DHB

<table>
<thead>
<tr>
<th>Indicator</th>
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<th>Asian</th>
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</tr>
<tr>
<td>Breast screening</td>
<td>66%</td>
<td>70%</td>
<td>70%</td>
<td></td>
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<tr>
<td>Cervical Screening</td>
<td>77%</td>
<td>70%</td>
<td>80%</td>
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</tbody>
</table>

#### Quality - Auckland DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Euro/other</th>
<th>Asian</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
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<tbody>
<tr>
<td>More Heart &amp; Diabetes Checks (Indian)</td>
<td>82%</td>
<td>92%</td>
<td>80%</td>
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<td>▲</td>
</tr>
<tr>
<td>PHD enrolment</td>
<td>90%</td>
<td>69%</td>
<td>90%</td>
<td></td>
<td>▲</td>
</tr>
<tr>
<td>Increased immunisation (5 year old)</td>
<td>83%</td>
<td>87%</td>
<td>93%</td>
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</tr>
<tr>
<td>Exclusive breastfeeding at 6 weeks (Plunket)</td>
<td>75%</td>
<td>62%</td>
<td>60%</td>
<td></td>
<td>▲</td>
</tr>
<tr>
<td>Exclusive breastfeeding at 3 months (Plunket)</td>
<td>64%</td>
<td>63%</td>
<td>60%</td>
<td></td>
<td>▲</td>
</tr>
</tbody>
</table>

#### Quality - Waitemata DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Euro/other</th>
<th>Asian</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart &amp; Diabetes Checks (Indian)</td>
<td>80%</td>
<td>82%</td>
<td>80%</td>
<td></td>
<td>▲</td>
</tr>
<tr>
<td>PHD enrolment</td>
<td>94%</td>
<td>86%</td>
<td>90%</td>
<td></td>
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</tr>
<tr>
<td>Increased immunisation (5 year old)</td>
<td>86%</td>
<td>94%</td>
<td>95%</td>
<td></td>
<td>▲</td>
</tr>
<tr>
<td>Exclusive breastfeeding at 6 weeks (Plunket)</td>
<td>72%</td>
<td>61%</td>
<td>60%</td>
<td></td>
<td>▲</td>
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<tr>
<td>Exclusive breastfeeding at 3 months (Plunket)</td>
<td>64%</td>
<td>60%</td>
<td>60%</td>
<td></td>
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</tr>
</tbody>
</table>

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### A question?

**Auckland & Waitemata DHB** Planning & Funding Analyst, Planning & Health Intelligence Team: victoria.chih@waitematadhb.gov.nz

Planning, Funding and Health Outcomes, Waitemata DHB

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### How to read

1. Most Actuals and targets are reported for the reported month (quarter; see scorecard header).
2. Actuals and targets in grey bold italic are for the most recent reporting period available where data is missing or delayed.
3. Trend lines represent the data available for the latest 12-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. Small data range may result small variations perceived to be large.

### Key notes

- **c.** Screens and coverage for 0-5 years, 0-24 months, 0-36 months.
- **b.** Screens and coverage 25 -69 years, 3 yr ending 31/12/2017.
- **a.** Screens and coverage 25 -69 years, 1 yr ending 31/12/2015.
- **d.** PHO enrolment
- **e.** Exclusive breastfeeding at 3 months (Plunket)
- **f.** Jun Q4 2016/17
- **g.** Increased immunisation (5 year old)
- **h.** Increased immunisation (2 year old)
- **i.** Increased immunisation (2 year old)
- **j.** Increased immunisation (2 year old)
- **k.** Increased immunisation (5 year old)
- **l.** Increased immunisation (2 year old)
- **m.** Increased immunisation (2 year old)
- **n.** Increased immunisation (2 year old)
- **o.** Increased immunisation (2 year old)
- **p.** Increased immunisation (2 year old)
- **q.** Increased immunisation (2 year old)
- **r.** Increased immunisation (2 year old)
- **s.** Increased immunisation (2 year old)
- **t.** Increased immunisation (2 year old)
- **u.** Increased immunisation (2 year old)
- **v.** Increased immunisation (2 year old)
- **w.** Increased immunisation (2 year old)
- **x.** Increased immunisation (2 year old)
- **y.** Increased immunisation (2 year old)
- **z.** Increased immunisation (2 year old)

### Performance Indicators

- **Achieved**/hit target
- **Substantially Achieved but off target**
- **Not Achieved/no progress made**

### Trend Indicators

- **Achieved** compared to previous month
- **Maintained** compared to previous month
- **Not achieved** compared to previous month

---

### Planning & Health Intelligence Team Contact

- **Victoria Chih** Planning & Funding Analyst, Planning & Health Intelligence Team: victoria.chih@waitematadhb.gov.nz
- **Vicki Aitken** Planning & Funding Analyst, Planning & Health Intelligence Team: vicki.aitken@waitematadhb.gov.nz
- **Samantha Brown** Planning & Funding Analyst, Planning & Health Intelligence Team: samantha.brown@waitematadhb.gov.nz
- **Jennifer Lovett** Planning & Funding Analyst, Planning & Health Intelligence Team: jennifer.lovett@waitematadhb.gov.nz

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### Quality - Auckland DHB

<table>
<thead>
<tr>
<th>eCALD Cultural Competency Training</th>
<th>Learners enrolled</th>
<th>Learners completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>166</td>
<td>150</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese subgroup</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Indian subgroup</td>
<td>73%</td>
<td>90%</td>
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### Quality - Waitemata DHB

<table>
<thead>
<tr>
<th>eCALD Cultural Competency Training</th>
<th>Learners enrolled</th>
<th>Learners completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>341</td>
<td>150</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese subgroup</td>
<td>80%</td>
<td>65%</td>
</tr>
<tr>
<td>Indian subgroup</td>
<td>57%</td>
<td>65%</td>
</tr>
</tbody>
</table>

---

### Contact Information

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- **Jennifer Lovett** Planning & Funding Analyst, Planning & Health Intelligence Team: jennifer.lovett@waitematadhb.gov.nz

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### Planning & Funding and Health Outcomes - Waitemata DHB

- **Learners enrolled**
- **Learners completed**

---

### How to read

1. **c.** Screens and coverage for 0-5 years, 0-24 months, 0-36 months.
2. **b.** Screens and coverage 25 -69 years, 3 yr ending 31/12/2017.
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10. **j.** Increased immunisation (5 year old)
11. **k.** Increased immunisation (2 year old)
12. **l.** Increased immunisation (2 year old)
13. **m.** Increased immunisation (2 year old)
14. **n.** Increased immunisation (2 year old)
15. **o.** Increased immunisation (2 year old)
16. **p.** Increased immunisation (2 year old)
17. **q.** Increased immunisation (2 year old)
18. **r.** Increased immunisation (2 year old)
19. **s.** Increased immunisation (2 year old)
20. **t.** Increased immunisation (2 year old)
21. **u.** Increased immunisation (2 year old)
22. **v.** Increased immunisation (2 year old)
23. **w.** Increased immunisation (2 year old)
24. **x.** Increased immunisation (2 year old)
25. **y.** Increased immunisation (2 year old)
26. **z.** Increased immunisation (2 year old)
4.1 Equity Focus in System Level Measures Planning Process

Recommendation:

That the Committee:

a) Receive the deep dive presentation on equity in the System Level Measures planning process.

b) Note that the 2018/19 System Level Measures Improvement Plan is currently under development.

c) Note that there is an intentional and deliberate focus on equity in the development and evolution of the Plan, and that the Committee are asked to consider how this can be strengthened.

Prepared by: Shayne Wijohn (Portfolio Manager) and Leesa Russell (Auckland Metro System Level Measures Project Manager), Aroha Haggie (Māori Health Gain Manager), Dr Catherine Jackson (Public Health Physician, System Level Measures).

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

Glossary

ALT - Alliance Leadership Team
COPD - Chronic obstructive pulmonary disease
Manawhenua - Refers to local people/tribes – Ngāti Whātua (ADHB/WDHB) and Tainui (CMH)
MOU - Memorandum of Understanding
PHO - Primary Healthcare Organisations
SLM - System Level Measures
Whānau - Family

1. Executive Summary

The System Level Measures (SLM) metro Auckland Improvement Plan has a deliberate intent to strengthen the focus on equity during the 2018/19 planning process. This paper provides some background to the Community and Public Health Advisory Committee deep dive presentation into the evolving SLM programme of work, provides some reflections from the 2017/18 SLM planning and implantation processes, and to seek advice on strengthening the equity focus.

2. Background

The SLMs Framework, introduced in 2016, aims to improve health outcomes for people by supporting DHBs to work in collaboration with health system partners, particularly primary care, using specific quality improvement measures and a focus on equity and service integration. All DHBs and Primary Health Organisations (PHOs) are required to have a SLM Improvement Plan. The Auckland region has taken a unique approach and has developed a metro Auckland Improvement Plan, for the three DHBs and seven PHOs, in partnership and approved by the Counties Manukau Health and Auckland DHB/Waitemata DHB Alliance Leadership Teams (ALTs).
The 2018/19 SLM planning process has a deliberate and intentional focus on health equity. This has been informed by reflection on the 2017/18 planning and implementation processes, seeking advice and expertise from manawhenua and Māori and Pacific providers in addition to, and facilitated by, the Māori and Pacific Health Gain Teams, and providing PHOs with an opportunity to hear and consider different views before embarking on the 2018/19 planning cycle. It should be noted that SLM planning advice has not yet been received from the Ministry of Health.

**Key Learning from 2017/18**

Reflection on 2017/18 planning and implementation processes have resulted in learnings for the 2018/19 plan, including:

- Setting equity targets is challenging.
- Without a specific focus on equity, service utilisation in some areas has improved more for non-Māori non-Pacific resulting in an increased equity gap.
- A better understanding of how data is presented to practices to encourage a focus on high-risk populations.
- Good quality data is necessary and can drive service improvements targeted to populations with the poorest health outcomes.
- Ensuring a strong focus on prevention of those conditions that are having the greatest impact on high-risk populations.
- There are specific programmes which have evidence to improve engagement and effectiveness for high-risk populations.

There are three streams of SLM data reporting – the Static Report (most up to date information presented in one report by DHB, PHO and ethnicity), the Quarterly update to Board and the Dynamic report (interactive web based tool called StatPlanet). Please find appended the SLM static report to inform discussions alongside the deep dive presentation.

The Committee are asked to consider the following questions:

- **What is the Committee's view on equity targets?**
  Equity targets are targets that measure the gap between certain populations (e.g. ethnicity, age, location, gender). They emphasise the need to investigate and invest in alternative services/models that raise the outcomes of the lowest achieving population to be at least equal to the highest, thus eliminating the gap and achieving equity.

- **What are other strategies and actions that could improve the equity focus of the 2018/19 SLM Improvement Plan?**
  The discussions about the SLM plan have included Māori workforce development, culturally appropriate models of care, greater levels of accountability through equity targets and involvement of Māori in oversight activities, and the inclusion of Māori health providers and manawhenua in SLM planning and implementation activity.

- **How else could we engage Māori in SLM planning?**
  Māori health providers have been engaged face to face on several occasions, their feedback will form part of the Plan’s content. Manawhenua, through Ngāti Whātua, are also engaged in these meetings.
System Level Measures Quarterly Report

Prepared by: Wendy Bennett (Planning & Health Intelligence Manager – Auckland and Waitemata DHBs) and Leesa Russell (Project Manager Auckland Metro System Level Measures)
Endorsed by: Dr Debbie Holdsworth (Director, Funding – Auckland and Waitemata DHBs), Dr Karen Bartholomew (Acting Director Health Outcomes – Auckland and Waitemata DHBs), Tim Wood (Deputy Director Funding – Auckland and Waitemata DHBs)

Glossary

ACP  Advance Care Plan
ALT  Alliance Leadership Team
ARPHS  Auckland Regional Public Health Service
ASH  Ambulatory sensitive hospitalisations
CVD  Cardiovascular disease
HT  Health Target
HQSC  Health Quality and Safety Commission
PES  Patient Experience survey
PHC  Primary health care
PHO  Primary Health Organisation
POAC  Primary Options for Acute Care
SLM  System level measure
WCTO  Well Child/Tamariki Ora

1. Strategic Alignment

Community, whanau and patient centred model of care

Our commitment to improvement against the System Level Measures (SLMs) demonstrates our dedication to our communities, patients and families to work to continually improve the quality of care we deliver and enhance the experience of our patients in their interactions with health care providers.

Emphasis and investment on both treatment and keeping people healthy

System Level Measures focus us to make improvements across the whole system. Activities focused on both treatment and keeping people healthy are identified within the 2017/18 System Level Measures Improvement Plan.

Intelligence and insight

The SLM programme of work is focused on using evidence-based solutions to effect change across the system and monitoring for that change to help understand how our activities contribute to our overarching goals.

Evidence informed decision making and practice

Taking a whole of system approach also focuses us on how we work together to achieve not only better outcomes for our patients and communities, but also how we achieve that sustainably, effectively and efficiently.
2. Introduction

The New Zealand Health Strategy outlines the high-level direction for New Zealand’s health system to 2026 to ensure that all New Zealanders live well, stay well, get well. One of the five themes in the Strategy is value and high performance. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health (MoH) worked with the sector to develop a suite of System Level Measures to provide a system-wide view of performance. Building on the work outlined in the 2016/17 System Level Measures Improvement Plan, in 2017/18, improvement milestones and contributory measures for each of the system level measures (SLMs) have been prioritised, in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Counties Manukau Health and Auckland Waitemata Alliances are firmly committed to including more contributory measures over the medium to longer term, once the structures, systems and relationships to support improvement activities are more firmly embedded. This plan reflects a strong commitment to the acceleration of Māori health gain and the elimination of inequity for Māori.

The steering group and working groups have continued to meet in 2017/18, in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs. Steering group membership includes senior clinicians and leaders from the seven PHOs and the three DHBs. The steering group is accountable to the two Alliance Leadership Teams (ALTs) and provides oversight of the overall process. Working groups were responsible for drafting contributory measures and identifying the related interventions to be included in the local improvement plans. Each working group is chaired by a PHO lead and supported by a DHB public health physician. Working group membership consists of senior primary care and DHB clinicians, personnel and portfolio managers.

The ALTs are strongly committed to improving performance where it matters most over the medium to longer term. The intention is to build on the 2016/17 improvement plan and activities, in line with Ministry expectations for 2017/18.

This second improvement plan (2017/18) includes the additional 2 SLMs (5. and 6. below):
1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates
5. Babies living in smokefree households at six weeks
6. Youth are healthy, safe and supported.

For each SLM, there is an improvement milestone to be achieved in 2017/18. The milestone must be a number that either improves performance from the district baseline or reduces variation to achieve equity. For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally.

This report includes the latest available data for each DHB for both the SLMs and their contributory measures. It also outlines each working group’s progress against the improvement activities identified in for each SLM in the SLM Improvement Plan.
### System Level Measure Reporting

#### 1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds

**Measure:** Rate per 100,000 domiciled 0-4 year-olds.

<table>
<thead>
<tr>
<th>District / Region</th>
<th>Target 2017/18</th>
<th>Actual</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>7,278 (max.)</td>
<td>6,686</td>
<td>12-monthly</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>6,754</td>
<td>6,833</td>
<td></td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>5,409</td>
<td>5,336</td>
<td></td>
</tr>
<tr>
<td>Metro Auckland</td>
<td>6,430</td>
<td>6,252</td>
<td></td>
</tr>
</tbody>
</table>

#### 2. Acute Hospital Bed Days

**Measure:** Age-standardised rate per 1,000 domiciled population.

<table>
<thead>
<tr>
<th>District / Region</th>
<th>Target 2017/18</th>
<th>Actual</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>425 (max.)</td>
<td>404</td>
<td>12-monthly</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>451</td>
<td>464</td>
<td></td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>414</td>
<td>417</td>
<td></td>
</tr>
<tr>
<td>Metro Auckland</td>
<td>429</td>
<td>428</td>
<td></td>
</tr>
</tbody>
</table>

**Target 2017/18:**
- 2% reduction for total population by June 2018
- 3% reduction for Māori population by June 2018
- 3% reduction for Pacific population by June 2018

#### 3. Patient Experience of Care

**Measure:** DHB Adult inpatient Experience Survey: Aggregated Domain Score (1/10).

<table>
<thead>
<tr>
<th>District / Region</th>
<th>Target 2017/18</th>
<th>Actual</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>8.5 (max.)</td>
<td>8.6</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>8.5</td>
<td>8.4</td>
<td></td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>8.5</td>
<td>n/a</td>
<td>Nov-17</td>
</tr>
</tbody>
</table>

**Measure:** Practices participating in Patient Experience Survey.

- Alliance Health Plus: 50% (min.) 80% (max.)
- Auckland PHO: 38% (min.) 59% (max.)
- Commissions: 50% (min.) 59% (max.)
- EastHealth: 48% (min.)
- North Shore Medical Centre: 80% (min.)
- Procare: 46% (min.)
- Total HealthCare: 50% (min.) 47% (max.)
- Metro Auckland: 50% (min.) 47% (max.)

#### 4. Amenable Mortality

**Measure:** Age-standardised rate per 100,000 domiciled 0-74 year-olds.

<table>
<thead>
<tr>
<th>District / Region</th>
<th>Target 2017/18</th>
<th>Actual</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>71.4 (max.)</td>
<td>79.2</td>
<td>12-monthly</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>102.3</td>
<td>101.4</td>
<td></td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>64.3</td>
<td>68.9</td>
<td></td>
</tr>
<tr>
<td>Metro Auckland</td>
<td>78.6</td>
<td>83.0</td>
<td></td>
</tr>
</tbody>
</table>

**Target 2017/18:**
- Two percent reduction (on single year baseline) by June 2018

#### 5. Youth Health

**Measure:** Chlamydia testing coverage for 15-24 year-olds.

<table>
<thead>
<tr>
<th>District / Region</th>
<th>Target 2017/18</th>
<th>Actual</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>80% (min.)</td>
<td>40%</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>80%</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>80%</td>
<td>35%</td>
<td></td>
</tr>
</tbody>
</table>

**Target 2017/18:**
- Eighty percent of pregnant women aged 15-24 years are screened for chlamydia

#### 6. Babies Living in Smokefree Households

**Measure:** Percentage of babies for whom smoke-free household status is not recorded by 6 weeks.

<table>
<thead>
<tr>
<th>District / Region</th>
<th>Target 2017/18</th>
<th>Actual</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>10% (min.)</td>
<td>10%</td>
<td>6-monthly</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>10%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>10%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Metro Auckland</td>
<td>10%</td>
<td>12%</td>
<td></td>
</tr>
</tbody>
</table>

**Target 2017/18:**
- Reduce to less than 10% by June 2018

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Legend

- **Target met / on track**
- **Improvement needed**
- **Significant improvement needed**
Overall Progress Report

Overarching activities for Q2:
- Implementation is on-going. Regional implementation plan is complete.
- Q1 reporting approved by the Ministry
- First steps to BAU are underway with the proposed approach discussed at Regional Funder Forum, NRA Board and ALTs anticipated in February.
- SLM reporting embedded in business as usual.
- First version of dynamic reporting circulated. Training of on the use of StatPlanet rolled out to each PHO in individual train the trainer sessions.
- The data set is formally complete, although constantly updated.
- Pre-planning cycle coordination initiated.
- PHO Implementation meeting embedded and beginning to create initiatives in (only) primary care.

Ambulatory Sensitive Hospitalisations 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting.

In New Zealand children, ASH accounts for approximately 30% of all acute and arranged medical and surgical discharges in that age group each year. However, determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure.

It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This measure can also highlight variation between different population groups that will assist with DHB planning to reduce disparities.

A composite ASH measure is preferred because it gathers up more conditions and aligns with the intention of using measures that operate at a system level rather than ones that focus on a specific condition or service.

In 2017/18, the overall improvement milestone is to achieve a reduction in ASH rates for 0-4 year olds of 5% by June 2018. There is no ethnic specific target reduction set at present, however ethnic specific rates must be monitored and reported and interrogation of approach to ensure that interventions reduce not worsen inequity. Metro Auckland’s rate is 6,252 per 100,000 for the 12 months to September 2017 (latest results). This is more than a 5% reduction on the results to September 2016 (baseline) of 6,758 per 100,000 population.
Contributory Measures

1. Māori babies fully immunised by 8 months of age

The goal for 2017/18 is to achieve the national target of 95% coverage per quarter. To achieve this goal, the current whole-of-pathway focus of the immunisation programme would continue. For Quarter 2 2017/18, none of the metro-Auckland DHBs met the target overall, with results for Auckland DHB showing a sharp decline for Māori (from 90.2% in Q1 to 78.3% in Q2). This is being investigated and mitigation strategies implemented.
**Improvement Activities**

- Current immunisation programme (primary care coordinators, general practice systems, outreach immunisation service, Māori and Pacific providers, secondary care)
- Continue to develop specific activity to improve Māori coverage (including ways to improve timeliness of immunisation), with leadership from Māori health gain teams and Māori leaders within primary care
- Develop links between immunisation outreach services and Māori Tamariki Ora providers to improve vaccination coverage for their enrolled children.
- Investigate the possibility of Well Child Tamariki Ora nurses providing immunisation
- Utilise Whānau Ora services for immunisation of hard to reach children.
- Promote immunisation in antenatal classes
- Investigate whether significant numbers of Māori babies are not engaged with general practice, with a view to include improvement activities to connect Māori whānau into the current newborn enrolment work.

**Progress Report**

All DHBs and PHOs continued with business as usual activities throughout the quarter.

Closing the equity gap and targeting high risk children are priorities for DHBs, and scoping activities have begun for in-hospital immunisation monitoring and documentation.

There is activity in each of the named improvement activities, although Well Child/Tamariki Ora (WCTO) immunisers and Whanau Ora service utilisation has not yet been addressed.

The PHO implementation meeting scheduled for 27 February will report back on the contribution of PHOs to this measure, with identification of barriers to immunisation and a set of strategies developed to identify and engage high risk children. This work will be focused on opportunistic vaccination in various settings.

NIR inform of issues weekly related to Māori babies and provide overdue lists for follow up by immunisation coordinators - good partnerships have developed. This also picks up messaging errors from Medtech to NIR.

Comprehensive Care PHO is engaged with Te Ha Oranga in Wellsford to support improvement around Northern rates.
2. Skin infections

The goal is a reduction in hospitalisation rates by 5% by June 2018, from a baseline of 907 per 100,000 0-4 population as at September 2016. To achieve this goal, there are a number of targeted activities around promotion of key prevention messages, in various community settings. The latest data is for the 12 months to September 2017 and shows a result of 738 per 100,000 0-4 population, nearly a 19% reduction on baseline. However, results are much higher for Māori and Pacific populations and also typically fluctuate between quarters.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improve distribution of resources to primary care, urgent care, Well Child Tamariki Ora services, and early childhood education centres</td>
<td>The clinical network has a working group who are implementing education resources to PHOs which will enable key messages to family.</td>
</tr>
<tr>
<td>• Deliver an educational package ‘skin infection combined key messages’ to primary care, urgent care, WCTO services, and early childhood education centres. Use forums such as the Pacific Community Child Health Network (managed by TAHA, the Well Pacific Mother and Infant Service) to reach community groups.</td>
<td>The PHO implementation meeting shared educational resources and strategies for best practice implementation of these improvement activities, with agreement to share further learnings at quarter’s end.</td>
</tr>
<tr>
<td>• Use DHB nurse educators and other health promotion resources in a coordinated way, so that health promotion messages reach early childhood education centres and other organisations that connect with families of young children. Currently Counties Manukau DHB and Auckland DHB have nurse educators; Waitemata DHB does not</td>
<td>Auckland PHO is developing resources for specific skin infections to be provided to patients, and these will be shared with the Metro Auckland PHOs.</td>
</tr>
<tr>
<td>• Link in to early childhood education centre health promotion activities delivered Auckland Regional Public Health Service</td>
<td></td>
</tr>
<tr>
<td>• Consider further development of primary care skin clinics. (Working group suggest this is an analysis or discussions document activity about reinstatement of primary care skin clinics)</td>
<td></td>
</tr>
<tr>
<td>• Consider new approaches for providing access to care, e.g. community outreach, pharmacies, parish nurses.</td>
<td></td>
</tr>
<tr>
<td>• Consider the opportunities for community pharmacy to provide more education on the best use of topical and oral products</td>
<td></td>
</tr>
<tr>
<td>• Consider targeted outcomes for Pacific and Māori children.</td>
<td></td>
</tr>
</tbody>
</table>
3. Oral Health

The goal is 95% enrolment with oral health services amongst preschool children. The recently finalised Oral Health Strategy is the basis of the improvement, with SLMs aligning and supporting this work.

As at December 2017, the metro-Auckland result shows that around 88% of 0-4 year olds are enrolled with the Auckland Regional Dental Service. This is much lower for Māori at 71%. Counties Manukau have the lowest rate of enrolment overall at 81.5%, Waitemata the highest at 95%.

**Percentage of preschool children enrolled in DHB funded oral health services as at December 2017 (rolling 12 months)**

<table>
<thead>
<tr>
<th></th>
<th>Auckland</th>
<th>Waitemata</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>65%</td>
<td>71%</td>
<td>81.5%</td>
</tr>
<tr>
<td>Pacific</td>
<td>81%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>45%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>20%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

**Imagery Activities**

*From the 2017 Pre-school Oral Health Strategy:*
- Oral health promotion at national, community and individual level. Focus on Pacific churches and parenting groups.
- Messaging to align with Raising Healthy Kids National Health Target.
- Increase awareness of free dental services.
- Upskill primary care, Well Child Tamariki Ora and secondary care providers in lift-the-lip assessments, knowledge of dental services and referral processes.
- Engage with the newborn enrolment project, which is: implementing systems to refer newborns for enrolment with the National Immunisation Register, general practice, oral health providers, Well Child Tamariki Ora providers and newborn hearing screening services.
- Increased number of extended hours and Saturday dental clinics in appropriate locations.
- Consider a targeted intervention for Pacific and Māori children to address inequity.

**Progress Report**

The Oral Health strategy has been finalised and is now moving toward implementation.

Primary care met to discuss their contribution to these activities on 15 November 2017.

Primary care plan to support increased Auckland Regional Dental Service (ARDS) referrals and train the trainer for lift the lip assessments are being rolled out in February to all PHOs.

Project management met with ARDS to discuss the data used for SLMs and agreed an audit to address some inconsistencies, possibly in utilisation, identified by geo-mapping provided by the Planning and Health Intelligence team at Auckland and Waitemata DHBs.

Many of the activities in this measure are the agreed responsibility of ARDS under the Pre-School Oral Health Strategy. Several meetings with ARDS have been undertaken this quarter to support their implementation as far as possible.
4. Respiratory Conditions Potentially Preventable by Immunisations

The goal is to increase flu vaccination coverage by 10% (from a baseline of 13% at December 2016) for children who are hospitalised with a respiratory illness. To achieve this goal, there is a focus on provision of information in a timely manner and improved key messages around flu vaccine for eligible children. This measure is across the calendar year in line with the flu season May to December. So the cohort is established at 1 March and vaccination rates are measured for these children at 31 May, 31 July and 30 September, with the final measure as at 31 December. Below shows rates at the first and last time points across the 2017 year flu season (i.e., as at 31 July 2017 and at 31 December 2017). Rates were highest overall for Auckland DHB at both time points and lowest for Counties. However, Waitemata DHB showed the most improvement between time points (3%). Māori and Pacific rates are lowest.

Flu vaccination rates between July to Dec 2017 for children hospitalised with a respiratory condition

<table>
<thead>
<tr>
<th></th>
<th>Jul-17</th>
<th>Dec-17</th>
<th>Jul-17</th>
<th>Dec-17</th>
<th>Jul-17</th>
<th>Dec-17</th>
<th>Jul-17</th>
<th>Dec-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>10%</td>
<td>15%</td>
<td>5%</td>
<td>10%</td>
<td>0%</td>
<td>5%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>Euro/Other</td>
<td>15%</td>
<td>20%</td>
<td>10%</td>
<td>15%</td>
<td>5%</td>
<td>10%</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Māori</td>
<td>20%</td>
<td>25%</td>
<td>15%</td>
<td>20%</td>
<td>10%</td>
<td>15%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Pacific</td>
<td>25%</td>
<td>30%</td>
<td>20%</td>
<td>25%</td>
<td>15%</td>
<td>20%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>60%</td>
<td>70%</td>
<td>45%</td>
<td>55%</td>
<td>25%</td>
<td>35%</td>
<td>20%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Improvement Activities

- Develop the current activity to identify and vaccinate all children aged 0–5 who qualify for the free influenza vaccine
- Build on current activity to support both influenza and pertussis vaccine offer to all pregnant women, e.g., vaccinator at antenatal clinics, promotion campaigns, lead maternity carers education opportunities
- Undertake activities in primary and secondary care:
  - Secondary care
    - Develop a documented, consistent system for providing lists of hospitalised children to PHOs and monitoring through the Influenza season (when the vaccine is available)
    - Make it mandatory to fill in the sections on discharge letters on eligibility for special immunisations
    - Promote vaccinations to patients and their families and proactively refer patients back to GPs for vaccinations.

Progress Report

- The Planning and Health Intelligence team are working towards centralised (regional) processes for the flu vaccination eligibility notification, in line with early and more consistent supply of eligibility information to primary care.
- An education programme was agreed for later in the year, with key messages at conferences and on web-based platforms to decrease barriers to access.
- Conversations about the feasibility of offering influenza vaccination to all children 0–4 years have been postponed until the key actions in this SLM Plan have been undertaken.
- Work is underway by Comprehensive Care PHO to develop Paediatric focused flu resources to support practices.
**Improvement Activities**

**Primary care**

- Immunisation coordinators in PHOs provide education to general practice staff on special immunisations while visiting practices, and
- The Immunisation Advisory Centre will provide education and support to general practice, to improve understanding of who is eligible for special immunisations and to enhance processes for identification and recall, through continuing medical and nursing education sessions.

- Develop systems for measuring the impact of these activities, e.g. on readmissions for respiratory illness
- Consider the feasibility of offering Influenza vaccination to all children aged 0-4 years
- Pregnancy related immunisations: develop data definitions and agreed consistent process steps and monitoring points.

**Acute Hospital Bed Days Per Capita**

Acute hospital bed days per capita is a measure of acute demand on secondary care that is amenable to good upstream primary care, acute admission prevention, good hospital care and discharge planning, integration of services and transitions between care sectors, good communication between primary and secondary care, can all help reduce unnecessary acute demand. Good access to primary and community care and diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed day’s per capita rates will be illustrated using the number of bed days for acute hospital stays per 1000 population domiciled within a DHB with age standardisation.

Certain conditions are more likely to result in unplanned hospitalisation alongside other contributory factors such as the referral process to ED (self, provider variation, ambulance etc.). Primary care interventions are key and can have significant impact on hospital admission rates.

The Auckland Metro age standardised acute bed day rate per thousand population was calculated to be 437.7 as at September 2016 with a target set to reduce the rate by:

- 2% for the total population – 428.9 standardised acute bed days/1000 by June 2018
- 3% for the Māori population – 604.6 standardised acute bed days/1000 by June 2018
- 3% for the Pacific population – 729.6 standardised acute bed days/1000 by June 2018

It must be noted that any new beds opening will need to be adjusted for, as supply side changes will impact this indicator in a stepwise fashion.

While standardised rates for all Metro-Auckland DHBs have been generally declining each year, Counties Manukau Health’s rates have risen slightly in the last year. The metro-Auckland overall rate is now slightly better than the June 2018 target at 428.3 standardised acute bed days/1000 (target is 428.9).
However, rates are much higher and more static for Māori and Pacific populations. While both Auckland and Waitemata have rates better than target, Counties Manukau is some way from achieving for Māori. For Pacific, no DHBs are meeting the target although Waitemata is the closest, with Auckland well above.

Standardised Acute Bed Days per 1,000 Māori Population: 12 months ending
Contributory Measures

1. ED Presentation Rates.

Overall reduction in ED presentations will result in less admissions and bed day use. There is some complexity involved in this measure however it is a good marker due to its correlation with actual admissions and also potentially avoidable admissions. The difficulty will come from wide confidence intervals for the measurement at a practice level. Other measures such as Primary Options for Acute Care (POAC) utilisation rates are also being monitored.

The methodology for calculating this measure has only recently been finalised and approved and a baseline established of 214.3 ED attendances per 1000 population (standardised), for the 12 months to 30 September 2016. The 2017/18 SLM Improvement Plan set a target of reduction of 2% by June 2018. Data to September 2017 shows ED presentation rates are much higher and rising for the Waitemata DHB population. Rates increased with the opening of the ED service at Waitakere Hospital. Only Auckland DHB has sustained performance below the target.

These rates are per 1,000 of the population and age standardised to the New Zealand population 2013 and presented as a moving 12 month rolling figure. Note that the data will be refreshed retrospectively for each reporting period, so previously reported figures may change.
Improvement Activities

Primary Options in Acute Care (POAC) activities:

- Determine baseline utilisation of POAC across the region, including an ethnicity-level and a practice-level analysis
- Identify gaps and areas for potential improvement
- Convene expert group to determine and agree consistent interventions
- Monitor POAC utilisation, intervention rate and impact
- Develop and implement an education programme to promote appropriate use of POAC
- Explore current barriers to general practices using POAC
- Develop practice-level reports showing POAC usage relative to peers
- Pilot new and innovative ways to encourage patients to use primary care services appropriately, e.g. social media campaigns, vouchers for after-hours care.

Progress Report

Initial POAC data analysis was undertaken in quarter 2. Increase in visibility and CME/CNE resulted in a marked increase in utilisation. We are now working towards more targeted utilisation for high risk populations to further reduce presentations.

Development of an education programme is underway and is likely to be led by the newly formed SLM PHO Education Group.

Individual PHOs are additionally incorporating this and other SLM focused education into their annual CME/CNE calendars and peer group sessions.

2. Acute readmission rates at 28 days

Avoidance of readmission to hospital following a recent discharge from hospital. The Ministry of Health have recently changed the methodology for calculating acute readmission rates at 28 days significantly. The latest Ministry results (to September 2017) show Auckland DHB has a result of 13.2%, Counties Manukau 11% and Waitemata DHB 12.8%. There has been little movement across the three data points, though a small decline is evident for all except Waitemata DHB. Only Counties Manukau is below the New Zealand rate.

For both Māori and Pacific, readmission rates for Auckland are highest and lowest for Counties Manukau. Readmission rates for Māori are also generally static though slightly higher than that for
the total population, whereas there is a marked decline across the data points for Pacific, except for Waitemata which has increased between this and last reporting period.

**Standardised acute readmission rates within 28 days Maori 12 months to September**

![Graph showing Maori acute readmission rates]

**Standardised acute readmission rates within 28 days Pacific 12 months to September**

![Graph showing Pacific acute readmission rates]
### Improvement Activities

- Determine baseline readmission rates by ethnicity, by PHO and across the region
- Explore the potential of risk stratification to identify patients at highest risk of readmission
- Review discharge planning processes across the hospital systems
- At the point of discharge and in primary care, target patients discharged with CHF, COPD and the frail elderly
- Encourage active follow up of patients discharged from hospital with a relatively high risk of readmission, in particular for those with CHF, COPD and the frail and elderly
- Ensure that patients discharged from hospital with a relatively high risk of readmission have a patient centred care plan and, ensure Advance Care Plans (ACP) are in place, with a focus on initiating the ACP in primary care settings.

### Progress Report

- Ministry data for this measure has now arrived and has been analysed
- AHBD working group is creating linkages between the DHBs and their ongoing projects in this area
- CMDHB has several working groups newly created to address the condition-based issues
- ADHB has ‘Using the Hospital Wisely’ programme and a specific consideration of chronic obstructive pulmonary disease (COPD)
- WDHB has the TransforMED programme which has a bed day reduction focus, and a frail and elderly emphasis
- The three programmes above are linking up with the Auckland DHB working group and sharing ideas and successes
- Risk stratification is ongoing at Counties Manukau Health.

### Patient Experience of Care

‘Person centred care’ or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

**Measures**

1. **DHB Adult Inpatient Survey**

The nationally applied DHB Adult Inpatient Survey has been conducted quarterly since 2014 and for 2016/17 the SLM milestone for patient experience focused on the Adult Inpatient Experience Survey. This survey captures four measured domains - communications, partnership, coordination, physical and emotional needs. The 2016/17 target was to achieve an aggregate score of 8.0/10 across all four domains measured, this was increased to 8.5/10 for 2017/18.

Interventions are aimed at improving patient experience scores in the four domains along with promoting the survey to improve participation and using the results to improve quality. Individual DHBs need to improve survey participation, particularly with respect to equity and foster greater regional collaboration. This may include working with Māori, Pacific and Asian provider teams within the hospital to facilitate feedback from recently discharged patients, and/or language specific initiatives.

Related interventions to improve response rates include exploring other modality options (e.g. use of tablets at the time of discharge), increasing email uptake during administration processes, and promoting the patient experience survey to patients via pamphlets and other resources.

Despite some fluctuation, there is little change over the time period observed, although there is a small overall improvement. Of note is that the national response rate decreased to around 23% compared with 26% previously. Response rates for surveys invited via email and SMS have decreased to 25 and 16%, respectively. Response rates for posted surveys decreased from around 42
to 32%. Low response from people aged 15–24 and 25–44 has continued, as did under-representation of Māori, Pacific or Asian people.

### Improvement Activities

- Individual DHB focus areas via annual planning will be worked on at a local level. For 2017/18 there will be a particular focus on enhancing connections through improved communication and addressing equity gaps, via specific programmes and initiatives, which will be locally delivered.
- A regional DHB group for patient experience of care meets monthly via teleconference and quarterly face-to-face. The SLM Improvement Plan will become core business for this group.
- Develop long-term strategies in response to specific equity challenges (Pacific and Māori specialist team engagement), and broaden communication and conversations for patients to improve their experience and journey of care.
- Share individual DHB learning and harness opportunities to replicate successes across Metro Auckland.

### Progress Report

This work is ongoing in DHBs. Regular joining-up occurs, with lessons learnt contributing to initiatives in primary care.

Representatives from the SLM group have been attending the Regional Patient Experience of Care Group to try to determine a business as usual home for this SLM. Presently a subgroup for SLM focused discussion is considered to be the most appropriate way forward with Regional expert representation and PHO/PHC membership planned.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
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<td></td>
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<td></td>
</tr>
<tr>
<td>• Share individual DHB learning and harness opportunities to replicate successes across Metro Auckland.</td>
<td></td>
</tr>
</tbody>
</table>

2. **The Primary Health Care Patient Experience Survey (PHC PES)**

The Primary Health Care Patient Experience Survey (PHC PES) is currently being rolled out across Auckland. In Auckland 6 PHOs with a total of 143 practices participated in the November Primary Health Care Patient Experience survey week. The survey was conducted in the first week of November.

According to the Health Quality and Safety Commission (HQSC), this will be implemented in all practices, but it is critically dependent on establishment of the National Enrolment System (NES), which has not yet been implemented in every practices. The 2017/18 target is to ensure 50% of each PHO’s practices (approximately 166 practices) are participating in the Primary Health Care Patient Experience Survey (PHC PES) by June 2018. As at November 2017 only 2 PHOs are meeting this target.
Improvement Activities

- Ensure socialisation of resources and support for practice-related activities, such as, PHOs follow HQSC/Ministry of Health ‘Getting Started’ resource pack and advice
- PHOs advise Cemplicity of PHO name and contact for survey, and IT key contact to enable log on via email address
- Practices are supplied with and follow getting started guide and resources
- Practices provide PHO with details to appear on survey invitation email, text message and online survey
- Marketing of the survey week (one week every quarter), process and survey intent across practices is enabled
- Practices check email addresses of all patients 15 years and over and save preferences
- Follow up by PHO and practices to view real-time patient experiences and appropriately respond to request for contact or any indicated follow up required
- Once survey is closed, practices and PHOs will review the final results of the survey.

Progress Report

The PHO Implementation meeting for PHC PES is scheduled on 13 March 2018 for PHOs to provide feedback on the February 2018 survey week.

PHOs are rolling out the survey to practices in tranches with a view to full participation by the end of the financial year.

Contributory Measures

1. E-Portals.
E-portals are a single gateway for patients to gain access to their general practice information which can include: booking appointments, ordering repeat prescriptions, checking lab results, and viewing clinical notes/records. More general practices are offering patient portals and there is scope within primary health care for them to positively impact the SLM milestone. This can be enabled through alternative access point/navigation for the patient, enabling coordinated self-managed care provision; maintaining and providing online communication; and partnering with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-physical needs).
For 2017/18 the target is that 55% of each PHO’s practices are registered with a portal and 15% of each PHO’s population have access to a portal. The latest (September 2017) results show that four PHOs have still to meet the 55% target for having portals in place. However, most PHOs have yet to meet the 15% target of enrolled patients registered to use portals.
**Improvement Activities**

- E-portals ambassadors and provider options will continue to be socialised amongst clinicians and consumers via PHOs and practices.
- PHO teams will provide support to practices to implement e-Portal enrolment systems.
- Portal options are explored by practices and adopted in a staged approach relative to level of clinician confidence and consumer request. These will include:
  - access to clinical data – diagnoses, notes, allergies, immunisations, lab results;
  - access to communications – messaging to doctor or nurse, repeat prescription, requesting appointments, self-scheduling;
  - access to education – condition specific information, websites with merit, self-management activities, and
  - PHOs will access resource materials and actively use these to support e-Portal implementation in practices and e-Portal uptake by patients.

**Progress Report**

- Update of e-portals is now increasing and PHOs are generally using a tranche approach to engage groups of practices per quarter.
- There is wide variation in the number of practices engaged in e-portals with some PHOs having 100% of practices engaged, and some at 0.
- For those outstanding practices, plans are in place for many to on-board over the forthcoming year.
- Some smaller practices have considerations to be made of the added value to patients and the cost implication of portals within their current operating model.
- Those PHOs without e-portals have a plan to implement.

**Amenable Mortality**

Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before an arbitrary upper age limit (usually 75).

For 2017/18 the decision was made to continue with the two contributory measures that have the greatest evidence-based impact on amenable mortality – cardiovascular disease (CVD) management and smoking cessation.

Amenable mortality rate per 100,000 population (age standardised), 0–74 year olds, using New Zealand estimated resident population as at June 30 was used as baseline:

<table>
<thead>
<tr>
<th>DHB</th>
<th>2013</th>
<th>2009-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>72.9</td>
<td>87.5</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>104.4</td>
<td>113.0</td>
</tr>
<tr>
<td>Waitemata</td>
<td>65.6</td>
<td>74.6</td>
</tr>
<tr>
<td>Metro Auckland</td>
<td>80.2</td>
<td>89.4</td>
</tr>
</tbody>
</table>

The goal is to achieve a 6% reduction for each DHB (on 2013 baseline) by June 2020, noting that changes in rates would generally only be seen over an extended timeframe of at least 3-5 years.

The current level of inequity in amenable mortality indicates the scope for health gain.
Based on five year trends, all three Metro Auckland DHBs show consistently declining rates as per graph below, despite an increase between 2013 and 2014 for Auckland and Waitemata DHBs. Given that there will always be some annual fluctuation and that the target extends to 2020, we should be on track to meet the 6% reduction by 2020.

**Contributory Measures**

1. **CVD Risk Assessment – to increase coverage of Māori to 90%**

As at December 2017, Māori screening rates were slightly below the target with Counties Manukau DHB screening 88.7% of the eligible population, while Auckland DHB had screened 88.5% and Waitemata DHB 86.4%. These results show a very slight decline from the preceding quarter’s results.
2. **CVD Management - to increase triple therapy by 5% (relative) for those with a prior CVD event and for those with a CVD RA of ≥ 20%**

Baseline for 2017/18 was set on performance as at the twelve months ended September 2016.

For triple therapy baseline results, Counties Manukau DHB recorded 58.1%, Auckland DHB 52.7% and Waitemata 53.8%. Latest performance (for the 12 months ended September 2017) shows a small deterioration in results for all DHBs – 51.3% for Auckland, 57.4% for Counties Manukau and 52.4% for Waitemata, with a metro-Auckland rate of 53.8%. Rates are lowest for Asian at 46.6% across the metro-Auckland region, followed by Other ethnicities at 52.4%.

For the 12 months ended September 2016, dual therapy pharmaceuticals dispensed to those with a CVD risk assessment score greater than 20% were 41.6% for Auckland DHB, 49.1% for Counties Manukau and 41.4% for Waitemata DHB. Little change in rates for any of the DHBs can be seen in the 12 months ended September 2017, with results recorded as 41.7% for Auckland DHB, 49.2% for Counties Manukau and 41.2% for Waitemata DHB, or 44.9% for the metro-Auckland region. Across metro-Auckland, rates are lowest for Other ethnicities at 40.3%, followed by Asian at 42.7%.

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**Improvement Activities**

- Follow up phone calls (evenings) for practice generated CVD RA recall letters to Māori
- Pilot of phlebotomy services in the practices or point-of-care testing when Māori males visit opportunistically.

**Progress Report**

These activities were discussed in the PHO implementation meeting in February, with a focus on increasing access to practices for young Māori males and facilitating the five year anniversary of CVD RA, which represents a workload bubble. Changes to the CVD consensus statement were also discussed, with implementation plan in early stages.

Several practices are piloting use of the cobas machine to opportunistically test Māori males on presentation to clinics, with an informal evaluation to follow in early 2018.
Improvement Activities

- Identification of patients at a NHI level who have had a CVD event and are not dispensed triple therapy. Feedback and comparison of these results to GPs via PHOs
- Total population and specific interventions for Māori, Pacific and Asian peoples to improve uptake and adherence to dual and triple therapy
- Post-event medication counselling and other rehabilitation services in hospital
- Ongoing medication counselling by community pharmacists
- Consider an activity focussed on ensuring access to prescription subsidy cards and reducing

Progress Report

There are regionally agreed definitions and standardised format of reporting for CVD dispensed medications available from the Northern Region Cardiac Network. Some PHOs have given approval to share the aggregated dispensing reports for regional reporting.

All PHOs have agreed to identify patients who are not on optimal therapy and feedback these results to GPs.

The PHO implementation meeting for this area was in February, and focused on upcoming changes to the CVD consensus statement which will require some patients be recalled and moved to optimal therapy. PHOs agreed to work regionally to determine the most efficient way of implementing these changes.

Educational resources have been developed by EastHealth and Total
### Improvement Activities

- prescription co-payments
- Establish a single process to report CVD indicators from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.

### Progress Report

Healthcare and will be shared regionally.

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#### 3. Increase rate of cessation support provided to enrolled smokers by 10%

The Auckland Metro DHBs have achieved the ‘brief advice ‘better help for smokers to quit’ health target since 2012. However, the routine provision of brief advice has not resulted in a substantial number of smokers accepting the offer of help to quit. For 2017/18 the target is an increase in cessation support by 10% disaggregated by ethnicity. Baseline data, for the quarter ended September 2016 showed rates of cessation support provided to smokers enrolled in PHOs was 24.7% for Auckland DHB, 24.4% for Counties Manukau Health and 32.9% for Waitemata DHB – with a metro-Auckland result of 27%. Latest results (for the quarter ended December 2017) show little movement from baseline rates with Auckland DHB recording a result of 25.8%, and Counties Manukau and Waitemata DHBs showing small decreases to 23.4% and 29.3% respectively. Overall metro-Auckland rate was lower at 25.8%. The Ministry of Health is not currently able to provide ethnic specific results. PHOs have agreed to provide the data locally but initial data sets are not of sufficient quality to include currently.

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![Enrolled smokers who received cessation support](image-url)

- ADHB
- CMDHB
- WDHB
- Metro
- Target

<table>
<thead>
<tr>
<th>Enrolled smokers who received cessation support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2</td>
</tr>
<tr>
<td>0%</td>
</tr>
<tr>
<td>2015/16</td>
</tr>
</tbody>
</table>
**Improvement Activities**

- Analyse reasons for historical low referrals to smoking cessation providers
- Improve referral pathways to smoking cessation providers
- Improve feedback to referrers from smoking cessation providers
- Access aggregated data for Auckland population
- Establish a single process to report smoking from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions
- Benchmark 'access to smoking cessation' READ codes across PHOs: i.e. the number of patients with codes 1, 2 and 3:
  1. ZPSC10 – referral to smoking cessation support
  2. ZPSC20 – prescribed smoking cessation medication
  3. ZPSC30 provided smoking cessation behavioural support.

**Progress Report**

Regionally agreed definitions have been developed which have been approved by the data custodian group. These have also been approved by the SLM steering group, with source requests delivered to organisations in late September and the second data upload was held in January 2018. However, initial data sets are not of sufficient quality to include currently.

**Youth Access to and Utilisation of Youth-appropriate Health Services**

The Youth Domains are five separate areas of youth health which combine to support a positive youth experience of health care. The focus this year is on Sexual and Reproductive Health. The overarching milestone is 80% of pregnant woman aged 15-24 years are screened for chlamydia during pregnancy.

There is work on-going in the contributory measures to set up other domains in preparation for next year.

![Chlamydia testing coverage of enrolled population as at Q2 2017 by domiciled DHB](chart)

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 04/04/18
All Pregnant Women are Screened for Chlamydia
The target for this year is 80% of pregnant woman aged 15-24 years are screened for chlamydia during pregnancy.
**Improvement Activities**

- Workforce development activities for lead maternity carers
- Data analysis looking for missed opportunities, e.g. primary care visits during pregnancy
- Data analysis looking for the potential to report back screening rates to lead maternity carers.

**Progress Report**

- Development of a prospective data definition is underway to enable a pregnancy alert to be provided to PHOs so that chlamydia testing can be carried out in a timely way. Completion is anticipated by March 2018.

**Contributory Measures**

1. **Development of Future Sexual and Reproductive Health Contributory Measures**

The target for this year is to establish a baseline in this measure.

**Improvement Activities**

- Analysis of SLM data by age, ethnicity, and PHO
- Identify gaps and potential areas for improvement
- Review the literature to identify options for improving access to chlamydia testing for Māori and Pacific youth including school-based services, pharmacy, community laboratories, primary care, outpatients, justice systems, and other opportunistic settings.

**Progress Report**

- The data definition for the SLM has been completed, as has analysis
- There is ongoing work to identify gaps and promote improvement, particularly in primary care and sexual health service providers
- A registrar has been identified to undertake the literature review and will be supervised by Dr Farrant, Chair of the Youth Network.

2. **Chlamydia Burden of Disease**

The target for this year is to establish a baseline in this measure.

**Improvement Activities**

- Establish regular reporting of chlamydia prevalence by age, ethnicity and locality.

**Progress Report**

- This data definition is in progress and has been approved by the Data custodians in September. The SLM Steering Group approved this data request in September, and the user request form was submitted in late September
- It is anticipated that data for this measure be released and analysed by early 2018.
3. Healthcare Utilisation by 15-24 year olds

The target for this year is to complete the analysis detailed in the activities.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
</table>
| • Explore the availability of data across services potentially accessed by youth and the feasibility of data linkage to explore systems-wide youth health service utilisation and identify gaps.  
• Baseline primary health care enrolment and utilisation. | • A baseline analysis is anticipated by June 2018  
• Auckland PHO has been scoping up a Youth Friendly Primary Care Project Plan to support a role out of a Youth Health Programme to the PHO Network in the next quarter. This is to support our youth to have full access to and utilisation of appropriate health services. The learnings and resources developed will be shared with the other Metro Auckland PHOs. |

4. Participation in the Child and Adolescent Mental Health Services Marama Real-Time Survey

The target for this year is to establish a baseline in this measure.

The latest report covers the period 1 July 2016 to 30 June 2017.

Survey rates of return are relatively low, with Waitemata DHB having the highest rate at 8.1%, followed by Counties Manukau at 2.4%, with Auckland at 0.7%. The Metro-Auckland DHBs response rate of 3.9% is higher than the national average of 2.7%. These equate to very small numbers, especially for Auckland DHB.

Because of the low response rate, especially for Auckland DHB, the results should be interpreted with caution.

Across the seven pre-set questions, Auckland DHB consistently had the largest proportion of patients (80.0-97.1%) answering ‘strongly agree’ or ‘agree’, with Waitemata DHB as the second highest (68.3-87.3%) and Counties Manukau DHB the lowest (46.6-65.6%).

The Metro-Auckland DHBs proportion of patients answering ‘strongly agree’ or ‘agree’ across the seven survey questions was 65.2-81.5%, which is lower than the national average of 67.7-85.2%, with the exception of the Support question where Metro-Auckland DHB’s ‘strongly agree’ or ‘agree’ response rate was 80.1% and the national response rate was 79.9%.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
</table>
| • Analysis of SLM data  
• Engage with Mārama, the regional child and adolescent Mental Health Service group, and service providers to identify gaps and potential areas for improvement. | • Analysis of initial results has been undertaken, but the low response rates limit the meaningfulness of results. |
5. Development of Baseline Data for Youth Domains:
   a. Alcohol and Other Drugs
   b. Access to Preventative Services
   c. Mental Health and Well-being

The target for this year is to establish a baseline in these domains.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Analysis of SLM data by age, ethnicity, and PHO</td>
<td></td>
</tr>
<tr>
<td>• Identify gaps and potential area for improvement.</td>
<td>• A baseline analysis is anticipated by end June 2018. The Ministry has signalled data will be available from March 2018.</td>
</tr>
</tbody>
</table>

Proportion of Babies Living in Smokefree Homes at 6 weeks postnatal

Baseline data from Well Child Tamariki Ora (WCTO) providers suggests that 98% of babies lived in a smokefree household at 6 weeks post-partum during Q1-2 of 2016/17. Given current smoking prevalence this is unlikely to be accurate. In addition, nearly 1 in 5 babies in Metro Auckland did not have smokefree household data recorded. Therefore, WCTO activities in the 2017/18 plan focus on improving data quality. As data quality improves, the proportion of babies living in smokefree households is likely to decline initially. Therefore, measuring the impact of activities on the SLM will be challenging in the short term.

Caution should be taken when drawing conclusions from this data. Data quality is questionable. The data below covers the period July – December 2016. Data prior to this time period is not of sufficient quality to include. While the percentage of babies living in smokefree households appears to be quite good, there are a significant proportion of instances where the question has not been asked, the field is blank or the response recorded is ‘unknown’, particularly for Counties Manukau DHB domiciled patients.

The milestone target for this measure is to reduce missing smokefree household data to <10% by June 2018.

Data Quality indicator: Percentage and number of instances where question not asked, unknown or missing - July - December 2016 Well Child/Tamariki Ora data

<table>
<thead>
<tr>
<th>Counties Manukau</th>
<th>Waitemata</th>
<th>Auckland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage missing data</td>
<td>Target</td>
<td>Number of events with missing data</td>
</tr>
</tbody>
</table>

[Graph showing data quality indicators for Counties Manukau, Waitemata, and Auckland]
Contributory Measures

1. Maternal Smokefree Services

The target for this year is to establish a baseline in this measure.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
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</thead>
<tbody>
<tr>
<td>• Improve regional data collection so that timely maternal smoking prevalence data is available, brief advice and quit support can be monitored, and referral to SSS for women who are pregnant and are current smokers can be monitored</td>
<td>• The smoking cessation health pathway has been reviewed and is awaiting clinical editor approval</td>
</tr>
<tr>
<td>• Analyse reasons for historical low referrals to smoking cessation providers, particularly for Māori women</td>
<td>• Smoking cessation incentives programmes are beginning start quarter 3 at Auckland/Waitemata DHB and ongoing at Counties Manukau Health</td>
</tr>
<tr>
<td>• Promote regional pathway for first trimester visit (includes smoking cessation referral) with a focus on Māori women</td>
<td>• A meeting with regional Midwifery representatives facilitated conversations around information sharing, and has led to a small working group ongoing to facilitate GP and LMC communications</td>
</tr>
<tr>
<td>• Facilitate early enrolment of pregnant women with lead maternity carers</td>
<td>• CME sessions have recently been initiated which will be shared regionally.</td>
</tr>
<tr>
<td>• Provide lead maternity carers and GP training on smoking cessation</td>
<td></td>
</tr>
<tr>
<td>• Provide feedback to lead maternity carers on their referral rates</td>
<td></td>
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<tr>
<td>• Provide pregnancy SSS incentives programme</td>
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<tr>
<td>• Arrange for SSS providers to attend pregnancy and parenting classes in the community (particularly those for Māori and Pacific)</td>
<td></td>
</tr>
<tr>
<td>• Explore innovative ways of engaging pregnant smokers to quit, with a focus on Māori women, e.g. through use of a Sudden Unexpected Death in Infancy App.</td>
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</tbody>
</table>
2. **Household Smoking Cessation**

The target for this year is to establish a baseline in this measure.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• WCTO Data Quality Improvement: Review and align data collection processes for SLM</td>
<td>• The Ministry have notified this working group that they will undertake data</td>
</tr>
<tr>
<td>measure across WCTO providers and provide SOPs for data collectors</td>
<td>collection improvement nationally</td>
</tr>
<tr>
<td>• Provide WCTO providers feedback on missing smokefree data rates</td>
<td>• The first data set has been received, however, the quality of the data is</td>
</tr>
<tr>
<td>• Scope processes to identify household members of pregnant women and newborns who</td>
<td>poor and the collection time frame is not current</td>
</tr>
<tr>
<td>are current smokers, including data collection processes</td>
<td>• Representatives attended meeting with the Ministry regarding consolidation</td>
</tr>
<tr>
<td>• Explore opportunities to offer smoking cessation support to whānau of newborn</td>
<td>and improvement of WCTO data collection.</td>
</tr>
<tr>
<td>inpatients and outpatients, and paediatric ED attendances</td>
<td>• We anticipate some further data in March 2018</td>
</tr>
<tr>
<td>• Explore additional ways of offering smoking cessation support to whānau of young</td>
<td></td>
</tr>
<tr>
<td>children, e.g. pharmacy initiatives, Well Child providers</td>
<td></td>
</tr>
<tr>
<td>• Support the work undertaken in the Amenable Mortality SLM.</td>
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