Community and Public Health Advisory Committees Meeting

Wednesday 06 June 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
06 June 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, 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

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
</tr>
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<tbody>
<tr>
<td>10.00 am</td>
<td>Confirmation of Minutes</td>
</tr>
<tr>
<td>11.00 am</td>
<td>Planning, Funding and Outcomes Update</td>
</tr>
<tr>
<td>12.00 noon</td>
<td>HPV Self-sampling for Cervical Screening – Research update</td>
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Auckland and Waitemata District Health Boards
Community and Public Health Committees
Member Attendance Schedule 2018

<table>
<thead>
<tr>
<th>NAME</th>
<th>April</th>
<th>June</th>
<th>August</th>
<th>November</th>
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<td>Max Abbott</td>
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<td>Lee Mathias</td>
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<td>Robyn Northey</td>
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<td>Allison Roe</td>
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✓ attended
* absent
* attended part of the meeting only
^ leave of absence
# absent on Board business
+ ex-officio member
# Register of Interests

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<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
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</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  
Step-daughter is a surgical registrar at Waitemata DHB | 18/04/18      |
<table>
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<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
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| 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 India Private Limited  
Director - Lee Mathias Limited  
Director - John Seabrook Holdings Limited  
Trustee - Lee Mathias Family Trust  
Trustee - Awamoana Family Trust  
Trustee - Mathias Martin Family Trust  
Member – New Zealand National Party | 21/02/18 |
| 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  
Sub-contractor - Te Ha Oranga/Te Runanga o Ngati Whataua  
Contractor – New Zealand Social Investment Unit  
Director – Healthcare Applications Ltd  
Husband - Part owner Turuki Pharmacy Ltd, Auckland  
Husband - Board member - Waitemata DHB  
Husband – Director Healthcare Applications Ltd | 27/04/18 |
| 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 04 April 2018

Recommendation:

That the draft minutes of the Community and Public Health Advisory Committee meeting held on 04 April 2018 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 04 April 2018

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 10.01am

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) (until 12 noon, item 4.1)
Zoe Brownlie (ADHB Board member)
Sandra Coney (WDHB Board member) (until 12 noon, item 4.1)
Warren Flaunty (Committee Deputy Chair - WDHB Board member)
Matire Harwood (WDHB Board member)
Lee Mathias (ADHB Board member)
Robyn Northey (ADHB Board member)

ALSO PRESENT:

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

PUBLIC AND MEDIA REPRESENTATIVES:

Bill Grieve (Chair, Hibiscus Hospice)
Nicolette Bodewes (Chair, North Shore Hospice)
Jan Nichols (Chief Executive, North Shore Hospice)

KARAKIA:

The Committee Chair invited Bruce Levi to open the meeting with a prayer.

WELCOME:

The Committee Chair welcomed those in attendance at the meeting.

APOLOGIES:

An apology was received and accepted from Allison Roe and for early departure from Edward Benson-Cooper.
DISCLOSURE OF INTERESTS

There were no declarations of interests relating to the agenda.

Sharon Shea advised that she is working with Te Ha Oranga, the provider arm of Te Runanga o Ngati Whatua who is delivering a new programme within the Auckland Women’s Prison in Wiri.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 06/12/17 (agenda pages 7 to 11)

Judith Bassett corrected Dame Sister Pauline Engel’s (not Francis) name in the minutes of 06 December 2017; Dame Sister Pauline Engel sadly passed away late 2017.

Resolution (Moved Judith Bassett/Seconded Warren Flaunty)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 06 December 2017 be approved.

Carried

The Committee Chair acknowledged Warren Flaunty and his recent retirement from the pharmacy profession.

Matters Arising (agenda pages 12)

Debbie Holdsworth summarised the matters arising reported.

In response to a question about the recent mumps outbreak Ruth Bijl said that there has been a slight decrease in the number of cases. With regard to immunisation, Waitemata DHB has undertaken a ‘catch-up’ programme in five low decile primary schools. Auckland DHB has also taken the opportunity to engage with the Pacific community through PHOs and tertiary institutes. In response to a question about the age of patients being diagnosed with mumps and whether there was an issue with the vaccine still being effective, Catherine Jackson noted that the primary reason for those diagnoses is that people have not been immunised. In 2001 when the vaccine age was adjusted from 11 years to 4 years of age, this resulted in a cohort that was not vaccinated. The majority of patients diagnosed were not fully immunised due to changes in the health system.

3. STANDARD REPORT

3.1 Planning, Funding and Outcomes Update (agenda pages 13 to 104)

One of the key highlights identified in the update report was the strengthened strategic partnership established between Hibiscus Hospice and the North Shore Hospice Trust. In attendance to present to the Committee were Bill Grieve (Chair, Hibiscus Hospice), Nicolette

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 06/06/18
Bodewes (Chair, North Shore Hospice) and Jan Nichols (Chief Executive, North Shore Hospice).

The Committee Chair invited the hospice representatives to open the discussion and highlight the work undertaken to form an alliance. The following was noted:

- Bill Grieve noted his background as a retired engineer, his role as Chair of Hibiscus Hospice for the past nine years and for a period as Chief Executive of the Hospice. He spoke about the focus of retaining costs and maximising revenue for the hospice as well as the support given and steps taken with Pat Alley as previous Chair of the northern region hospices. Following that, over a three year period a lack of clinical leadership was identified and at the hospice Board’s discretion, Simon Allan came on board and was instrumental in getting things back on track. Bill noted that in stepping into the role of Chief Executive the clear need for a change in style and culture was identified, as well as recognising the needs of a growing population. Radical change was needed and an alliance with North Shore Hospice was developed. A good relationship has been formed and a common Chief Executive, Jan Nichols, appointed.

- Jan Nichols spoke about the changes that have taken place to-date, noting the motivation from both Trusts to provide the best service. She said that funding is an issue from all sources, with equity issues in the district. Population growth is a significant issue, with a large number of people expected to die over the next 50 year period. In addition Jan noted that since being appointed as Chief Executive across the North Shore and Hibiscus Hospices, a HR hub has been developed. It is a small team that deserves much credit as no external consultants or resource was utilised in effecting the required changes and setting a single set of values, a single voice for the DHB, a single contract across both Hospices and an attractive employment plan. All clinical services were looked at with restrictions put in place, duplication in clinical management and administration has been streamlined; in particular a staff member, Ree, was noted for the exceptional role in working across services with a focus on supporting the clinical team. Areas of restructure have taken place with others in process or being finalised. Feedback on the proposed changes and those now in place was invited. It was also noted that as these are community hospices, there are also a lot of volunteers helping.

- Nicolette Bodewes noted her profession as a lawyer and that she had been on the Board of North Shore Hospice for five years. She advised that consideration is being given to forming a Foundation Trust, this depends on a legal technicality and ensuring that with regards to bequests, those willed to Hibiscus Hospice are used for that Hospice alone (this will also apply to fundraising). In addition it was noted that there is engagement with a PR company to present the Hospices’ story to the community.

- As at 1 July 2018, it is hoped both Hospices will be one entity, making required savings and providing a better service to patients and their families.

- In response to a question about lessons learnt, it was noted that: it can be done and where there is a will there is a way. There was a strong willingness of both boards to cooperate and work towards one goal, all Board members recognised one goal which was for the best service for patients. The transition has gone smoothly with there now being a combined Board. There is a motivated team to achieve the same goals.

- Bill Grieve also noted that often when a merger occurs there often is a dominate player, this has not occurred for the Hospices and both are seen as absolute equals. He acknowledged both Hospice Boards for their support in achieving this.

Warren Flaunty acknowledged the work undertaken and queried if there was any involvement from the West Auckland Hospice; in response Nicolette advised that there was
no involvement at this stage, but suggestions are welcome. She noted that there is room for growth and reiterated Bill’s comments that there is not a dominant party involved in the new alliance. Bill further noted that the key is common values and purpose.

The Committee Chair thanked Bill, Nicolette and Jan for attending and speaking at the meeting.

Debbie Holdsworth noted the key highlights in the Funding and Planning report. The following matters were discussed and response to questions included:

- Samantha Bennett noted the Asian, Migrant and Refugee Plan and that high level findings show that the Auckland DHB and Waitemata DHB are national leaders in Asian health. However, there were also disparities identified in high risk Asian groups, such as high numbers of Chinese smoking as well as obesity and diabetes for South Asian groups. The Plan is a high level summary and provides an understanding of cultural needs for the high risk groups.

- Lee Mathias noted a potential impact for the way in which data is collected, a third of our population is Asian and there is an opportunity to formally request changes via the DHB Boards in time for the next Census to allow better data outcomes. Samantha Bennett advised that Lifeng Zhou works closely with Statistics NZ and there is dialogue about the MELAA (Middle Eastern, Latin American and African populations) category and whether a broader category is needed. The Chair agreed and Samantha should report back to the Committee Lifeng’s progress with Statistics NZ.

- Tim Wood advised that the diabetes clinical indicators can now be reported at a more granular level. An understanding is being gained about what is being prescribed and what is being dispensed; however, whilst prescribing data shows an improvement in what is being prescribed, an equivalent improvement is not being show with respect to patients collecting their scripts from the pharmacy. Tim acknowledged the PHOs work in producing the data and starting to use it in a meaningful way to address disparity. In response to a question from Lee Mathias, Tim said that the data was stored by the DHBs and that there is a process across the three metro Auckland DHBs about having a repository in the Cloud on an ongoing basis.

- With regard to the diabetes clinical indicator data now available, the Committee Chair queried whether there is work on identifying any ethnic differences when collecting a prescription. Tim advised that the data collection is providing an opportunity to ask questions such as ethnicity differences; the Diabetes Service Level Alliance will start to look at the data and develop a work plan. The work plan will include areas like co-design with general practices, a programme of activity over the next two years and co-design of patients and general practice teams. A piece of work has been undertaken previously around high needs patients with general practices. He also noted two key areas of work that have a strong equity lens, being: a programme around improving podiatry care with GP practice teams and the way community podiatrists provide care; and there is work on improving the retinal screening programme. It is known that there is a high level of DNA rates and not enough screening capacity within the system.

The remainder of the report was taken as read. Additional matters raised and response to questions included:

- Warren Flaunty noted the update provided on aged residential care audits (page 31 of the agenda) and that it was not clear whether any spot audits had identified irregularities in the system; he also asked that a breakdown of corrective actions
between spot audits and normal certification be identified. Debbie Holdsworth advised that this will be responded to.

- Matire Harwood noted the ethnicity and inequity data reported in areas such as cervical smears and queried what is being done to change this. Debbie Holdsworth advised that this could be presented to the Committee as a deep dive and this would include cervical screening and breast screening. It was requested that the deep dive also include information on the cost for cervical screening (as it is not a free service) as well as the self-sampling programme and whether that will suit Maori women.

- In areas such as dental care and inequity, Ruth Bijl advised that oral health identified that clinic opening hours were not favourable and that Saturday clinics were introduced and are working well.

- Warren Flaunty noted the Zero Suicide Framework reported (page 35 of the agenda) and queried whether people who commit suicide are known to the DHBs services. Trish Palmer advised that they may have been known to the DHBs services, but might not be an active client. She also advised that a National Suicide Mortality Group had been established. It was also noted that a programme was in place across hospital presentations to address suicidal thoughts with targeted interventions; this is in the early stages with positive results being seen.

- In response to a question from Sandra Coney about programmes in schools to help prevent suicide, Trish Palmer advised that there is investment from the Ministry of Health and a call for resilience and mental health wellbeing programmes funded by the Ministry of Health from within school based programmes. Trish Palmer noted that Tamaki College are piloting a ‘peer up’ programme which is peer youth support; this is a 12 month programme that commenced in January 2018.

Dale Bramley noted that he and Ailsa Claire had recently met with the Alliance Chairs. He acknowledged the practice level data now being provided and the challenge in best utilising that data.

4. DEEP DIVE REPORT

4.1 Equity Focus in System Level Measures Planning Process (agenda pages 105 to 159)

The Chair opened this part of the meeting noting that the two DHB Boards had agreed to focus on Equity, and in particular, improving Equity for Maori, Pacific Peoples’ and other high need groups as an important strategic priority.

The purpose of this part of the CPHAC meeting is to give committee members an opportunity to guide DHB management about its expectations for equitable outcomes. Members are also encouraged to offer a future-focused view about ‘what works’, for management consideration.

Dr Catherine Jackson presented to the Committee on equity and system level measures.

Matters covered in discussion and response to questions included:

- Noting that there have been discussions around targeting specific populations to communicate health messages, including digitally targeting those groups.
- That there is room for improvement in learning from programmes that have been successfully communicated. The metro-Auckland DHBs could work together to understand what social marketing looks like and utilise that data.
• Noting that PHO data collected is reported back to general practices, but it is anonymised.
• In response to a comment and question from Matire Harwood about how workforce development and employment is a determinant of health outcomes and wellbeing, Ailsa Claire noted that it is recognised that the ADHB is the largest employer in the community. The ADHB is looking at how it can support and encourage its low paid workers in career pathways. She spoke about the ADHB programme ‘Thrive’ (which provides a framework of initiatives that may be replicated for employee groups); it was noted that ADHB has had 60 cleaning staff move to a level 3 grading and are now moving to healthcare assistant roles.
• In response to a question from Max Abbot about the graph presented for ‘acute bed days – equity,’ it was noted that the data is adjusted for age and not deprivation.

The Committee Chair acknowledged the presentation given and encouraged Committee members to provide feedback directly to Karen Bartholomew on the deep dive.

In response to a question about the reporting of system level measures, Karen Bartholomew noted that a quarterly report is submitted to both the Auckland DHB and the Waitemata DHB Boards. There is also reporting to each of the Boards Committees that focus on the each specific Committees purpose.

5. GENERAL BUSINESS

There were no items of general business.

The meeting concluded at 12.08pm

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS’ COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 04 April 2018

__________________________________ CHAIR
Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 30 May 2018

<table>
<thead>
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<th>Agenda Ref</th>
<th>Topic</th>
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<th>Expected Report Back</th>
<th>Comment</th>
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<tbody>
<tr>
<td>04/04/18</td>
<td>3.1</td>
<td>Data Collection – Statistics NZ</td>
<td>Samantha Bennett</td>
<td>Actioned. See response ‘action point 1’ below.</td>
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<td>04/04/18</td>
<td>3.1</td>
<td>Aged Residential Care Audits</td>
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<td>06/06/18</td>
<td>See agenda item 3.1, section 5.2.</td>
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<td>Cervical Screening</td>
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<td>06/06/18</td>
<td>To be part of the deep dive presented to the Committee 06/06/18.</td>
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Action Point 1

Data Collection – Statistics NZ

Statistics New Zealand hold the whole-of-government definition and classification of ethnicity. After every census Statistics NZ review the census questions and responses, and make adjustments to the classifications of ethnic groups. This is underway after the most recent census. The Middle Eastern Latin American and African (MELAA) level 1 category was introduced by Statistics NZ in 2006. Although the ethnic classifications in this group are diverse and small (<1% population approx. 34,000 people) the intention was for these groups to have increased visibility including of specific needs (language, social, health etc). We use this classification in health where it is relevant to do so.

An accurate record of the metro Auckland population ethnic-composition, and the health-service population, is important for planning and high quality delivery of services. With a growing super-diverse population, we have an interest in more granular classifications to address specific health issues and needs, for both Pacific sub-groups and for Asian, migrant and refugee sub-groups. Waitemata DHB and Auckland DHB have a strong focus on ethnicity data and have led the country on quality improvement projects to improve ethnicity data collected in hospital, primary care and community health services. We provided expertise to the Ministry of Health working group to redevelop the Ethnicity Data Protocols for the Health and Disability Sector (released October 2017, https://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols) which are now a HISO standard rather than a sector guideline. The new Protocols address electronic data collection and updating, as well as requiring collection of up to six ethnicities at the most granular level (Level 4). Application of these protocols in health will assist in more granular understanding of, and delivery of health services to, the diverse populations we serve.
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 Māori 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
AH+ - Alliance Health Plus
ARC - Aged Residential Care
ARPHS - Auckland Regional Public Health Service
ARLA - Alcohol Regulatory and Licencing Authority
CPHAC - Community and Public Health Advisory Committee
CVD - Cardiovascular Disease
DHB - District Health Board
HAT - Healthy Auckland Together
HCSS - Home and Community Support Services
HVAZ - Healthy Village Action Zones
ICD - International Classification of Diseases
IPS - Individual Placement and Support
MACGF - Metro Auckland Clinical Governance Forum
MoH - Ministry of Health
NGO - Non Governmental Organisation
NHI - National Health Index
NIR - National Immunisation Register
NZIS - New Zealand Institute of Sport
PHAP - Pacific Health Action Plan
PHO - Primary Health Organisation
PLAP - Provisional Local Alcohol Policy
WCTO - Well Child Tamariki Ora

1. Executive Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata District Health Boards’ (DHB) planning and funding activities and areas of priority, since its last meeting on 4 April 2018. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting’s agenda.
Highlights

- Both Auckland and Waitemata DHBs continue to exceed the Raising Healthy Kids target for all ethnicities with 100% and 99% respectively of children having their referrals acknowledged within 30 days.
- Over the past two years, the Workwise, Auckland DHB partnership has been the focus of Australasia’s first pilot of an implementation support and technical assistance project. This has led to a significant increase in the quality of Individual Placement and Support programmes. Waitemata DHB in partnership with the Ministry of Social Development have just started a pilot of Individual Placement and Support within Waitemata DHB provided Community Mental Health Teams.
- The Abdominal Aortic Aneurysm and Arterial Fibrillation screening extension programme for Māori is now complete. The data is currently being analysed and the evaluation is underway. The results will be reported to the Board once available.
- Auckland Regional Public Health Service (ARPHS) opposed a new application for an off-licence (bottle shop) in Takanini on the grounds of outlet density. After communicating its concerns to the District Licencing Committee, ARPHS was commended by the community, particularly the Māori Wardens, for being the first agency (to their knowledge) to give the Māori community a direct voice.

2. Planning

2.1 Annual Plans
We have received the Ministers Letter of Expectations and the Funding Envelope for 2018/19 on Friday 18 May 2018. However, the Ministry of Health (MoH) recently informed us that because the Crown Entities Act includes legislative timeframes for the preparation, and Ministerial review, of Statements of Intent and Statements of Performance Expectations we are required to provide a draft Statement of Performance Expectations (and new Statements of Intent if these are produced) to the Minister for his review no later than two months before the start of the financial year to which they apply. These are challenging to produce without corresponding planning advice, or finalisation of those measures and indicators which inform this part of the Annual Plan e.g. the System Level Measures Action Plan. Therefore, as advised by the MoH, the 2017/18 current measures were retained alongside updated baseline data. The document noted the need for updates once planning advice and other relevant information becomes available. This was provided to the Board for their review and approval on 26 April 2018 and submitted to the MoH on 30 April as required.

2.2 Annual Report
Initial drafting of reports commenced, timetables agreed with auditors. We are working on developing a library of suitable photographic material for this and future editions.

2.3 System Level Measure Improvement Plans
Consultation with key stakeholders has commenced to inform the development of the 2018/19 System Level Measure Improvement Plan: some primary care consultation, Māori and mana whenua consultation, we have started consumer consultation and have Pacific and other key stakeholder consultation planned. Consultation will broadly represent the general principles of the planning advice from last year as 2018/19 planning advice has not yet been received.

The next update of StatPlanet – the dynamic reporting – is due out in May. Updates and refinements to this tool are ongoing.
The Auckland and Waitemata (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 3 of the 2017/18 year.

### Auckland and Waitemata DHB Quarterly Performance Scorecard

#### 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>89%</td>
<td>96%</td>
<td>▼</td>
</tr>
<tr>
<td>Rheumatic Fever rate</td>
<td>3.8</td>
<td>1.1</td>
<td>▲</td>
</tr>
<tr>
<td>Oral Health - % utilisation by 2 years</td>
<td>63%</td>
<td>75%</td>
<td>▼</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>66%</td>
<td>60%</td>
<td>▼</td>
</tr>
<tr>
<td>Better help for smokers to quit - primary care</td>
<td>89%</td>
<td>96%</td>
<td>▼</td>
</tr>
<tr>
<td>Rheumatic Fever rate</td>
<td>1.4</td>
<td>0.7</td>
<td>▼</td>
</tr>
<tr>
<td>Oral Health - % utilisation by 2 years</td>
<td>65%</td>
<td>75%</td>
<td>▼</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>73%</td>
<td>80%</td>
<td>▼</td>
</tr>
</tbody>
</table>

#### 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>87%</td>
<td>96%</td>
<td>▼</td>
</tr>
<tr>
<td>Rheumatic Fever rate</td>
<td>10.0</td>
<td>0.7</td>
<td>▼</td>
</tr>
<tr>
<td>Oral Health - % utilisation by 2 years</td>
<td>65%</td>
<td>75%</td>
<td>▼</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>73%</td>
<td>80%</td>
<td>▼</td>
</tr>
</tbody>
</table>

#### Primary Care - Auckland DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO enrolment</td>
<td>83%</td>
<td>96%</td>
<td>▼</td>
</tr>
<tr>
<td>Diabetes management</td>
<td>56%</td>
<td>60%</td>
<td>▼</td>
</tr>
</tbody>
</table>

#### Primary Care - Waitemata DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO enrolment</td>
<td>52%</td>
<td>60%</td>
<td>▼</td>
</tr>
<tr>
<td>Diabetes management</td>
<td>60%</td>
<td>60%</td>
<td>▼</td>
</tr>
</tbody>
</table>

### Health of Older People - Auckland DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBSS clients with Clinical interRAI in last 2 yr</td>
<td>88%</td>
<td>85%</td>
<td>▼</td>
</tr>
<tr>
<td>HBSS clients with Clinical interRAI in last 2 yr</td>
<td>88%</td>
<td>85%</td>
<td>▼</td>
</tr>
</tbody>
</table>

#### Health of Older People - Waitemata DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBSS clients with Clinical interRAI in last 2 yr</td>
<td>83%</td>
<td>80%</td>
<td>▼</td>
</tr>
<tr>
<td>HBSS clients with Clinical interRAI in last 2 yr</td>
<td>88%</td>
<td>85%</td>
<td>▼</td>
</tr>
</tbody>
</table>

### How to read

- ** achieved/ unachieved from last target
- ** achieved/ not achieved from target
- ** achieved/ not achieved from last target

### Key notes

- ** achieved from last quarter
- ** achieved/ unachieved from target
- ** achieved/ not achieved from target
- ** achieved/ not achieved from last target
- ** achieved/ not achieved from last quarter
- ** achieved/ unachieved from target
- ** achieved/ not achieved from target
- ** achieved/ not achieved from last target
- ** achieved/ not achieved from last quarter

### A question?

- ** Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 06/06/18
3. **Primary Care**

3.1 **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. Both Auckland and Waitemata DHBs have failed to achieve the primary care ‘Better Help for Smokers to Quit’ health target in Q3, 2017/18. Preliminary data from the PHOs showed Auckland DHB performance at 89.4% and Waitemata DHB at 87.5%.

Overall, the results highlight an improvement in the performance of both Auckland and Waitemata DHBs with this health target.

At a PHO level, only Alliance Health Plus (AH+) 91.0%; National Hauora Coalition 90.0%; and Auckland PHO 89.5% successfully achieved the primary care ‘Better Help for Smokers to Quit’ health target. ProCare (Waitemata) experienced a decline in performance from 89.6% to 89.0%, while Comprehensive Care PHO’s performance improved from 82.7% to 85.7% in Q3, 2017-18.

<table>
<thead>
<tr>
<th>DHB</th>
<th>PHO</th>
<th>Target %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>Auckland PHO</td>
<td>89.5%</td>
</tr>
<tr>
<td></td>
<td>Alliance Health Plus</td>
<td>91.0%</td>
</tr>
<tr>
<td></td>
<td>National Hauora Coalition</td>
<td>90.0%</td>
</tr>
<tr>
<td></td>
<td>ProCare</td>
<td>89.1%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>Comprehensive Care</td>
<td>85.7%</td>
</tr>
<tr>
<td></td>
<td>ProCare</td>
<td>89.0%</td>
</tr>
</tbody>
</table>

All PHOs are prioritising activities and events as per their smokefree plans to proactively reach more smokers and achieve the target. The Primary Care team is monitoring PHOs performance closely and have requested the PHOs provide weekly reports on their smoking cessation activities. The weekly updates provide useful information on the progress being made and interventions and activities applied at a practice level by the PHOs.

The results are also shown in the Scorecard under Health Targets as well as in Figure 1 below:

- Auckland DHB – 89.4%, ↑2.5% from the previous quarter
- Waitemata DHB – 87.5%, ↑1.2% from the previous quarter

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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 06/06/18
3.2 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 diabetes and cardiovascular disease (CVD) clinical indicators are prioritised for performance monitoring. All metro Auckland PHOs (seven) are consistently reporting anonymised practice level data relating to these five clinical indicators and the performance is being reported to the Metro Auckland Clinical Governance Forum (MACGF) (Table 2).

Both Auckland and Waitemata DHBs have shown improvement in good or acceptable glycaemic control of the people with diabetes including Māori and Pacific people with diabetes (Table 2). Currently, the Primary Care team is working with the PHOs to further improve the quality of data and reporting.
Table 2: Auckland and Waitemata DHB performance against the MACGF Diabetes and CVD Clinical Indicators 31 March 2018

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Goal</th>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>Pacific</td>
<td>Total</td>
</tr>
<tr>
<td><strong>Clinical Indicators – Long Term Conditions Management - Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HbA1c Glycaemic control:</strong> 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>51.5% (↑1.4%)</td>
<td>50.3% (↑0.4%)</td>
<td><strong>61.4%</strong> (↑0.9%)</td>
</tr>
<tr>
<td><strong>Blood pressure control:</strong> 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>62.5% (↑2.6%)</td>
<td>64.6% (↑10.7%)</td>
<td><strong>67.8%</strong> (↑5.4%)</td>
</tr>
<tr>
<td><strong>Management of Microalbuminuria:</strong> 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>71.4% (↓0.5%)</td>
<td>71.3% (↑0.4%)</td>
<td><strong>71.5%</strong> (↑0.5%)</td>
</tr>
<tr>
<td><strong>CVD Secondary Prevention:</strong> Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)</td>
<td>70%</td>
<td>60.7% (↑1.1%)</td>
<td>62.9% (↑2.2%)</td>
<td><strong>58.6%</strong> (↑1.0%)</td>
</tr>
<tr>
<td><strong>CVD Primary Prevention:</strong> 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 on dual therapy (statin + BP Lowering agent)</td>
<td>70%</td>
<td>45.0% (↑0.7%)</td>
<td>54.7% (↑1.5%)</td>
<td><strong>48.2%</strong> (↓0.3%)</td>
</tr>
</tbody>
</table>

PHOs and metro Auckland DHBs established this standardised measurement system for the above five indicators in 2017 and have only been reporting on these indicators since June 2017. 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,

1 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.
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 is being undertaken as part of the Diabetes Service Level Alliance system redesign workplan.

There continues to be significant performance variations between ethnic groups (Figure 2). For example, there is a 8%-12% variation in the number of Māori and Pacific people with good or acceptable diabetes control when compared to the total diabetes population. These ethnic variations have remained consistent since April 2017. The Diabetes Service Level Alliance work programme is specifically designed to improve diabetes-related outcomes of Māori, Pacific and other high-risk populations.

**Figure 2: DHB performance, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (January 2017 – March 2018)**
Practice level data provided by the PHOs across both DHBs, highlighted there were nine out of 139 (6.5%) Auckland DHB practices and four out of 101 (3.9%) Waitemata DHB practices, that had achieved the glycaemic control target of 80% of their practice population with diabetes having an HbA1c <64mmol/mol in March 2018 (Figures 3 & 4). The practice level data also shows there is a large variation in performance against this target between practices.

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. The practices using the Profile for Mac Practice Management System are yet to upgrade their system to resolve the data extraction issues. It is envisaged that the upgrade of the Profile for Mac will happen in the near future.

3.3  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. 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 74.0% (↓0.7%) and 68.2% (↓0.5%) for Auckland and Waitemata DHBs respectively at the end of Q3 2017/2018 as compared to
Q2, 2017/18 results. Again, the Primary Care 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 point of care testing for HbA1c and lipid profile) 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 (Q3, 2017/18)

<table>
<thead>
<tr>
<th>% More Heart &amp; Diabetes Checks</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Source: MoH Quarterly Report)</td>
</tr>
</tbody>
</table>

Blood Pressure Control in patients with diabetes:
In quarter three, the percentage of enrolled patients with diabetes (aged 15-74 years) whose latest systolic blood pressure recorded was <140mmHg in the last 15 months remained unchanged for both DHBs except from minor fluctuations (Figure 6). Reporting of the systolic pressure of all ethnic groups in Auckland DHB has improved, demonstrating Alliance Health Plus’s submission of more complete data compared to the previous quarters. Both Auckland and Waitemata DHBs have at least 62% of people with diabetes with a systolic blood pressure under 140mmHg across all ethnicities.
Management of microalbuminuria in patients with diabetes
Between January 2017 and March 2018 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 except from the Pacific people with diabetes at Auckland DHB. The shift in the microalbuminuria of Pacific people is most likely to be caused by the data warehousing issues related to Alliance Health Plus, which resulted in loss of some data for Auckland. It is suspected that the presence of microalbuminuria may be under-reported. Once a more complete data set is available this will need further analyses.

Secondary CVD risk prevention
The secondary CVD risk prevention clinical indicator is defined as the percentage of enrolled patients with known CVD who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant) (Figure 8).
Improving secondary CVD risk management rates is a focus area for PHOs and Auckland and Waitemata DHBs 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 events. 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.

Secondary CVD risk prevention rates in the total population remained relatively stable for both Auckland and Waitemata during quarter three. 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 also significantly higher than those seen in the total population and have met the 70% management target (Figure 9).

Figure 8: Secondary CVD risk prevention in the total enrolled population, by ethnicity, January 2017 - March 2018

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4. CVD Secondary Prevention (Total CVD)</td>
<td>4. CVD Secondary Prevention (Total CVD)</td>
</tr>
<tr>
<td></td>
<td>[Graph Image]</td>
<td>[Graph Image]</td>
</tr>
</tbody>
</table>

Figure 9: Secondary CVD prevention in patients with diabetes by ethnicity – January 2017 - March 2018

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4. CVD Secondary Prevention (Diabetes)</td>
<td>4. CVD Secondary Prevention (Diabetes)</td>
</tr>
<tr>
<td></td>
<td>[Graph Image]</td>
<td>[Graph Image]</td>
</tr>
</tbody>
</table>
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 + BP lowering agent). This excludes those with a previous CVD event.

Over Quarter three, for both Auckland and Waitemata primary CVD risk prevention rates remained relatively unchanged during January 2018 to March 2018. Again Pacific people have the highest rates of primary CVD risk prevention management for the total and diabetes population.

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

Figure 10: Primary CVD risk prevention in total enrolled population, by ethnicity, January 2017 - March 2018

Figure 11: Primary CVD risk prevention in those with diabetes, by ethnicity– January 2017 - March 2018
4. **Children, Youth and Women**

4.1 **Immunisation**

4.1.1 **Immunisation Health Target**

The sustained focus on Māori pepe continues and additional efforts are being made to remove the equity gap. PHOs are making phone contact with whanau with the aim of providing more information and/or supports. The Outreach Service has increased ‘door knocking’ and an additional mobile service is being trialled. The mobile service has been provided at no cost by Plunket, and the DHB is staffing the mobile with an experienced nurse vaccinator. Considerable coordination effort is also being provided by the DHB with NIR and PHO engagement. We continue to track progress for Māori pepe baby by baby. Work continues to progress on the Co-Design project to develop better targeted resources to promote immunisation in our community. Work is also progressing supporting the establishment of an enhanced Well Child Tamariki Ora (WCTO) service at Te Whanau o Waipareira to provide immunisation to tamariki enrolled in their WCTO services who are overdue immunisations.

We acknowledge that PHOs have also provided considerable support to practices following power outages which caused some disruption to vaccine cold chain. It is also a very busy time for practices as funding of Zoster vaccine started 1 April for those 65-88 years of age and the annual influenza vaccine season is in full swing.

A range of awareness activities are underway as part of Immunisation Week (30 April - 4 May).

All these factors combine to create a significant increase in work for practices which can affect achievement of the health target. At this time (end April) we have vaccinated 1,679 Waitemata babies and 1,235 Auckland babies who are turning eight months in Q4.

**Quarter to date for all infants turning 8 months - ADHB (as at 28/04/18)**

<table>
<thead>
<tr>
<th>Turning 8 months in Q4</th>
<th>Last week – quarter to date</th>
<th>This week – quarter to date</th>
<th>Maximum achievable (Q4)</th>
<th>Decline and opt off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>87.8%</td>
<td>89.4%</td>
<td>95.2%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Māori</td>
<td>71.8%</td>
<td>74.5%</td>
<td>88.9%</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

**Quarter to date for all infants turning 8 months - WDHB (as at 28/04/18)**

<table>
<thead>
<tr>
<th>Turning 8 months in Q4</th>
<th>Last week – quarter to date</th>
<th>This week – quarter to date</th>
<th>Maximum achievable (Q4)</th>
<th>Decline and opt off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>84.9%</td>
<td>85.8%</td>
<td>93.4%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Māori</td>
<td>73.1%</td>
<td>73.3%</td>
<td>89.2%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

The relatively higher decline rate for Māori in both DHBs has been raised with PHO leadership at the Alliance Leadership meeting in early May. The Alliance Leadership Team were asked to consider the quality of conversations with whanau and whether there were additional training resources the DHB could help provide.

4.1.2 **Antenatal immunisations**

In addition to the health target, the Metro Auckland Alliance Leadership Team has committed to a focus on antenatal immunisation. This work is aligned to the System Level Measures Activity.
Reminder cards for antenatal Boostrix have been distributed to primary care, pharmacies and Lead Maternity Carers and a parallel antenatal Influenza reminder card is in development. The cards developed by the Funder have also been adopted by Counties Manukau Health. This regional approach works well for women and practices particularly as maternity care is not restricted by DHB boundaries.

PHO/practice level analysis of pregnancy immunisation coverage has been shared with PHOs. There are significant opportunities for improvement as demonstrated by the wide range of results across practices.

The opportunity to vaccinate women attending antenatal appointments has been identified. This has the potential to improve equity. Almost half of the Pacific and one third of Māori women who birth at Auckland DHB attend a DHB antenatal clinic. This group of women are least likely to be vaccinated in primary care. Funding to provide vaccinations alongside antenatal clinics has been approved by the Auckland DHB Chief Executive.

4.1.3 Mumps catch up programme
Since early 2017, metro Auckland has been experiencing an outbreak of Mumps. The school based MMR vaccine catch up programme in the Waitemata DHB area (five schools) has been completed and the programme in 10 Auckland DHB area high schools has just begun. This programme will run during school terms two and three. The programme has been well received by school communities.

The Auckland Regional Public Health Service (ARPHS) continues to lead the communications across the region, see section 10 for more information.

4.2 Obesity Health Target – ‘Raising Healthy Kids’
Both Auckland and Waitemata DHBs continue to exceed the Raising Healthy Kids target for all ethnicities with 100% and 99% respectively of children having their referrals acknowledged within 30 days. A procurement process has been undertaken for a Positive Parenting and Active Lifestyle service for pre-school children, pregnant women and their whānau. The preferred providers have been selected and contract negotiations are nearly complete. This will add a comprehensive referral option.

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 06/06/18
4.3 Oral Health – including Maternal Oral Health

The Ministry of Health annual reporting for 2017 has just been completed and is provided in the table below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Total</th>
<th>Māori</th>
<th>Pacific</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Caries free at five years of age - ADHB</td>
<td>65%</td>
<td>61%</td>
<td>50%</td>
<td>31%</td>
<td>70%</td>
</tr>
<tr>
<td>Children Caries free at five years of age - WDHB</td>
<td>68%</td>
<td>67%</td>
<td>55%</td>
<td>48%</td>
<td>71%</td>
</tr>
<tr>
<td>Preschool children enrolled in DHB funded Oral Health Services - ADHB</td>
<td>95%</td>
<td>91.5%</td>
<td>69.1%</td>
<td>91.8%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Preschool children enrolled in DHB funded Oral Health Services - WDHB</td>
<td>95%</td>
<td>95.4%</td>
<td>72.8%</td>
<td>87.3%</td>
<td>102.0%</td>
</tr>
</tbody>
</table>

As previously reported to CPHAC, the Metro Auckland Preschool Oral Health Strategy was developed in 2017 to support improving the oral health of Māori and Pacific pre-schoolers. There is a significant equity gap between Māori, Pacific and Other children. Eliminating this gap is the focus of the Preschool Oral Health Strategy. Some improvements in service delivery are evident as a result of this change in focus (such as provision of Saturday clinics and more frequent recall for Māori and Pacific children).

The preschool enrolment target was not met in Auckland DHB, however, there has been an increase for all ethnicities from last year. The target was met in Waitemata. Efforts are being made by the service to ensure that ethnicity is being recorded correctly in the Titanium system. The implementation of the Supportive Treatment Pathway and opening of Saturday clinics will support children to be seen more regularly and enable preventative treatments such as fissure sealants. Saturday clinics have been welcomed by families.

The Auckland Chief Executive has approved funding for a pilot based in Tamaki to improve oral health in pregnant women. Oral health deteriorates as a consequence of pregnancy, and poor oral health contributes to poor birth outcomes including low birth weight and prematurity. The new service will be located in Tamaki and be available to pregnant women who have a community service card and are in need of dental services.

4.4 Healthy Housing

The healthy housing service, Kainga Ora, has now been in place for over a year. Referrals are steady and the service has become well known amongst relevant referrers. To date there have been:

- Auckland DHB - 347 eligible referrals including 1,476 individual family members. Of these, 99 referrals were for pregnant women/new mothers (pregnant women are a particular focus as the programme aims to intervene early, before respiratory illnesses become a chronic condition)
- Auckland DHB - 520 interventions have been delivered including 36 families moving into new social housing.
- Waitemata DHB - 362 eligible referrals including 1,658 individual family members. Of these, 129 referrals were for pregnant women/new mothers
- Waitemata DHB - 602 interventions have been delivered including 41 families moving into new social housing.

The focus for Q4 is on ensuring Kainga Ora is receiving all eligible referrals. To support this, discharge lists for each of the MoH eligibility groups will be analysed. The intent is to obtain all Auckland DHB and Waitemata DHB discharges with the relevant discharge International Classification of Diseases (ICD) codes and geocoding for 0-5 year olds, maternity admissions, neonate discharges and high risk
maternity clinic lists. This work is being undertaken in partnership with public health physicians and paediatricians.

Kainga Ora continues to work on improving feedback loops and communication with referrers. Ministry for Social Development and Kainga Ora have worked together to develop a robust reporting process that meets both organisations needs and ensures that no whanau fall through the gaps. Housing New Zealand and Kainga Ora are in the process of improving reporting mechanisms so they are fit for purpose while ensuring whanau needs are addressed.

The MoH have conducted a national evaluation of the healthy homes initiative services which indicates positive outcomes for whanau. The final report is not yet available. Further evaluation is required to support the development of a service improvement framework locally and nationally. Kainga Ora have developed a service evaluation framework with the support of Dr Tom Robinson. A survey with whanau who have had all identified interventions closed will form part of the evaluation.

### 4.5 Rheumatic Fever

Contracts for Rheumatic Fever Prevention are in place with all PHOs except National Hauora Coalition. There are Rheumatic Fever champions in adult and paediatric services in both DHBs. Reduced primary school based services (sore throat management in line with clinical guidelines following presentation with a sore throat) continue to be provided by Starship Community (Auckland DHB) and Child & Family West (Waitemata DHB) as part of business as usual activity. Services are also provided in the secondary schools where the DHBs fund a school based primary care health service.

The Clinical & Operational Group, chaired by Auckland DHB paediatrician and attended by PHO representatives, has been reinstated. The Group has completed its first meeting for 2018 and will continue to meet on a monthly basis going forward.

The Pacific Communications plan continues to be implemented. In the last quarter the radio programme was initiated and the social media messages have continued to be released.

Data provided by the Ministry of Health on new cases of Rheumatic Fever is provided in the table below showing both actual number of cases and rates for the three metro Auckland DHBs.

<table>
<thead>
<tr>
<th></th>
<th>Rate/100,000</th>
<th>2016</th>
<th>2016/2017</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitemata</td>
<td>3.1</td>
<td>3.0</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>Auckland</td>
<td>5.4</td>
<td>4.7</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>7.9</td>
<td>9.3</td>
<td>10.2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Number of new cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitemata</td>
<td>18</td>
</tr>
<tr>
<td>Auckland</td>
<td>26</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>42</td>
</tr>
</tbody>
</table>

As previously described, and because of small numbers, interpretation of data is challenging. However, it is possible that the data suggests that in spite of concerted school based swabbing programmes in Counties Manukau, significant progress has not yet been made. Therefore, the focus of effort is appropriately on the determinants of RhF, namely cold, damp, crowded housing and poverty. It is not yet possible to describe the suite of activities in Waitemata or Auckland DHBs as contributing to a significant reduction in disease.
4.6 Cervical Screening

Cervical screening is the subject of a deep dive at this meeting.

5. Health of Older People

5.1 Age Residential Care (ARC)

15 ARC facilities in Auckland and Waitemata DHBs were affected by the recent power outages; the longest outage lasted 10 days for one Waitemata facility. A number of issues were identified as a result of this event and debriefing sessions are being set up for all ARC providers to share lessons learnt and identify improvements that can be made to their emergency planning. Currently all facilities are audited on their emergency planning during certification and surveillance audits.

Work is continuing on the mechanism for incorporating pay equity funding into the 2018/19 ARC bed day rates and minimising the ‘overs’ and ‘unders’ that occurred this year leading to some providers being in pay equity deficit. However, there has been discussion around the need for continuing transitional support funding and how this could be managed within the allocated pay equity funding as there are still likely to be some cases of material pay equity deficit in 2018/19.

5.2 Aged Residential Care Audits

The two types of audits for ARC are certification audits and surveillance audits; the latter are unannounced. From time to time questions arise about whether surveillance audits lead to more corrective actions due to their unplanned nature for facilities. This is a difficult comparison to make as surveillance audits cover a reduced number of standards and criteria compared to certification audits, and have a service delivery and quality risk management focus. However, reviewing specific standards covered by both types of audits does not show a pattern that one type of audit is receiving more corrective actions than the other.

<table>
<thead>
<tr>
<th>2017/18</th>
<th>Quarter 1</th>
<th></th>
<th>Quarter 2</th>
<th></th>
<th>Quarter 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ADHB</td>
<td>WDHB</td>
<td>ADHB</td>
<td>WDHB</td>
<td>ADHB</td>
<td>WDHB</td>
</tr>
<tr>
<td>Total Number of audits</td>
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<td>6</td>
<td>14</td>
<td>9</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Unannounced audits (surveillance)</td>
<td>1</td>
<td>2</td>
<td>14</td>
<td>9</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Average number of corrective action per audit</td>
<td>1.66</td>
<td>4.7</td>
<td>2.85</td>
<td>4.1</td>
<td>2.25</td>
<td>5</td>
</tr>
<tr>
<td>facilities &gt; 5 corrective actions</td>
<td>1</td>
<td>2</td>
<td>2*</td>
<td>4</td>
<td>0</td>
<td>3</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(30%)</td>
<td>5 (33%)</td>
<td>18 (50%)</td>
</tr>
<tr>
<td>Facilities with no corrective actions</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Facilities achieving a continuous improvement*</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Number of complaints the DHB</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

* The gold standard attainment against an audit criterion is ‘continuous improvement’ (CI). CI is achieved when a criterion is fully attained and continuous improvements against the Health and Disability Sector Standards are demonstrated indicating quality improvement processes in place against service provision and consumer safety or satisfaction.
5.3 Home and Community Support Services (HCSS)
Planning and Funding supported the Ministry of Health with hosting a Future Models of Care workshop for the Northern Region in April and is also actively involved in the Future Models of Care Management Group and the Working Group developing an outcome measures framework for HCSS.

At a local level the Waitemata HCSS Working Group has been reviewing client categories and functions of the system for a new HCSS model of care; the Group is cognisant of the national work underway.

Auckland DHB continues refinement of its existing restorative HCSS model. A cultural responsiveness workshop was held with Auckland DHB HCSS providers that focused on the Meihana Model. A project group has been formed to further develop outcomes from this workshop.

National consultation on the Medication Guidelines for HCSS, prepared by Waitemata DHB and its HCSS providers, closed at the beginning of May; 91 responses were received, which are now being analysed by HealthCERT.

The complexities of incorporating pay equity funding and guaranteed hours funding into DHB contracts are yet to be fully understood. A national Working Group has been set up and it is intended this funding will be incorporated into DHB contracts by 1 July 2019.

5.4 Other Health of Older People Activity
Low referrals to the falls prevention programme have been an ongoing issue despite a wide range of strategies to increase referrals. This is particularly concerning when the number of older people who have falls with injury is high. E-referrals have now been set up to enable GPs to more easily refer patients to either the In Home Strength and Balance Programme or the community group exercise sessions approved by ACC. The in-home programme is for people who are too frail to access the community easily while the group exercise sessions are for those people who are able to get out and about in their neighbourhoods.

6. Mental Health and Addictions

6.1 Government Inquiry into Mental Health and Addiction 2018
The inquiry was established by the Government in response to widespread concern about Mental Health and Addiction services in the sector and broader community, with the purpose of identifying unmet needs and developing recommendations for a cohesive approach for the next five to 10 years. The focus is to improve promotion of good mental health and support for people.

The Chair of the Inquiry wrote to all district health boards requesting information about:
- relevant current services
- relevant future services
- views about what is working well, gaps and unmet needs, priority groups and where the focus should be in the future.

Both Auckland and Waitemata DHBs consulted with a range of stakeholders, using information provided by the Inquiry Panel to structure online and face-to-face discussions, using the following headings:
- Description of current situation
- What is working well in mental health and addiction (and suicide prevention)
Both DHBs have provided the Inquiry with a stocktake document (with Auckland DHB completing their submission and submitting with Stocktake and Waitemata DHB planning a submission prior to 30 June 2018). Auckland DHB has members of the Inquiry on site over parts of Monday 7 May and Tuesday 8 May 2018 with Waitemata DHB being visited on Wednesday 9 May 2018.

Engagement mechanisms across both DHBs included workshops and discussions with the following groups and individuals:

- Mental Health Addiction DHB Senior Management Staff
- Service clinical directors and Managers
- Clinical team leaders, charge nurses, lead clinicians
- Pacific and Māori team input
- Tūhono (forum of Mental Health and Addictions DHB and NGOs services and consumer representatives)
- Consumer leadership
- Mental health and addiction service users (via workshop participation and online survey)
- Family/whānau advisors
- Nursing workforce (frontline clinicians)
- Allied health workforce (frontline staff)
- Medical workforce (frontline psychiatrists)
- Representatives from the Ministry of Social Development, Housing, Probation, Police, Corrections, Education, and Youth Justice, together with tāngata whaiora and their whānau (to discuss addiction services)
- Workshop run around particular topics and engagement across the sector for:
  - Addiction
  - Suicide Prevention and Postvention
  - Funding and Planning approaches
  - Pacific People
  - Still to be completed is a workshop for both DHBs for Asian, Migrant and Refugee communities.

The reflections and advice from people with lived experience of mental health and addiction problems is critical to this Inquiry. An online survey of service users and family/whānau was funded by Auckland DHB and undertaken by mental health NGO Changing Minds as part of the Auckland DHB and Waitemata DHB consultation processes’. These are not new themes to people familiar with the Mental Health and Addiction sector. They have been extracted from the online survey with a demographically diverse sample of Metro Auckland people responding to the survey.

The high-level themes of this feedback are:

- The importance of being treated as a whole person and that the concept of “self” includes autonomy, culture, identity, the right to make decisions, and that distress is inherently personal
- The importance of having relationships with people who understand that our whānau encompasses our whānau, our peers, our communities, and our connections and friendships with other human beings
- The importance of the therapeutic relationship provided by the mental health services workforce focused on supporting people to get well

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 06/06/18
• The environment is the world we each live in including the social determinants and inequalities that influence our mental health and that our environment is part of the solution to our wellbeing
• The mental health system needs to be integrated, easy to navigate and access, offer choice and different approaches to meet diverse needs and complexities including access to affordable private care.

What could be done better: themes from sector consultation:
• A nationwide prevalence study of mental illness was last completed in 2006 (Te Rau Hinengaro). The data from this study is now out of date and needs to be refreshed to inform funding and service design.
• The mental health sector requires a national strategy in order to set the direction of travel which will be used to inform service design.
• Specialist mental health services are required to design services using a more flexible approach which includes delivering regular clinical care outside of business hours and in ‘non-traditional’ health settings. This will support individuals to maintain employment and vocational pursuits while on their recovery journey.
• Investment in ‘step up’ and ‘step down’ services such as acute alternatives, acute respite, recovery respite and crisis cafes is required across the mental health continuum in order to provide a range of options for clients requiring support during acute episodes of illness.
• Strengthening the peer workforce and developing a family/whānau workforce is required to support clients through education and signposting.
• Investment in cultural competency training across the specialist mental health workforce is required to meet the needs of our increasingly ethnically diverse population.
• To support system level integration there is a need at the national level to move beyond policy (indicating collaboration is a good thing to do) and into strategy with appropriate governance and accountability, resourcing for implementation and monitoring and evaluation of existing and evolving models.

6.2 Auckland DHB Mental Health and Addiction Programme Board Work Plan
The Mental Health and Addiction Programme Board was established in 2017 as a key leadership and advisory group reporting to the Auckland DHB Board (via the Executive Sponsor Group). Its purpose is to take overall responsibility for the effective running of the Mental Health and Addictions programme.

Throughout the delivery stage of the programme, the Board will:
• Receive feedback from the Programme’s assurance systems and Executive Sponsor Group
• Resolve change controls arising from significant variations
• Provide visible leadership, direction and commitment, effectively championing the programme and communicating goals and progress
• Own risk and issues at the highest level
• At the end of each phase, provide a recommendation to the Executive Sponsor Governance Group in respect to ongoing arrangements.

The following Programme Board initiatives are in development, based on established and promising evidence of effectiveness:

6.2.1 Supporting effective and safe prescribing in mental health services
There is considerable evidence for the effectiveness of antipsychotic drugs in the treatment of psychosis, but no evidence to suggest that doses of antipsychotics higher than the recommended
dosages are more effective than standard doses in any clinical situation or patient group (Royal College of Psychiatrists, 2014):

- Those people who are prescribed more than one antipsychotic concurrently are more likely to receive a high total antipsychotic dose and are at an increased risk of side-effects and tend to spend longer in hospital.
- In addition, people are not offered choice on reducing and/or stopping medical interventions or provided with alternatives to medication interventions. People are not offered a service to support them to reduce or stop medication safely.

This project will:

- Audit current prescribing practices
- Establish recommended doses
- Offer taper-off option to people currently on medication in specialist services
- Provide screening and monitoring of side effects and put in place interventions to address risks.

The project aims to reduce inadvertent high-dose prescribing, provide people with better choices, improve the quality of clinical practice standards for prescribing, provide education and information about medication for all parties, monitor side-effects of medication and implement strategies to address risk factors.

### 6.2.2 Supporting effective and healing practices - Alternatives to medication in mental health services

This project aims to identify and deliver evidence-based interventions that demonstrate effectiveness in improving mental health, including evidence that such interventions will provide good value for health system resources. Interventions could include: nutrition, sleep, exercise, talking therapies, employment, family/whānau therapy and provision of self-management information. The project will provide good examples of interventions for which empirical evidence is strongest. Service and intervention mapping of current services will be undertaken, using co-production with a multidisciplinary approach and leadership.

### 6.2.3 Housing Project

It is estimated that 7% of people accessing Auckland DHB NGO mental health and addiction services have ‘homeless accommodation status’. The Housing Project aims to increase and improve the range of accommodation options for people with enduring and serious mental illness and/or addiction – working with other services and Government agencies. The project will address the barriers and gaps of meeting the housing needs for people being discharged from inpatient services and followed-up by community-based specialist mental health services at Auckland DHB.

Outcomes to be measured include:

- Increased knowledge of the current accommodation and housing provision for clients accessing specialist mental health services
- Improved availability of stable, safe, quality and affordable housing that supports wellbeing and recovery
- The upgraded Housing New Zealand accommodation in Greys Avenue is fit for purpose to support the complex needs of clients with severe and enduring mental health needs
- Enhanced pathways to discharge service users in a timely way to the most appropriate housing.

### 6.2.4 Individual Placement and Support (IPS) Employment model

Workwise and Auckland DHB have been working in partnership for 10 years to deliver employment support services to people in contact with mental health and addiction services. Over this time, the
Evidence for the effectiveness of evidence-based practices in employment support for people who experience serious mental health conditions (also known as IPS) has strengthened considerably. From the outset, Workwise aligned its practices to this evidence base.

Over the past two years, the Workwise – Auckland DHB partnership has been the focus of Australasia’s first pilot of an implementation support and technical assistance project. This has involved a dedicated expert, an IPS Implementation Manager, providing on-site technical assistance to the clinical and employment teams to increase their alignment to evidence-based practices.

The main outcomes2 from the first two years of the programme in Auckland have been:

- A significant increase in referrals made to and people accepted onto the IPS programmes
- Approximately 40% of people referred and accepted had a diagnosis of psychosis
- A significant increase in the quality of the IPS programmes
- Health professionals more willing to consider employment for a greater number of people on their caseloads
- 560 people participated in the IPS programme
- 213 people secured competitive employment
- There was a decrease in the time it took from referral to securing jobs
- 75% of people secured jobs more than 16 hours per week and the average wage was $18.04/per hour.

Financial modelling for the cohort referred from July 2015 to June 2016, with 71 people obtaining jobs, calculates the savings to MSD in welfare benefits in the first year as $439,366. Total returns to the government from welfare savings and taxes paid would be $590,440. The findings and experiences from this pilot have generated high levels of interest in other parts of the country for increasing access to high quality IPS programmes.

Waitemata DHB in partnership with MSD have just started a pilot of IPS within Waitemata DHB provided Community Mental Health Teams. Working with MSD in the Oranga Mahi programme will robustly test the fidelity of the IPS model in a defined cohort of clients with serious mental illness.

### 6.2.5 Zero Suicide through Leadership, Support and Continuous Improvement

Based on United States, United Kingdom and Queensland models, this new initiative aims to reduce and prevent suicide and self-harm rates in Auckland DHB localities. It will involve co-design between stakeholders to develop a regional strategy, and utilise quality improvement methods (Plan, Do Study, Act) to build on current and emerging interventions. Zero suicide initiatives in the United Kingdom included mental health promotion, suicide risk counselling for relatives of people admitted to psychiatric care, and improved scrutiny of medication for recently discharged psychiatric patients. The quality improvement model demonstrated how the combination of localised changes at person and organisation level could have an effective role in suicide prevention (Shankar et al., 2017). Auckland DHB has identified funding for a three-year project which will include co-design, audit of organisational culture, analysis, and PDSA: Plan Do Study Act – to test out system change being implemented.

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Planned outcomes include:

- Reduce suicide and self-harm rates
- People who present with suicidal thoughts and self-harm attempts and their whānau are supported and able to access services and interventions that improve wellbeing
- A safety culture (Just Culture) that no longer finds suicide acceptable, and supports clinical personnel.

Waitemata DHB is at early stages of identifying their approach to Zero Suicide Framework and the resources required to take actions.

6.2.6 Equally Well initiatives - Improving the physical health of people who have severe and enduring mental illness

This collaborative project aims to improve the physical health of people with mental health conditions, and involves the following groups:

- People who present with psychosis for the first time
- People who are newly prescribed antipsychotic medication
- Mental Health and Addiction staff (training in having a conversation about alternatives to medication and side effects)
- Specialist Mental Health services
- General Practice
- NGO providers.

The 2017 Health Needs Assessment by the Health Gain Team on the Physical Health Status of people with chronic serious mental illness in Auckland and Waitemata DHBs is tied into our Equally Well work. A key finding from the first phase of analysis is that most (92-94%) of ProCare and Auckland PHO patients with serious mental illness are enrolled with primary care, and ProCare patients regularly attend primary care.

Future areas of focus include:

1) how we can improve the long-term physical health of patients presenting with psychosis for the first time
2) developing a wrap-around service approach for patients new to anti-psychotic medication and addressing prescribing, adverse side effects risks (as part the ‘supporting effective and safe prescribing in Mental Health Services’ programme).

6.2.7 Awhi Ora – Supporting Wellbeing

As part of the Tamaki Wellbeing programme, between October 2015 and June 2016, Auckland DHB worked with three NGOs and two local GP surgeries to develop a service that offers community-based wellbeing support, which at its heart is person-centred, relational, and collaborative. This service is called Awhi Ora - Supporting Wellbeing, and was co-designed in partnership with members of the Tāmaki community, people who used the service, and people who provided the service. A set of tools was developed to help grow and develop the service further. These include principles for practice, the key relationships needed to make the service work, and some experience journeys – maps of how people experienced the support process and what they achieved.

The Awhi Ora – Supporting Wellbeing service has expanded across Waitemata DHB as part of a suite of services introduced into the community as part of implementing the Our Health in Mind five year Strategy. The Awhi Ora – Supporting Wellbeing service is currently being evaluated as part of the Fit for the Future Ministry of Health funding. Early results demonstrate the value of offering social interventions as part of the menu of support options for people. While the full evaluation report
won’t be available until September 2018, the clinical indicators show the intervention is as effective as clinical interventions with a 10- to 15-point drop between entry and exit on the Kessler 10 (level of distress) score.

6.2.8 Paired Up Youth Peer Support Service Pilot and Evaluation
Auckland DHB has contracted Connect Supporting Recovery in partnership with other NGOs and services to pilot and evaluate ‘Paired Up – Youth Peer Support Services’, a 12-month pilot to run within the Tamaki College population group for the 2018 calendar year. Paired Up will support Tamaki College, Auckland DHB and the wider Tamaki community in achieving their suicide prevention and youth resiliency goals, by creating a network of connected young people sharing guidance about positive wellbeing while taking purposeful action through groups, events and activities.

6.2.9 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 and in the right place. A comprehensive 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. The key deliverable will be a finalised continuum of care for Auckland and Waitemata DHBs, with recommendations for investment and/or disinvestment.

6.3 Fit for the Future Waitemata DHB
The Waitemata DHB Fit for the Future evaluation is currently in the data collection phase, with progress on track to meet timelines for the subsequent evaluation deliverables. The evaluation is focussed on the implementation of the Our Health in Mind strategy, as follows:

- Enhanced specialist support is delivered in four practices by two Waitemata DHB psychiatrists; the key intended outcome of this intervention is to develop capability and empower practices to confidently manage patients in primary care
- Direct telephone access to specialist support from a psychiatrist is available to general practice teams across Waitemata DHB. This service provides valuable and timely information exchange. Additional 2017/18 funding for primary mental health initiatives was used by ProCare to develop enhanced practice teams at two practices, by Comprehensive Care to pilot e-Therapy for patients not accessing face-to-face therapy sessions, and by Hearts and Minds to provide additional Primary Mental Health Initiatives groups
- Awhi Ora Supporting Wellbeing, designed to provide patients with wellbeing or social support via a lead NGO, is at the set-up and initial implementation stage at Waitemata DHB and has been implemented at Auckland DHB for over 15 months
- The Framework for enhanced integrated practice teams presents key principles and insights to promote enhanced integrated practice teams in Primary Care was a co-designed approach across both DHBs to support new approaches in primary care services.

6.4 Fit for the Future Auckland DHB
The Auckland DHB evaluation is currently in the data collection phase, with progress on track to meet timelines for the subsequent evaluation deliverables. The programme of work is focussed on the up-scaling and development of existing community based initiatives that meet the needs of people with moderate mental health issues. This consists of:

- 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)
• evaluating these services and supports 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 contracted Synergia to complete the evaluation between September 2017 and September 2018.

Current status:

• The framework is being prototyped in four practices across three PHOs
• The evaluation is on track with provisional results available for Awhi Ora and data collection currently taking place for the rest of the framework
• The full evaluation report is to become available at the end of September 2018.

6.5 Pay Equity Settlement for Mental Health and Addictions Care and Support Workers

The Terra Nova Care and Support Workers (Pay Equity) Settlement (April 2017) addressed historical pay equity issues for care and support workers in the aged and disability residential care and home and community support services sector. It explicitly excluded care and support workers in the mental and addiction sector. This decision was challenged by the unions, and consequently in August 2017, the MoH, unions, NGO Peak Body representatives, and the DHBs (led by Ron Durham/CE) began meeting to determine if there was validity to the challenge.

In December 2017 the MoH concluded there was merit to the claim, and recommended to Ministers that formal negotiations should commence. In February 2018, Minister Clarke announced government support for negotiations to begin for the inclusion of mental health and care support workers in the Settlement. The terms of the settlement and implementation processes are under negotiation, subject to Cabinet approval. The MoH aims to take a paper seeking approval to the Cabinet meeting on the 18 June 2018.

It is anticipated that the settlement will be implemented by 1 August 2018 at the earliest, and back dated to 1 July 2017. It is also expected that DHBs will contribute a portion of the pay increase, through application of CCP, and that DHBs and providers will resolve this through contract negotiation.

Mental Health Funders have been providing information to the MoH to help inform this process, since August 2017, including:

• Support staff qualification levels, by provider, by Purchase Unit Code
• Clarification of contracts for inclusion or exclusion
• Clarification of Purchase Unit Codes for inclusion or exclusion
• 17/18 price uplift applied, by provider, by relevant Purchase Unit Code

The MoH have developed a data collection tool, which has been sent to all providers to complete and upload by 4 May 2018. This data is required to calculate the total cost of a settlement, which is required for Government approval and will also provide an indication of the funding providers will receive to pay any eligible workers the new wage rates. The data includes employment details for the eligible workforce covering the period 1 July 2017 to 31 March 2018.

Of note, the mental health funder holds a number of named National Health Index individual contracts in ARC services. These clients do not meet the ARC funding criteria, but have been assessed as having needs best met in these services. The bed day payments have historically been aligned to ARC payments. However, in July 2017, the MoH instructed that the pay equity bed day increase for ARC ($9.41 per bed day) could not be applied to these mental health funded beds. It is expected that
now that the Settlement applies to mental health, these additional rates can be applied, and backdated.

7. **Māori Health Gain**

7.1 **Māori Health Services Design**
As part of the ongoing development of outcomes contracting the Māori Health gain team are working on a project to determine the future design and focus of Māori health services across Auckland and Waitemata DHBs. As part of this project a literature review has been completed looking at indigenous models of health, current strategic directions and characteristics of effective health systems for indigenous peoples. Further to this a range of Māori health experts will be engaged as well as a series of meeting with local Māori health providers. These engagements along evidence and literature will help inform future Māori health service design and priorities. It is expected that a report on the project will be presented to the respective Boards in the first quarter of 2018/19.

7.2 **Workforce Development**
The Māori health gains team have established a PHO working group to develop and implement a workforce ethnicity reporting tool and process to report primary care workforce date by ethnicity. The project will assist the establishment of a baseline which will then inform strategies to increase the number of Māori in the health workforce. This project is aligned to the Māori workforce Alliance Leadership Team work programme priorities, is supported by the Auckland and Waitemata Alliance Leadership Team and is part of the current Auckland and Waitemata DHBs Māori health plan 2017/18.

7.3 **Abdominal Aortic Aneurysm (AAA) update**
The AAA and Arterial Fibrillation screening extension programme for Māori is now complete. The data is currently being analysed and the evaluation is underway, including a range of quantitative measures and health professional and whānau interviews. The results will be reported to the Board. The outcome of a Health Research Council application for a larger study across Auckland and Waikato are currently awaited. The Māori coordinator for AAA has been secured to support the roll-out of the larger HPV self-sampling project aimed at improving equity in cervical screening.

7.4 **Regional Māori Health Plan**
Initial approaches have been made to engage the planning teams across Auckland, Waitemata and Counties Manukau DHBs to develop a 2018/19 regional Māori health plan. The intent is to use the parameters already established in the 2017/18 Māori health planning processes as the foundation for agreeing priorities and actions. Additional consideration will need to be given about the alignment with the Service Level Measures and Annual Planning processes and priorities.

7.5 **Whānau House – Henderson**
Two business cases have now been completed to support the actions against recommendations as a result of the Whānau House Health Needs Assessment (HNA). The priority areas are child health, youth health, mental health and primary care services. The first business case is focused on an enhanced immunisation service for children and their families who are experiencing challenges in achieving timely immunisation, especially to support the target of 95% of children being fully immunised at eight months. Focus is on focused outreach support for clients access services through whānau house as well as improving the link for those who need access to whānau ora services. The second business case is the Taitamariki youth mental health proposal which is seeking to identify and support at risk youth and prevent and reduce alcohol and drug abuse, this service will particularly
focus on life and resilience skills. An additional focus for us is the evaluation of the Waitemata DHB Diabetes Service – Te Hononga Oranga, which is currently underway. The intent is to deliver an evaluation report followed by a business case by the end of June 2018.

8. Pacific Health Gain

8.1 PHAP Priority 1 – Children are safe and well and families are free of violence

Alliance Health Plus (AH+) PHO has been chosen as the provider of Positive Parenting and Active Lifestyle programme in the Auckland DHB area, for children identified as overweight or obese in the Before School Programme. We continue to work with the Child Health Team and AH+ to implement the programme.

Te Whanau o Waipareira Trust is the provider for Waitemata. We are also involved in meetings with Waipareira and will support them in their work with Pacific families if required.

In terms of parenting education, we continue to seek resources for its implementation and had recently met with Vakatautua and the Ministry of Social Development. Vakatautua is a Pacific provider who had developed a parenting programme specific for Pacific parents and had delivered a number of programmes as a pilot funded by the Ministry of Health. The programme was evaluated but resources have not been available for further implementation. We had explored the programme implemented by the Parenting Place, but parents pay to participate in the programme and it is delivered in a particular site at particular times and this presents a number of barriers to access by Pacific parents.

The final report from the evaluators of the Healthy Babies Healthy Futures programme has been received. The Report is based on service delivery from 1 October 2016 – 31 March 2018. The service objectives of the service are to:

- Improve women’s health during antenatal and postnatal periods through the promotion of healthy eating and keeping physically active
- Promote healthy feeding of babies, including encouraging and supporting exclusive breastfeeding to at least six months or more
- Promote health feeding (including the introduction of healthy foods) and physical activity of children of children at pre-school age
- Support mothers to be confident with cooking skills to enable healthy eating choices

In relation to the text match component of the programme, 1,492 mothers or significant relatives enrolled for receiving the text messages out of a target 1,500.

769 women completed the six module face-to-face workshops out of a target of 360.

In terms of changes to lifestyle, of 540 women who responded to a post participation survey, 92% made at least two positive changes to eating behaviour and 51% are physically active more often.

8.2 PHAP Priority 2 – Pacific People are smoke-free

The primary care team is funding training for smoke-free champions from the Enua Ola and Healthy Village Action Zones (HVAZ) churches and other groups, to be able to engage people who smoke in a supportive and motivational discussion about stopping smoking. They will also be trained to refer willing smokers to West Fono and Procare for quit smoke support.
8.3 Priority 3 – Pacific people are active and eat healthy
The NZ Institute of Sport (NZIS) offered to provide NZQA Level 4 training for members of HVAZ and Enua Ola who wish to qualify as personal trainers. 17 people have taken up the training, 10 from HVAZ and seven from Enua Ola. Tuition fees for this course are usually $5,500 per student, but NZIS is offering it free of charge.

NZIS requested that Waitemata/Auckland DHBs work in partnership with them to provide:

- Support through
  - Additional mentoring/tutoring as required for the students
  - Wellness sessions
- Health education for all NZIS students specifically sexual health education
- Health screening
- Help promote NZIS courses in the Pacific community
- Advice from Pacific communities as to how NZIS could better support Pacific students

The Pacific Team has agreed to the above requests. The two personnel at the Pacific Science Academy and members of the Pacific Planning and Funding Team will provide mentoring/tutoring as well as facilitate access to sexual health educators from the DHBs, parish community nurses will provide health screening, HVAZ and Enua Ola co-ordinators will promote NZIS courses in the community as well as facilitate access to advice from the community as to the support Pacific students need.

The North Shore Enua Ola churches/groups have completed their 2017/18 Aiga Challenge weight loss competition. 159 people participated and completed the eight week programme. A total of 160 kgs was lost. 10 people had maintained their weight loss in the past three years.

8.4 PHAP Priority 4–People seek medical and other help early
We are working with West Fono to create a Fanau Ola Integrated Service contract, similar to the integrated service contract that we currently have with AH+ PHO. The new contract will consist of the re-configuration of three different contracts for an asthma nurse, diabetes nurse and social workers, into one. The new contract will create a team of social workers and nurses who will assess the health and social service needs of a family, work with the family to create a plan to respond to their needs and work together with the families to implement the plan from delivering the service themselves or referring to outside agencies.

8.5 PHAP Priority 5 - Pacific people use hospital services when needed
Our focus continues to be on child health and the gains to be made especially in oral health. Programmes and initiatives have already been signed off for implementation such as the varnish programmes targeting Kohanga Reo and Language nests centres.

Rheumatic fever is a disease that almost exclusively affects North Island Māori and Pacific children aged 4-19 years. A Rheumatic Fever workshop was held in Mangere on May 10. The workshop included presentations on the latest New Zealand-based research on rheumatic fever risk factors as well as community insights on what worked in the delivery of the rheumatic fever prevention programme, what didn’t and what opportunities there are to do things differently. There was reflection on the information presented and discussion of ways forward.
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**

We are rolling out of actions from the Asian, migrant and refugee health plan 2017-2019.

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% target (Waitemata) and 71% target (Auckland) by 30 June, 2018 (current rate 88% (Waitemata) and 70% (Auckland) as at Q4 2017/18)
- 80% of eligible Asian women will have completed a cervical sample by 2020 (current rate 69.5% (Waitemata) and 54.3% (Auckland) as at Dec 2017)

The Waitemata DHB Asian PHO enrolment rate has increased by 2% to reach 88% with 2,385 new enrollees, and in Auckland DHB by 1% with 1,530 new enrollees between Quarter 3 and Quarter 4.

We are:

- Presenting information about the NZ health & disability system and health services at the ANZ Migrant Expo (16 June) with over 10,000 new migrants expected to attend; and ongoing to institutes, settlement services and communities
- Promoting influenza immunisation messaging in translated languages (Chinese and Korean) to ethnic communities; Asian, migrant, student, refugee and asylum seeker partners; and institutes via their online, social media and hardcopy information platforms
- Presented health literacy information about improving access to - and patient experience of - breast and cervical screening to Asian general practitioners at the Auckland Chinese Medical Association Conference (5 May)
- Populated the Auckland Regional HealthPathway for Asian, migrant and refugee targeted support services for the two following pathways - Mental Health Community Support, and; Migrant and Refugee Services
- Contributed to the Mental Health Inquiry for Asian and former refugee mental health; and Review of Asian Stop Smoking Service in Waitemata DHB paper
- Conducting an Oral Health and Healthy Eating study to investigate Chinese, Filipino, Middle Eastern and Indian parents’ and caregivers’ knowledge, attitudes and behaviours towards their child’s healthy eating and oral health to inform decision making of culturally appropriate provision of oral health services and development of tailored oral health and healthy eating information.

**Indicator: Increase opportunities for participation of eligible refugees enrolled in participating general practices as part of the Refugee Primary Care Wrap Around Service funding**

Activities include:

- Reviewing the Service Specifications of the Refugee Primary Care Wrap Around Service Agreements
- Delivered frontline cross cultural professional development training to primary care staff (11 May)
- Promoting NZ health & disability system and information about the Refugee Primary Care Wrap Around Service to asylum seeker and mainstream support agencies at the National Asylum Seeker Forum (6 June).
10. Auckland Regional Public Health Service (ARPHS)

10.1 Disease Management

**Mumps outbreak**
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 7 May 2018, 1,258 confirmed and probable cases have been notified to ARPHS, there are currently 7 cases under investigation.

A mentioned in ARPHS’s previous update, volumes continue to decrease as demonstrated in the following graph (blue bars are new notifications).

ARPHS continues to undertake our ‘manage it’ approach, which means:

- promoting vaccination
- assisting GPs in managing cases
- providing disease surveillance.

**Pertussis outbreak**
Since 1 September 2017 Auckland has been in the midst of a pertussis outbreak with 576 confirmed and probable cases (to 20 April 2018). The MoH declared a national outbreak on 1 December 2017.

There has been a 30% decrease in numbers of confirmed/probable cases notified in the last four weeks as compared to the previous four week period. ARPHS is working with seven schools and six Early Childhood Education Centres’ to manage cases and contacts in these key settings.

**Measles Contact Tracing**
ARPHS received four notifications for measles in the first four months of 2018, one of whom was a secondary case, with three other cases who were contagious on their plane flights into New Zealand, requiring large contact tracing as part of our public health response. More than 500 contacts from the plane flights, medical centres, public places where the cases visited, and households required follow up. Another 67 contacts were notified to other public health units to be followed up in other parts of the country. Episodes such as these require substantial resources from ARPHS to enable timely public health responses.
Media messages were released to the public and health professionals to support this work.

**Dengue Fever**
From 1 August 2017 to 27 April 2018, 206 confirmed and probable dengue cases have been notified to ARPHS. The majority of cases (91%) reported recent travel to the Pacific Islands, particularly Samoa (124), Tonga (40), Fiji (21) and French Polynesia (2). 146 cases (71%) have been hospitalised, mostly for severe dengue (fever or bleeding disorders), and the ethnic groups commonly affected identified as Samoan (n=121) and Tongan (n=36).

The number of dengue notifications to ARPHS continues to decline, from a peak of 84 in January 2018, to seven in April 2018.

**10.2 Environmental Hazards**

**10.2.1 SIMS Pacific Fire**
On 7 March 2018 ARPHS responded to a hazardous substances fire at SIMS Pacific Metals, 263 James Fletcher Drive, Otahuhu. ARPHS conducted a risk assessment and actively engaged with Fire and Emergency New Zealand, Auckland Council and Worksafe for risk communication. The range of materials involved in this fire was unknown. However, it was likely that scrap metal, car parts, petrol, oil and other possible pollutants were involved. ARPHS advised the public in surrounding areas to take precautionary measures to prevent breathing in smoke. On the day of the fire, fact sheets were distributed to more than 350 downwind households, nine childcare centres and ten schools. Following the incident, ARPHS followed up with Auckland Council and Fire and Emergency New Zealand to provide feedback and comment for preventing similar incidents in the future.

**10.2.2 Border Health**
During December 2017 ARPHS responded to three *Aedes aegypti* mosquito interceptions at Auckland International Airport Limited (this mosquito can transmit illnesses such as Dengue and Zika, and border control is required to keep it from becoming established in New Zealand). Enhanced surveillance was subsequently carried out over December 2017 and January 2018, with results showing no further exotic mosquito activity. In March 2018 a six monthly mega biosecurity surveillance audit was completed at Auckland International Airport Limited, with some recommendations made towards improving mosquito control.

**10.3 Wai Auckland**
The three Auckland DHBs have committed funding of $150,000 per annum over three years to a tap water project, titled “Wai Auckland”. The DHBs have requested ARPHS redevelop the Wai Auckland business case to reflect this level of funding. Other progress to date:

- Auckland Transport has agreed to fund infrastructure (increased access to public drinking water fountains), and has appointed internal staff to work on the project
- Auckland Council has started improving water infrastructure, and has noted the inclusion of a “statement of service” to guide quality water fountains in its Long Term Plan (the ten year budget)
- Watercare has committed to collaborate with Wai Auckland to make water more accessible and available in public areas
- HAT partner organisations have committed to supporting the programme and are meeting this month to have input into an implementation plan
- The Auckland Dental Association has expressed interest in joining the project.
10.4 Notice of 1080 drop in the Hunua Ranges

ARPHS has been informed an aerial 1080 operation will be undertaken by Auckland Council in the Hunua Ranges this winter. ARPHS met with Council about this year’s operation, which follows the first aerial 1080 operation in the Hunua Ranges in winter 2015. The 2015 operation was the first aerial 1080 operation in Auckland in a decade, Council correctly anticipated that pest numbers (rats, possums, stoats) would need to be addressed on a 3-5 yearly basis with repeating operations.

Council has indicated to ARPHS it will submit its Vertebrate Toxic Agent application by the end of May 2018. It takes ARPHS approximately two to four weeks to conduct risk assessment, communicate conditions with Council, and issue the final permit. The drop is planned for August, weather permitting. Track clearances, water sampling and auditing will take place in the following weeks by Auckland Council, Watercare and ARPHS.

10.5 Alcohol

10.5.1 Provisional Local Alcohol Policy appeals

Following the Alcohol Regulatory and Licencing Authority’s (ARLA) decision (in July 2017) on the original appeals made against Auckland’s Provisional Local Alcohol Policy (PLAP), further appeals have ensued. There are now two concurrent legal processes for ARPHS to monitor and respond to in order to support measures that will reduce alcohol related harm in our communities.

The elements that ARLA found to be unreasonable were sent back to Council for reconsideration, and Council subsequently resubmitted an amended PLAP. Progressives, Food Stuffs and Redwood Corporation lodged appeals to Council’s resubmitted PLAP. ARPHS (through the Medical Officer of Health) is an interested party to the appeals process. A timetable for the hearing has yet to be scheduled.

The above parties also lodged judicial reviews with the High Court in response to ARLA’s original decision in July 2017. ARPHS is exercising its right to be heard in relation to the judicial reviews, with a date tentatively set for 29 April 2019.

ARPHS will be required to review submissions from the various parties, prepare evidence and/or legal submissions and attend hearings in order to continue to support Auckland Council to arrive at a reasonable and effective Local Alcohol Policy that contributes to reduced alcohol related harm within the Auckland region.

10.5.2 Withdrawal of alcohol off-licence application

ARPHS opposed a new application for an off-licence (bottle shop) in Takanini on the grounds of outlet density. Approval of the application would have meant there were four off-licences within a 1km radius. Takanini has high socioeconomic deprivation and Māori population and already experiences high levels of alcohol-related harm compared to other areas. The new store would have exacerbated this further.

After communicating its concerns to the District Licencing Committee, ARPHS was commended by the community, particularly the Māori Wardens, for being the first agency (to their knowledge) to give the Māori community a direct voice.

The media story about this application can be found at https://i.stuff.co.nz/auckland/local-news/papakura-courier/102630353/communitys-fierce-resistance-forces-liquor-shop-applicant-to-withdraw.
ARPHS’s opposition to this application was in line with its newly developed regulatory protocol, which provides an evidence based framework of public health concern priorities.

### 10.5.3 Collaborative relationship with Māori Wardens

ARPHS has developed an excellent partnership with the Māori Wardens who are consulted on new applications for on-licences and off-licences in areas of high socioeconomic deprivation.

The Māori Wardens have described the partnership with ARPHS as historic, and are championing our relationship as an example to be followed by others.

ARPHS has also delivered community capacity building training with the Māori Wardens. This training supports them to make and keep evidence that can be relied on in court when objecting to an application. The Wardens are able to enter licensed premises under the Māori Community Development Act 1962.

We have also extended this work to the smokefree space. The Ministry of Health has commended ARPHS, and note that this model is the first of its kind in New Zealand.

### 10.6 Healthy Auckland Together (HAT)

HAT has been undertaking the following:

- Made a complaint to the Advertising Standards Authority (ASA) against a McDonald’s television advertisement that presented an occasional food (fries) in a way that is appealing to children and young people.
- The 2018 monitoring report is being prepared for publication. HAT partners met to discuss the results and have input into the final report. An infographic of the key findings will be developed.
- HAT partners (Auckland Council, Healthy Families MMP, Healthy Families Waitakere, ARPHS) have been working together to build a business case to fund and support healthier food and drink environments at local board funded events (including Movies/Music in Parks, community events, and signature events e.g. Waitangi and Christmas). The partners have been gathering needs, insights and data from event producers, vendors, and public attendees during the 2017-2018 events season. The partners are currently analysing the data and will model their business case after the ‘Zero Waste Events’ initiative, which has seen good success in reducing waste at events.

### 10.7 Illegal tobacco trading in Mangere

A recent undercover operation by ARPHS in Mangere revealed three out of the ten outlets investigated were selling cigarettes illegally to teenagers. The Mangere Otahuhu area has the lowest life expectancy and one of the highest rates of smoking of any local board.

ARPHS regularly carries out stings using teenage volunteers who visit retailers to ensure that tobacco sales comply with the legislation. By law, retailers should be requesting ID for individuals who look under 25 buying tobacco.

Retailers face hefty punishments for selling tobacco to minors including criminal convictions and fines of up to $10,000 if prosecuted. A conviction means restrictions on employment, business and international travel.

A media release appealed to community groups and/or individuals to take action in the fight against childhood tobacco addiction, advising how to make an anonymous complaint.
### 10.8 Submissions

ARPHS completed and submitted four formal submissions between end of March and beginning of May 2018.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 March</td>
<td>Auckland Council’s proposed Regional Pest Management Plan</td>
<td>ARPHS requested that it immediately be notified of any emerging issue involving an organism that might present a human health risk.</td>
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<tr>
<td>9 April</td>
<td>Auckland Council’s draft Auckland Waste Management and Minimisation Plan 2018</td>
<td>The District Health Board sustainability advisors and Medical Officer of Health at ARPHS broadly supported the draft plan, including the Council’s ‘zero waste by 2040’ vision. The submission noted the health sector is a substantial generator of waste material which has differing levels of hazard and complexity. ARPHS and the DHB sustainability advisors expressed a strong interest in working with Auckland Council on approaches to health service waste minimisation and management.</td>
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</tbody>
</table>
| 24 April | Sale and Supply of Alcohol (Renewal of Licences) Amendment Bill (No 2) – NZ Parliament | ARPHS supports the intent of the proposed Bill to provide the licensing authority with the discretion to refuse a renewal of a licence if inconsistent with a LAPs location and density policies. However, ARPHS recommended accompanying changes to the current LAP process to support the Bill’s intent, including:  
  - Development of policy guidance to support local authorities to decide how a reduction in existing off-licence premises in a locale would be managed  
  - Review of the appeal process  
  - The ability for local authorities to bring into force elements of a LAP not subject to appeal. |
| 2 May    | Government Policy Statement on Land Transport 2018/19 – 2027/28       | ARPHS supports the GPS on Land Transport and recommended that:  
  - Giving safety the number one priority for all road users is an important strategy for reducing death and serious injury  
  - Health-related equity is prioritised in both this and the part two GPS on Land Transport (the Ministry of Transport noted that a second stage GPS is likely to be required in order to fully realise Government’s direction for transport investment). |
4.1 HPV Self-Sampling for Cervical Screening – Research Update

Recommendation:

That the Community and Public Health Advisory Committee:

1. Note that the HPV self-sampling research programme has been established to address inequity in cervical cancer outcomes and access.

2. Note that Feasibility Study (Study 1) includes an approach to optimise the novel technology for Māori women first, and includes a series of focus groups and an evaluation of cultural appropriateness and women’s experience.

3. Note that Study 1 is now complete, and that the results have informed the larger Randomised Controlled Trial (Study 2) which has begun recruitment in May 2018.

Prepared by: Dr Karen Bartholomew (Acting Director Health Outcomes), Aroha Haggie (Manager, Māori Health Gain), Anna Maxwell (HPV Self Sampling Research Coordinator), and Jane Grant (Research Nurse)

Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

HPV - Human Papillomavirus
NCSP - National Cervical Screening Programme
RCT - Randomised Controlled Trial

1. Executive Summary

There are inequities in cervical screening coverage for Māori, Pacific and Asian women. The large coverage gap, particularly for Māori women, is persistent and longstanding. A simple, safe, and convenient self-test may improve access for women who are currently not participating in cervical screening. An upcoming change in the cervical screening programme to human papillomavirus (HPV) primary testing provides a window of opportunity to understand how HPV self-sampling technology could be introduced in the New Zealand context, and specifically how it might address inequities.

In order to understand how to best optimise the technology and robustly test potential approaches, Waitemata DHB and Auckland DHB are undertaking a research programme, which contains a series of interconnected implementation research projects. The findings will have immediate policy relevance to the Ministry of Health on how self-sampling may best be incorporated into the National Cervical Screening Programme (NCSP).

This report outlines findings of the HPV Self-Sampling Feasibility Study (Study 1) and its associated focus groups and evaluation of cultural appropriateness and women’s experience. This paper also provides an update on the translation of learnings into the context of the larger study Randomised Controlled Trial (RCT; Study 2) which is funded by the Health Research Council (HRC) and conducted with partners at Massey University.
2. **Strategic Alignment**

| Community, whānau and patient centred model of care | This is a community based research project for women, specifically aimed at groups least well served by the current cervical screening programme. Women’s current screening experience and their experience of the self-test screening process are central to the project. |
| Emphasis and investment on both treatment and keeping people healthy | Self-testing aims to make screening easy, emphasising the importance of cervical screening as a preventative health check. The test identifies women with high risk types of HPV, the main risk factor for developing cervical cancer. |
| Service integration and/or consolidation | The project involves a close collaboration between primary care, Waitemata DHB and Auckland DHB colposcopy services, cervical screening independent providers and laboratory services; under the leadership of the Planning and Funding Health Gain and Māori Health Gain Teams. |
| Intelligence and insight | Innovative ways to address access barriers are required to ensure that all women benefit from cervical screening. |
| Evidence informed decision making and practice | The project is based on an extensive body of international evidence and laboratory validation of self-sampling for HPV. The studies will provide evidence to inform optimisation of self-sampling to the New Zealand environment. |
| Outward focus and flexible, service orientation | The project has been designed to contribute to national decision-making on screening programme policy. |
| Operational and financial sustainability | A more simple, inexpensive, and convenient technology than clinician testing, self-testing has the potential to be a financially and operationally sustainable adjunct to the screening programme. |

3. **Background**

Cervical cancer is almost completely preventable through HPV vaccination and screening. Despite initiatives to reduce barriers to screening, such as targeted free smears, communication campaigns, offer of alternative providers, outreach (Independent Service Provider) and tailored practice-level data-matching, there has been little improvement in cervical screening coverage for Māori, Pacific and Asian women. Māori women are still twice as likely to be diagnosed, and three times as likely to die from cervical cancer than European/Other women, and the recent Invasive Cervical Cancer Audit publication\(^1\) confirms that most women who develop cervical cancer are either unscreened or under screened.

In our regions there remain persistent inequities in cervical screening coverage, particularly for Māori women. This is the key driver of the DHB research programme to robustly test innovative methods.

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3-yearly cervical screening ethnic-specific coverage rates to March 2018

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Waitemata DHB coverage (Target 80%)</th>
<th>Auckland DHB coverage (Target 80%)</th>
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<tbody>
<tr>
<td>Māori</td>
<td>59.7%</td>
<td>54.5%</td>
</tr>
<tr>
<td>Pacific</td>
<td>69.7%</td>
<td>68.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>69.2%</td>
<td>53.4%</td>
</tr>
<tr>
<td>NZ European/Other</td>
<td>77.1%</td>
<td>76.0%</td>
</tr>
</tbody>
</table>

Source: National Cervical Screening Programme, DHB Quarterly Report.

The NCSP announced it will be transitioning from cytology (looking for cervical cell changes) to testing for oncogenic HPV testing, the main risk factor for cervical cancer (primary HPV screening). A paper outlining this change and the background evidence was provided to CPHAC in November 2016. The change to primary HPV screening allows the potential for self-collected samples via a low vaginal swab (cervical sampling is not required), a strategy that is increasingly being incorporated into cervical screening programmes internationally. Australia introduced primary HPV screening in late 2017, including self-sampling as an adjunctive approach.

Oncogenic HPV detection using vaginal self-sampling is comparable to detection by clinician-cervical sampling, provided that high performing laboratory assays are used to test the samples for the presence of HPV. Modelling for the Australian programme change demonstrates that even a one-off HPV self-test provides a 41% lifetime risk reduction for cervical cancer death, and if she returns to regular screening a 95% lifetime risk reduction, compared to remaining unscreened. International experts on HPV self-testing advocate a robust understanding of local context when considering HPV self-testing in an organised screening programme. The DHB research programme covered in this paper is designed to provide high quality evidence on implementation in our local context, as an innovative tool for reducing inequities.

Questions to address regarding how self-sampling would work in New Zealand environment include:

- Whether it is acceptable for women who are currently never screened or under screened (measured by uptake and acceptability questionnaire)
- What things might help optimise uptake, including how the test is presented, how women are invited and obtain the kit (focus groups and preference information in acceptability questionnaire)
- How women would be supported for any follow up testing or treatment required (because this is where the health benefit is), and what resources are required to ensure high follow up (>90% women)
- How it might work in practice in primary care, in the context of the current programme
- The level of knowledge and educational needs for women and for providers.

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An overview of Waitemata and Auckland DHBs’ HPV self-sampling research programme to address these questions is given below.

HPV Self-Testing – Overview of DHB Research Programme

4. **Research approach and activities**

The research programme was initiated with Māori women intentionally, both as a Treaty of Waitangi responsibility and to ensure that the new technology is optimised for the group of women least well served in the current programme. Study 1, *Feasibility Study: HPV Cervical Screening Self-sampling for Māori women in West Auckland*, was informed by kaupapa Māori experts on the research team, screening and clinical experts and local primary care experience as well as international evidence and advisors. Study 1 and the associated focus groups and evaluation received ethical and research office approval, approval from the National Screening Unit Research and Evaluation Committee and the NCSP National Kaitiaki Group for the use of Māori women’s data. The studies also received approval from the Metro Auckland Clinical Governance Forum (primary care clinical leadership) and individual PHO and practices. The projects have been a close collaboration with primary care (three PHOs and five practices), drawing on the expertise of clinical champions in women’s health, the laboratory, health literacy experts, cultural advisors as well as similar studies overseas. The evaluation was conducted by Te Whanau o Waipareira’s research and evaluation arm (WaiResearch), and was conducted from a kaupapa Māori perspective.
Eligible women were never-screened and under-screened (≥5 years since screening) aged 30-69 years, resident of Waitemata or Auckland DHBs. Women were identified through the PHO datamatch lists (primary care and NCSP-Register data). The study protocol details the inclusion and exclusion criteria, however all women excluded from the study but requiring follow up were referred appropriately (colposcopy, primary care and/or independent service provider).

Study 1 activities:
- Seven focus groups, initially with under-screened Māori women, later also with Asian and Pacific women, centred on women’s experience of screening, examining the barriers and enablers to screening, including HPV self-sampling. Study information was refined using an iterative process of testing, improvement and retesting materials to optimise the experience for these target population groups. Cultural advisors ensured the tikanga of the focus group approach and facilitated conversations with women in a safe environment. Self-testing was available at the focus groups sessions if women wished to participate.
- Eligible Māori women from five practices in West Auckland were invited via a range of means to attend a clinic individually to discuss the study, consent and take a self-test. Women were also asked to complete two questionnaires – a knowledge questionnaire and an acceptability questionnaire which included preference information. This project tested uptake and the feasibility of invitation methods and working with clinics.
- A provider education package was developed and delivered to participating practices and PHOs. Knowledge questionnaires and brief evaluations were carried out with providers at these sessions, to inform future education requirements.
- An evaluation by WaiResearch (27 interviews with women and study staff) assessed how well the study aligned with kaupapa Māori best practice and best outcomes, cultural appropriateness and women’s experience.

5. Findings

5.1 Focus group findings: materials optimisation
- Women were very clear what visuals they responded to and information they wanted to know in order to make a fully informed decision to the offer of a HPV self-test and their involvement in the study
• There were clear differences between the different ethnic groups, for example on the appropriateness of anatomical pictures on instructions, the inclusion of pictures of ‘real women’ or not and the information layout and colour scheme.
  
  ...the name of the study needs to clear and state what it means, and we need to see real women (Asian woman)
  
  ...when I saw that brochure I knew there was something special about the approach to wahine (Māori woman)

• Materials for Māori women were refined, re-tested and used in Study 1; and for Pacific and Asian women refined for Study 2.

5.2 Women’s experience of current screening
Focus group discussions and responses to questionnaires identified a range of personal, practical and health system barriers to participating in current screening programme. Many of the women reported that they had made a conscious decision in the past not participate in cervical screening due to embarrassment, negative experience, lack of information and inconvenience. Cost remained a factor, but was not the primary reason reported by focus group participants.

<table>
<thead>
<tr>
<th>Reason for not recently or never having had a smear (ranked)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Embarrassment</td>
</tr>
<tr>
<td>2. Prior negative experience</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3. Lack of information or knowledge</td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td>4. Inconvenience</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>5. Cost</td>
</tr>
</tbody>
</table>
5.3 Self sampling uptake and experience
A total of 84 women completed HPV self-testing in Study 1 and the focus groups. Universally they reported it a positive experience, all found it easy, more convenient, less embarrassing and less uncomfortable than speculum/smear. Responses from Māori women below:

That was so easy! I would come back every six months to do this test
Why aren’t all women offered to do this? It was so quick and easy!
OMG that was so much better

<table>
<thead>
<tr>
<th>Focus Groups</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended</td>
<td>20</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Completed self-test</td>
<td>18</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Percent</td>
<td>90%</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinic Invitation – Māori women</th>
<th>Number of women</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible women identified</td>
<td>366</td>
<td></td>
</tr>
<tr>
<td>Able to be contacted (5 attempts)</td>
<td>114</td>
<td>31% of eligible women</td>
</tr>
<tr>
<td>Declined</td>
<td>25</td>
<td>22% of women contacted</td>
</tr>
<tr>
<td>DNA clinic appointments</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Completed the self-test</td>
<td>46</td>
<td>41% of women contacted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12% of eligible women</td>
</tr>
</tbody>
</table>

Learnings from Study 1:
• There was a low rate of contactability despite five contact attempts at different times of day and using different methods (phone, letter, text) in in different order, and using different staff to contact women (both Māori and non-Māori research nurses, kaiawhina, PHO employed Māori nurse).
• Although 78% of women contacted agreed to participate when contacted, there was a relatively high DNA rate – only 41% of those contacted and agreeing actually did complete the test. Opportunity costs and barriers to attendance remain, even though the response to the novel technology was positive.
• The overall prevalence of HPV was 4.7% (consistent with oversea literature 2-8%).
• The level of knowledge about HPV among participants was low, and there were gaps in knowledge among health professionals (these will be reported elsewhere).

5.4 Evaluation themes
In the evaluation, all 27 women interviewed reported the study invitation process as culturally appropriate. Interviewees talked of the invasiveness of traditional testing methods and previous poor experiences (their own and whānau) with services creating a sense of vulnerability and disempowerment.
The focus group discussion, and the study consenting process, discusses HPV vaccination as well as HPV testing for cervical screening. A co-benefit of the study is that a number of women became activated as champions and advocates for HPV self-sampling and HPV vaccination in their communities. Supported by culturally appropriate research methods, participating women felt empowered to promote their learning and experience in their communities.

For Māori women, the following themes emerged from the evaluation (WaiResearch) and the focus groups:

5.5 Translation of learnings to inform the larger study
The combined experiences in the Study 1 projects have been valuable in informing the upcoming large Randomised Controlled Trial (RCT) which is inviting 7,000 Māori, Pacific and Asian women across Auckland and Wellington.

Enhancements to Study 2 include:
- changes to the clinic arm methodology to promote better access for women
- the addition of an opportunistic sub-study to robustly test this invitation approach
- refinement of the acceptability questionnaire
- optimisation of materials for sub-groups of Asian and Pacific women.

Additionally key clinical/lab parameters have been confirmed.

6. Conclusion
Indications from the Study 1 focus groups, feasibility study and evaluation are that HPV self-testing is highly acceptable. Co-designing with women and key partners, and taking a health literacy and kaupapa Māori approach, were valuable strategies. Making screening easy with optimised materials and respectful processes has significant potential for reducing barriers to participation in cervical screening. The technology also offers opportunities for improving access for other groups of women,
for example disabled women, older women and obese women.

Like elsewhere internationally, the small studies presented here indicate that the increase in uptake from self-testing is likely to be modest (in the order of 15-20%) but important. Practical learnings from women and other partners in Study 1 have been directly incorporated to optimise the next phase of research and the impact on participation reported. Study 2 will robustly test the actual uptake in a larger sample, and will also test whether there is a difference in the method of invitation (mail-out, clinic based or opportunistic offer). In the future there is likely to also be opportunities to test alternative invitation approaches (e.g. community health workers, other settings), and we are working with other researchers in the field. The research programme will provide policy relevant information to the NCSP on self-testing as an adjunctive strategy to improve equity when the programme transitions to primary HPV testing.