Community and Public Health Advisory Committees Meeting

Wednesday 20 February 2019

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
20 February 2019

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

Apologies:

AGENDA

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

Items to be considered in public meeting

1. AGENDA ORDER AND TIMING

2. CONFIRMATION OF MINUTES

10.00am 2.1 Confirmation of Minutes of the meeting held on 21/11/2018
Actions Arising from previous meetings

3. DECISION PAPER

4. INFORMATION PAPER

10.05am 4.1 Metro-Auckland Healthy Weight Action Plan for Children: Second Report

10.35am 4.2 Community Based Diabetes Care Programme Update

11.05am 4.3 Maori Health Update

5. STANDARD REPORTS

11.35am 5.1 Planning, Funding and Outcomes Update
- Executive Summary
- Planning
- Primary Care
- Child, Youth and Women
- Health of Older People
- Mental Health and Addictions
- Maori Health Gain
- Pacific Health Gain
- Asian, Migrant and Refugee Health Gain

6. GENERAL BUSINESS
### Auckland and Waitemata District Health Boards
#### Community and Public Health Committees
#### Member Attendance Schedule 2019

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<th>NAME</th>
<th>February</th>
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- ✓ attended
- ✗ absent
- * attended part of the meeting only
- ^ leave of absence
- # absent on Board business
- + ex-officio member
# Community and Public Health Advisory Committee (CPHAC)

## REGISTER OF INTERESTS

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<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
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<tr>
<td>Max Abbott</td>
<td>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</td>
<td>19/03/14</td>
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<tr>
<td>Edward Benson-Cooper</td>
<td>Chiropractor – Milford, Auckland (with private practice commitments)</td>
<td>07/12/16</td>
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<td>Zoe Brownlie</td>
<td>Programme Supervisor at Auckland Regional Public Health Service Member - PSA Union Board member - RockEnrol Partner - Youth Connections, Auckland Council Partner - Aro Arataki Children’s Centre Committee Son - Aro Arataki Childcare Centre</td>
<td>26/06/18</td>
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<tr>
<td>Sandra Coney</td>
<td>Member - Waitakere Ranges Local Board, Auckland Council Patron - Women’s Health Action Trust Member - Portage Licensing Trust Member - West Auckland Trusts Services</td>
<td>15/12/16</td>
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<td>Warren Flaunty</td>
<td>Member - Henderson-Massey Local Board Auckland Council Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder - Green Cross Health Director - Life Pharmacy Northwest Chair - Three Harbours Health Foundation Director - Trusts Community Foundation Ltd Trustee - Hospice West Auckland (past role)</td>
<td>12/09/18</td>
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<td>Dr Matire Harwood</td>
<td>Senior Lecturer - Auckland University 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</td>
<td>10/05/18</td>
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<td>Lee Mathias</td>
<td>Chair - Health Promotion Agency Chair - Health Innovation Hub (until the end of the Viclink contract in line with the director appointment) Chair - Medicines New Zealand 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 Director - Health Alliance Limited (ex officio Auckland DHB) (past role)</td>
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<td>Robyn Northey</td>
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<td>Sharon Shea</td>
<td>Chair - Maori Expert Advisory Group, Health and Disability Systems Review</td>
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<td>Principal - Shea Pita Associates Ltd</td>
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<td>Allison Roe</td>
<td>Chairperson - Matakana Coast Trail Trust</td>
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<td>Member - Rodney Local Board, Auckland Council</td>
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<td>Judy McGregor</td>
<td>Head of School, Social Science and Public Policy - Auckland University of Technology</td>
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<td>Associate Dean Post Graduate - Faculty of Culture and Society</td>
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<td>Pat Snedden</td>
<td>Director and Shareholder - Snedden Publishing &amp; Management Consultants Limited</td>
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2.1 Minutes of the Community and Public Health Advisory Committees meeting held on 21 November 2018

Recommendation:

That the Minutes of the Community and Public Health Advisory Committees held on 21 November 2018 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 21 November 2018

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

Items considered in Public Meeting

COMMITTEE MEMBERS:

Sharon Shea (Committee Chair - ADHB Board member)
Max Abbott (WDHB Board member)
Judith Bassett (ADHB Board member)
Edward Benson-Cooper (WDHB Board member)
Zoe Brownlie (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren 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)

ALSO PRESENT:

Judy McGregor (WDHB Board Chair)
Dale Bramley (WDHB Chief Executive Officer)
Ailsa Claire (ADHB Chief Executive Officer)
Tim Wood (Deputy Director Funding, Auckland and Waitemata DHB)
Karen Bartholomew (ADHB and WDHB Acting Director Health Outcomes)
Meg Poutasi (ADHB Chief Strategy, Participation and Improvement)
Nicole Song (WDHB 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:

Gaylene Sharman (Whanau Ora Manager, HealthWest)
Anne Marie Woodward (Child Health Manager, HealthWest)
Sue Claridge (Co-ordinator, Auckland Women’s Health Council

KARAKIA:

The Committee Chair opened the meeting with a prayer.
WELCOME:

The Committee Chair welcomed those in attendance at the meeting.

APOLOGIES:

Apologies were received from Committee member Max Abbott and Debbie Holdsworth (ADHB and WDHB Director Funding).

DISCLOSURE OF INTERESTS:

In relation to items 4.1 and 4.2, Zoe Brownlie declared that she works for Auckland Regional Public Health Service. The Committee did not identify any conflict arising from her interest and given that those items are information papers only, it was decided that she should remain in the room for these items. There were no other declarations of interests relating to the agenda.

Lee Mathias disclosed that she is Chair of Collective Hospitality Group and director of Orakei Estates Limited.

The Committee Chair declared that she has been appointed as Chair of Māori Expert Advisory Group for the Health and Disability Systems Review to which Dale Bramley is also a member.

ACKNOWLEDGEMENTS:

Robyn Northey acknowledged ADHB mental health services for being very helpful to her relative who was sick in Dubai and needed advice about his return to New Zealand and access to services when he arrived.

Edward Benson-Cooper acknowledged that the first metro-combined DiSAC meeting is due to be held on 28 November.

Zoe Brownlie acknowledged Faumui Penelope (Lope) Ginnen joining ADHB as Deputy Chair.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

Lee Mathias requested amendments at p11 to reflect her comments made that the role of nurses should be regional without limiting their scope.

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 29/08/18

Resolution (Moved Edward Benson-Cooper/Seconded Robyn Northey)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 29 August 2018 be approved.
Carried

Matters Arising (agenda pages 16)
Noted

2.2 Circulated Resolutions 25 September 2018

Resolution (Moved Lee Mathias / Seconded Matire Harwood)

That the resolution be endorsed.

Carried

3. DECISION ITEM

3.1 Community Water Fluoridation Position Statement

David Sinclair (Medical Officer of Health, ARPHS) and Jane McEntee (General Manager, ARPHS) joined the meeting and introduced this paper which was taken as read.

The matters discussed were as follows:

- The report provides an update on the Health (Fluoridation of Drinking Water) Amendment Bill and seeks the Committee’s endorsement on a position statement, which has already been endorsed by Counties Manukau DHB. A joint Auckland region DHB position will confirm that oral health is a key priority for equity and will provide transparency on the DHB’s position on community water fluoridation prior to any Board decision on fluoridation. A paper on oral strategy update will be presented next.

- Judy McGregor asked whether the DHBs have any decision-making role in relation to non-fluoridated areas. David Sinclair advised that once the legislation is passed the DHBs’ position confirming the Ministry of Health’s guidance will initiate the supply of fluoridation in those areas through local Councils next year or the year after. Lee Mathias commented that Onehunga should be included.

- Allison Roe noted that 98% of Europe has rejected fluoridation of water, as has the whole of China as well as Japan and that recently Israel had fluoridation removed from the water following a Supreme Court decision. Denmark, Germany, Finland are the leading countries in dental health and none of them have water fluoridation. Allison queried whether we thought their scientists and regulatory bodies relied on flawed science to make their decisions? Or was it because they have examined the facts and no longer wished to contaminate either their drinking water or their crops? Only Ireland and Singapore have mandatory fluoridation. Allison expressed that the associated health harm has not been reported to the Board, that there is
no known biological need for fluoride in the human body, or our waterways. In her opinion, adding fluoride to any water supply is a travesty and indictment on human rights.

- David Sinclair responded by stating that a large number of European countries have fluoridation in their salt. In terms of health impact, David noted that a researcher and an author of a book on fluoridation in China confirmed that it was difficult to find any adverse health effects of fluoride even with the high level of fluoride in groundwater of China. David Sinclair will provide the research papers to Allison Roe.

- Allison Roe commented that people have a choice to eat salt and that fluoride added to water is not the same as that which occurs naturally. Fluoride in water is also non-dose related, meaning that an active person may ingest far more than someone who is inactive and therefore receive more fluoride. She wondered in regard to dose, if there had been any consideration given to the 700,000 New Zealanders currently taking antidepressants for which the active ingredient is fluoride? She expressed concerns that there does not appear to be any scientific evidence to prove that fluoride improves dental health by swallowing it, but that water fluoridation is linked to thyroid underactivity harm, which could lead to obesity and heart disease making our job as a health board harder. She further noted that the Harvard studies found that fluoride had been described as a neurotoxin that was found to reduce the IQ in young children.

- Ailsa Claire commented that community water fluoridation is an excellent public health approach in contributing to oral health. The DHBs must however be mindful about decisions that are made and their impact on different populations. In support, Dale Bramley commented that the DHBs recognise that there are groups of New Zealanders who do not support water fluoridation. It is also recognised that because of the complexity the scientific evidence to date may not be conclusive but is sufficient for the DHBs to support it consistent with the recommendations from WHO, Ministries of Health in Australia and New Zealand, Office of the Prime Minister’s Chief Science Advisor and the Royal Society of New Zealand. On balance, it is appropriate for the Boards to support in his view which can be one of the responses to address inequities in oral health outcomes and oral health problems in children.

- Edward Benson-Cooper referred to the statement in the report that water fluoridation is recommended as best practice both nationally and internationally. He questioned whether stating that water fluoridation is the best practice is accurate in light of the fluoride in salt that is widely used. David Sinclair confirmed that it is accurate and the difference is with the implementation methods. Edward further pointed out that the exact level recommended by the Ministry of Health should be recorded in the resolutions (0.7 to 1 ppm fluoride).

- Judith Bassett expressed concern regarding the delay with the provision of community water fluoridation even if the Committee makes the recommended
endorsement and suggested that Auckland MPs be notified of the DHBs position once the respective Boards have accepted the recommendations to speed up Parliamentary process.

- Sandra Coney noted her disappointment with the lack of scientific evidence and suggested that the DHBs could take better action to encourage the Health Research Council to sponsor or support research on fluoridation in New Zealand.

- Warren Flaunty asked whether there is any data or analysis done on effects of children in areas in New Zealand where there is no community water fluoridation. David Sinclair advised that in the last decade, there has not been much improvement to close the gap in oral health between Māori and Pākehā children. Children and adults from lower socio-economic areas, in which Māori and Pacific people are over-represented, have higher rates of tooth decay and untreated tooth decay.

- Robyn Northey noted that New Zealand Dental Services found that dental caries severity in children living in Onehunga was much worse than in Mangere. David Sinclair advised that the Onehunga population is too small to undertake a detailed research but that national DHB child oral health statistics in relation to oral health outcomes in areas that are and are not fluoridated will be circulated. Lee Mathias noted that Taranaki produced a report after 2 years without fluoridation and that periodically the Ministry of Health commissions Health Promotion Agency to undertake literature researches outsourced to independent parties.

- It was agreed that the fluoride level be specified for recommendation 3 as suggested by Edward Benson-Cooper. In respect of Sandra Coney’s recommendation to encourage an independent research, it was noted that the Chief Executives of WDHB and ADHB will consider approaching the Health Research Council to foster an independent research into issues of fluoridation.

Resolution (Moved Robyn Northey/Seconded Lee Mathias)

That the Community and Public Health Advisory Committee recommends to the Auckland DHB and Waitemata DHB Boards that they endorse the position on Community Water Fluoridation as follows:

1. The DHB confirms that tooth decay is an important population health issue that causes significant avoidable harm and health inequities
2. The DHB supports the Ministry of Health’s position that community water fluoridation is an important, safe and effective component of a population health approach to protect against tooth decay
3. The DHB supports fluoridating community water supplies to the level recommended by the Ministry of Health being 0.7 to 1 ppm fluoride.
4. The DHB notes these recommendations are based on scientific evidence that community water fluoridation:
   i. Is established best practice both in New Zealand and internationally
   ii. Is effective at reducing tooth decay
iii. Is safe at recommended levels of fluoridation
iv. Is cost saving in community water supplies for more than 1000 people
v. Has an important role in reducing inequities in tooth decay as it reaches all groups in a community equally
vi. Has been found by the Courts to be legal and not a medication.

Carried

Allison Roe noted her dissent in respect of recommendations 2-4. She supports the Chief Execs approaching the Health Research Council for independent research into the issue of water fluoridation.

4 INFORMATION ITEM

4.1 Oral Health in the Auckland Region (agenda page 27-46)

Corina Grey (Public Health Physician), Ruth Bijl (Funding & Development Manager, Womens/Child & Youth Health), Stacey Strang (Programme Manager, Oral Health), Stephanie Doe (General Manager, Child Women and Family Services), and Meia Schmidt-Ulii (Division Head, Child Women and Family Services) joined the meeting for this item.

The matters highlighted were as follows:

- Last year, a Preschool Oral Health Action Plan for metro Auckland region was developed to respond to long-standing inequities preschool oral health outcomes. By the age of 5 approximately 60% of Māori and 70% of Pacific children have had some dental decay compared to 30% of non-Māori/Pacific children. Dental health affects young children’s ability to sleep, eat and learn. The Action Plan is divided into promotion, prevention and early detection and treatment being the responsibilities of ARDS, Well child Tamariki Ora and primary care providers who have been involved in the implementation of the plan over the last 12-18 months.

- A joint project involves 4 Northern DHBs and ARDS to help health providers to provide clear and consistent healthy weight and oral health messages to families and to develop community engagement coordinators within ARDS to support outreach and oral health promotions.

- ARDS has been automatically pre-enrolling children from birth since mid-2017 at ADHB and WDHB which has resulted in an increase of number of children enrolled in services by the age of one - 77% for ADHB and 92% for WDHB (WDHB started 6 months ahead of AHDB). To improve access, ARDS has undertaken a key initiative of matching the length of the recall period to the level of dental health needs. This included a directive to put all Māori and Pacific children on six-month recalls unless clinical assessment indicated otherwise.

- ARDS is the only community oral health service offering Saturday clinics. 4000 kids and over have been seen at these clinics by January. It was found
that only one third of the visits were by Māori or Pacific. To improve access for Māori and Pacific children ARDS is alternating venues for these clinics with additional sites.

- Community based programme for topical fluoride varnish for all children is provided by ARDS. A programme of topical fluoride application to preschoolers in high-needs early childhood education centres is also being systematically rolled out across the metro Auckland region. Since March this year, nine different centres have been seen most of which are Kohanga Reo and Pacific Islands nests. All centres visited every 6 months to ensure that the children receive regular preventative therapy. The Committee Chair commented that the paper presented lacks reference to whanau voice in the implementation and feedback which should form part of shaping the service. It was noted that the evaluation will specifically focus on whanau experience. Data on the outcomes will be reported back to the Committee.

- Edward Benson-Cooper suggested that the future reports cover more comparisons between what was done previously and now.

- Lee Mathias raised her concern about Duraphat being the oldest and most commonly used varnish and asked what assurances exist to ensure that the best available type of fluoride varnish is being used. Other suppliers with modern forms of varnish are forced to be registered with MedSafe and PHARMAC at a high cost and time delay. The Committee Chair requested that information is provided to the Chief Executives for consideration.

- She recommended that this concern be raised to the Minister. She confirmed that she has no related interest to declare.

- Judy McGregor queried in relation to the long waiting time for referrals for paediatric treatment noted at p28. Ailsa Claire noted that a range of activities were underway including additional clinics to deal with the length of waiting time. At assessment general anaesthetic may be required for dental surgery partly due to the waiting times. Undertaking extractions quicker without general anaesthetic or the need for the secondary dental service would be ideal. Dale Bramley supported this view and commented that overall, a significant improvement is evidenced across a number of indicators produced in the report. Caries free rates are improving and enrolment and access for younger children are improving.

- Judith Bassett noted the capacity issues in recommendation (d) in the paper. She referred to the planned service for pregnant women/new mothers in the Tamaki area to receive free maternal oral health care and highlighted its importance. Ruth Bijl confirmed that a pilot in Tamaki has been initiated, and has included learnings from the Waitemata DHB maternal project previously funded by the Ministry of Health.

- Lee Mathias queries whether the new University of Otago dental school in planned in Counties Manukau would be available for all metro Auckland. Dale Bramley shared his understanding that the facility would be accessible by all Aucklanders.
- Warren Flaunty raised whether the DHBs should advocate for public dental health system. Dale Bramley advised that the Ministry of Health is already considering how the dental service could be included in the public health service and that the DHB Boards should support. Long queues at the Pain Clinic for temporary filling or extraction and a number of attendances at ED due to dental pain were noted, as were the impact on educational outcomes for children.

- For adolescents, it was noted that only 69% is transferring from dental therapists to contracted dentists and that the number of contracted dentists is decreasing. Auckland’s mixed model of having contracted dentists as well as mobile dentists produce a good coverage for Māori and Pacific children, however.

- In relation to Table 4 at p45, Sandra Coney suggested including a breakdown data on “Other” ethnicity. Corina Grey advised that the ethnicity reporting replicates the Ministry’s but local data allows more granular reporting for Asian ethnicity and this has been conducted previously.

- As a general comment, Allison Roe encouraged the team to find opportunities learn from international examples. International studies that may be of interest to the Committee could be uploaded in the Diligent Resource Centre. It was noted that the fluoride varnish programme was developed in Scotland and significantly improved outcomes.

- In relation to the high proportion of dental therapists at retirement age (p38), Edward Benson-Cooper noted that the values and needs of Māori and Pacific dental therapists should be considered.

Resolution (Moved Robyn Northey/Seconded Edward Benson-Cooper)

That the Community and Public Health Advisory Committee:

a) Note that oral health is a vital component of general health and that there are persistent inequities in oral health outcomes.

b) Note a range of activities are now underway to address inequities, particularly focusing on the pre-school cohort.

c) Note the importance of prevention initiatives including fluoridation of water, health promotion, teeth brushing and protective treatments including the application of fluoride varnish.

d) Note there are capacity issues resulting in delays in time to treatment for hospital-based (secondary) dental care. Work is currently being done to understand these challenges and support hospital and community oral health services.

e) Recommends to the ADHB and WDHB Boards to support a comprehensive dental care access for all New Zealanders as part of public health system.

Carried
4.2 Auckland Regional Public Health Service (ARPHS) update (agenda page 47-56)

David Sinclair (Medical Officer of Health) and Jane McEntee (General Manager, Auckland Regional Public Health Service (ARPHS)) were present for this item.

The following matters highlighted and discussed:

- **Meningococcal Disease:** There was a random cluster of 8 meningococcal cases in the last month in the Auckland region. At this time no cluster has been identified and the volume is similar to last year but there has been an increase in non B meningococcal cases which is being monitored by the Ministry of Health. There had been Meningococcal W cases in New Zealand, particularly in Northland. There is vaccination available for this and plans are underway to address outbreaks.

- **Ill traveller notification:** On 9 September, ARPHS was notified of an ill traveller notification on an international flight from Australia with 100 passengers. The ill passengers were returning from Saudi Arabia. The Ministry of Health officers assessed the passengers and all passengers were allowed to disembark from the plane. Warren Flauntly asked if those passengers were reassessed at a later date. Jane McEntee advised that the initial assessment did not require a follow up but those passengers were given information to contact Healthline if they feel unwell. As part of the discussion it was noted that the Middlemore Hospital’s emergency response services to infectious diseases has been decommissioned in consultation with the Ministry.

- **Notice of aerial 1080 drop in Hunua Ranges:** In September the aerial 1080 operation was challenged in the Environment Court and a temporary injunction was applied with the interim hearing held on 13 September. The Court made the decision to allow the operation. Auckland Council proceeded with the 1080 aerial application and ARPHS has conducted an operational audit in accordance with permit conditions. Allison Roe queried how consent is obtained from the locals and how the water quality from Waitakere Ranges is monitored. David Sinclair advised that Auckland Council managed the consultation process with the local neighbourhood. Water samples were tested and there were no adverse findings.

- **Healthy Auckland Together:** The Advertising Standards Authority (ASA) complaint made regarding McDonalds was not upheld. However, after meeting with McDonalds the website happymeal.co.nz was removed by agreement. A marketing comic supported by three Auckland DHBs was released on promoting healthy food and this comic has received 18000 impressions on social media. A complaint about a Kinder Surprise advertisement has been submitted to ASA and the decision on this will be announced this week. Food and Drink policy is implemented across various sectors working with food stallers including Diwali stallholders and ATEED event organisers. Public health input for an Auckland Transport vending procurement was noted.
• **Safeswim**: Sandra Coney expressed concern with the posting of signs at the beach in regards to water quality where other conditions (such as surf) should prevent people from swimming. Judy McGregor queried what role DHBs play in respect of health? David Sinclair advised that the main role for ARPHS is on advising on health risks and to address the issues of overflows with Auckland Council, provide information on seasonal notifications and website. Source of pollution is difficult to identify as at times it is caused by malfunctioning septic tanks, dogs and birds. Auckland Council now has a new water quality targeted rate aimed at improving separation of waste and storm water. Safeswim was congratulated for winning the Smart Water Category of the Smart Cities Asia Pacific Awards.

• In relation to the healthy events work in partnership with Auckland Council and Healthy Families Waitakere (p53), it was noted the funding had dramatically reduced by the Ministry. Sandra Coney requested information on the effects of that reduced funding.

Ailsa Claire invited the Committee to comment on the reporting method/style by ARPHS. Members commented that they found the report useful and covered a range of activity. Matire Harwood commented that the relationship with the Board and the Ministry should be explicitly stated in the report. Time tracking data where appropriate was suggested by Judy McGregor to show where progress is made or not made. A briefing paper for the Committee on the role of ARPHS and its contribution to the role of the DHBs is to be included in the next report. Ailsa Claire made a general comment that funding for public health service has reduced over time and this meant that the focus had to be on public protection rather than health promotion.

**Resolution**

**That the Community and Public Health Advisory Committee:**

(a) Receives this update from Auckland Regional Public Health Service.
(b) Notes the key pieces of work that are underway and/or completed since the last update in May 2018.

**Carried**

5. **STANDARD REPORT**

5.1 **Planning, Funding and Outcomes Update** (agenda pages 57-78)

The following matters were discussed from this report:

• In relation to ‘Better Help for Smokers to Quit’ (p60) Warren Flaunty suggested that the data from community pharmacies should be captured.
• In relation to ‘Transgender Healthcare’ (p70), it was noted that there is no age restriction on gender reassignment surgeries and that the DHBs do not have a decision making role.
• there is no age restriction to access the service.
• The need to improve diabetes management was noted at p59.
• At p72 (Health of Older People) Judy McGregor asked if data can be produced on both ARC and HCSS from equity perspective. Tim Wood will check and report back to the Committee.

The meeting concluded at 11:51am.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS’ COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 21 NOVEMBER 2018

___________________________ CHAIR
# Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 12 February 2019

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>29/08/18</td>
<td></td>
<td>Diabetes Management A more detailed update on diabetes plan about the initiatives and progress.</td>
<td>Tim Wood</td>
<td>February 2019</td>
<td>Refer report on February agenda</td>
</tr>
<tr>
<td>21/11/18</td>
<td>4.2</td>
<td>Healthy Families Waitakere – information requested on the effects of reduced funding from the Ministry.</td>
<td>Leanne Catchpole</td>
<td></td>
<td>Please refer response below.</td>
</tr>
</tbody>
</table>

Health Families Response: There has been no reduction in funding. There has been a change in the service specification that shifts the focus “from establishment and implantation to amplification and scale. The vision for the Healthy Families NZ locations over the next four years is twofold; accelerating innovation and collaborating within the current location and amplification of systems changes across the 10 locations as a collective, and identifying opportunities for sustainability long term.” This is a quote from the revised MOH service specification.

Recommendation:

That the Community and Public Health Advisory Committee:

1. Note progress against the Healthy Weight Action Plan which is a work in progress.

Prepared by: Rebecca McCarroll (Public Health Dietitian), Ruth Bijl (Funding and Development Manager – Women, Children and Youth), Leani Sandford (Acting Pacific Health Gain Manager), Shayne Wijohn (Māori Health Gain Manager)

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

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ARPHS</td>
<td>Auckland Regional Public Health Service</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>CPHAC</td>
<td>Community and Public Health Advisory Committee</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>ESBHS</td>
<td>Enhanced School Based Health Services</td>
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<tr>
<td>GPs</td>
<td>General Practitioner</td>
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<tr>
<td>HAT</td>
<td>Healthy Auckland Together</td>
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<tr>
<td>HBHF</td>
<td>Healthy Babies Healthy Futures</td>
</tr>
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</table>

1. Executive Summary

The Metro-Auckland DHB Healthy Weight Action Plan for Children was developed in accordance with our vision that “All Tamariki in the Auckland Region of New Zealand are of a healthy weight”. Health sector led actions were established in the plan, to contribute to the cross-sectoral response required to address childhood weight management. This second Report on Action Plan Indicators informs progress made in the implementation of the plan for the period 1 July – 31 December 2018. Actions and indicators are presented by DHB and target population: women of childbearing age, pregnant women, infancy and pre-school/school aged children and adolescents. This Report on Action Plan Indicators is being presented to CPHAC to provide an update on progress.
2. Background

This is the second Report on Action Plan Indicators for the Metro-Auckland DHB Healthy Weight Action Plan for Children. The first report, documenting delivery against outcomes, was presented to CPHAC in August 2018. This follow on report details progress made in the period 1 July – 31 December 2018. Monitoring and reporting on the Healthy Weight Action Plan for Children will continue to occur at regular intervals, or as requested by CPHAC. For indicators that are already reported on elsewhere, information on progress toward meeting the indicator(s) is provided. For some individual programmes instituted as part of the plan, more rigorous monitoring and evaluation plans have been developed. For the next round of reporting the indicators will be reviewed and updated to ensure actions which have been fully achieved are replaced with new actions, or closed as appropriate. The Action Plan will be updated annually. In addition, annual monitoring of the current and future health of Aucklanders continues to be undertaken by HAT.

3. Report on Action Plan Indicators (Auckland and Waitemata DHBs)

A summary of progress during Q1 and Q2 is provided below. The full report is provided in Appendix 1.

3.1 Women of childbearing age
- Progress towards being fully compliant with the National Healthy Food and Drink Policy has been made in the past six months. The goal is to work towards full compliance by August 2019.
- The Green Prescription programme continues to target our priority populations, including Māori and Pacific.
- Scoping of an adult obesity service as part of the bariatric pathway is now in the Māori health pipeline.
- A new Pacific action is being written for the next round of reporting.

3.2 Pregnant women
- The Healthy Babies Healthy Futures (HBHF) programme continues to exceed targets for engaging with our priority populations. A new action measuring the number of children whose mothers receive support from HBHF is being developed, along with a plan for DHB-specific reporting.
- Research related to healthy eating during pregnancy and gestational diabetes continues with timeline targets being met. This will be used to provide improved information resources for pregnant women and health professionals.

3.3 Infancy
- A new pilot for breastfeeding support for Māori is currently being scoped.
- GPs, primary care nurses and well child staff continue to receive training, and report an increase in confidence, for having conversations about healthy weight with families with overweight children.

3.4 Pre-school/school aged children and adolescents
- A dietitian has been contracted to work with high needs early childhood centres to help them improve their food environments; support for Kōhanga Reo is now being scoped.
- A multi-component, whānau-focused physical activity and nutrition programme for overweight/obese pre-school aged children is being delivered and evaluated.
- Work is on-going ensuring contracted schools have a healthy food and beverage policy; next steps include reviewing all food and beverage policies to ensure quality / adherence to the Ministry of Health guidelines.
4. Highlights

From this second Report on Action Plan Indicators the following highlights have emerged. Note: the reporting cycle for this period is six months, compared with the previous 12-month cycle.

- The National Healthy Food and Drink Policy is being successfully implemented across the three metro-Auckland DHBs; the implementation plan is on track.
- Green Prescription referral targets for Māori clients continue to be exceeded.
- The Healthy Babies Healthy Futures team have once again successfully engaged with specific priority community groups (Māori, Pacific, Asian, and South Asian) to have healthy conversations with mothers about improving nutrition and physical activity – all engagement targets were exceeded. Engagement with Asian mothers was exceptional (more than double the target). The number of Community Learning Programme groups held within community settings was much higher than the 6-monthly target. In addition, the target of promoting HBHF to 600 pregnant mothers at the earliest possible stage when engaging with the DHB was well exceeded: 1034 mothers were given the opportunity to engage.
- Culturally appropriate antenatal education is available which supports and promotes breastfeeding. Prioritisation of delivery to Māori, Pacific and Quintile 5 groups is on-going.
- Three randomised controlled trials (TARGET, GEMS and HUMBA studies1) related to healthy eating during pregnancy, including women with Gestational Diabetes Mellitus, are progressing well and are still on track.
- GPs, primary care and public health nurses, and healthcare workers have been trained across the region on having conversations about healthy weight with families with overweight children; 98% of participants identified an increase in confidence following these sessions; 233 people have been trained in the reporting period.
- Both DHBs have been exceeding the health target, with 100% of children identified as obese at their B4 School Check being referred to a health professional. There has also been a decrease in percentage declines for health professional support, for both Māori and Pacific families in Auckland DHB and Pacific families in Waitemata DHB.
- A regional growth chart solution for use in secondary care (Sysmex) has been implemented across the three DHBs and is receiving positive feedback.
- Most Enhanced School Based Health Services (ESBHS) schools have healthy food and beverage policies in place in Waitemata DHB. Half of the Auckland DHB schools do. Nurse Educators are working with the remaining schools (one in Waitemata and five in Auckland) to ensure an appropriate policy is put in place this year.
- Following a gap analysis of healthy food environments in and around early childhood centres a dietitian has been contracted to help high needs early childhood centres to improve their food environments.
- The number of Māori children referred to the Active Families (whānau-focused physical activity and nutrition programme for overweight/obese school aged children) has increased in both DHBs and the number of Pacific children referred has increased in Waitemata DHB.

1 GEMS: Gestational Diabetes Mellitus Study of Diagnostic Thresholds; Liggins Institute, the University of Auckland. Funder: HRC
TARGET: Optimal Glycaemic Targets for Gestational Diabetes: the randomised trial – TARGET; Liggins Institute, The University of Auckland. Funder: HRC
HUMBA: Healthy Mums and Babies Trial; Department of Obstetrics and Gynaecology, the University of Auckland. Funders: Counties Manukau Health, Cure Kids, Lottery Health Research, RANZCOG Mericia Barnes Trust, Gravida National Centre for Growth and Development, and the University of Auckland Faculty Development Research Fund and Reinvestment Fund

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19
• A health professional’s guide for oral health and healthy weight messages has been developed and is ready for publishing. Plans are in place to disseminate the guide.

5. Off track

The following actions are currently off track. Note: the reporting cycle for this period is six months, compared with the previous 12-month cycle.

• No Pacific, and only six Māori, patients received bariatric surgery at Waitemata DHB during this reporting period, which is lower than previous. During this time 57 patients from ‘other’ ethnicities received the surgery. In Auckland DHB 15 Pacific and nine Māori patients received surgery, which was similar to the previous reporting cycle; 42 patients from ‘other’ ethnicities received the surgery. Current reporting from the Auckland DHB bariatric service indicates that, after the service changes made last year, there is no longer inequity in completion of the surgical pathway by ethnicity.
• Scoping of an adult obesity service as part of bariatric pathway is now in the Māori health pipeline; however this project is delayed from its original timeline.
• There has been no progress since the last reporting cycle on the implementation of the National Healthy Food and Drink Policy for Organisations in the community; however, Auckland Regional Public Health Service (ARPHS) has recently employed a Dietitian who will be working in this space.
• The pregnancy and parenting education smartphone app and website is still receiving good feedback regarding utilisation from target groups; however, the content and promotion of the resource still to be reviewed.
• The Auckland DHB breastfeeding community clinic and home visiting approach has been discontinued as evaluation data indicated it did not successfully reach target populations.
• The number of pregnant women referred to Green Prescription has decreased since the last reporting cycle. Plans are being made to better promote Green Prescription for pregnant women to Lead Maternity Carers.
• The Positive Parenting and Lifestyle (PPAL) Programme (whānau-focused parenting, physical activity and nutrition programme for overweight/obese pre-school aged children) was launched in July 2018. Both providers are experiencing limited engagement of families attending the programme. A community engagement plan has been developed and both DHBs are implementing a quality improvement approach, including an evaluation plan.

6. Conclusion

This second Report on Action Plan Indicators for the Metro-Auckland DHB Healthy Weight Action Plan for Children presents an overview of activity during Q1&2. The Action Plan indicators have been developed collaboratively across the region, with consistency in data collection and reporting, where appropriate. The indicators will be reviewed and updated before the next round of reporting; updates will occur annually to ensure actions which have been fully achieved are replaced with new actions, or closed as appropriate. Regular updates to CPHAC will continue. While many actions remain on track, it is important to recognise that broader societal and environmental factors need to be harnessed to shift the population as a whole towards a healthy weight.
### APPENDIX 1 - Healthy Weight Action Plan for Children Reporting: Q1 and Q2 at January 2019

**Women of Childbearing Age**

<table>
<thead>
<tr>
<th>Actions</th>
<th>Time-frame</th>
<th>Measures</th>
<th>Priority Popn</th>
<th>ADHB</th>
<th>WDHB</th>
<th>CMDHB</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigate access barriers to bariatric surgery for Māori and Pacific women of child bearing age</td>
<td>Jun-18</td>
<td># of Bariatric surgeries in 2017/18:</td>
<td>Māori</td>
<td>9</td>
<td>6</td>
<td></td>
<td>Total surgeries 1/7/18 – 31/12/18, ADHB: 42; WDHB: 63.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pacific</td>
<td>15</td>
<td>0</td>
<td></td>
<td>Total surgeries 30/6/17 – 30/6/18 ADHB: 70 (17 Māori, 22 Pacific); WDHB: 95 (18 Māori, 10 Pacific). Total surgeries 2016/17, ADHB: 82; WDHB: 98; CM Health: 156</td>
</tr>
<tr>
<td>Scope what an Adult Obesity Service (intensive lifestyle intervention Tier2-3 service) might look like as part of the bariatric pathway</td>
<td>Dec-17</td>
<td>Complete (Y/N)</td>
<td></td>
<td>In pipeline</td>
<td>In pipeline</td>
<td>In Māori health pipeline</td>
<td></td>
</tr>
<tr>
<td>Promote Green Prescription to primary care and identify and address barriers to primary care referrals</td>
<td>Jul-18, Jul-19, Jul-20</td>
<td># of adults enrolled in Green Prescription by ethnicity</td>
<td>Māori</td>
<td>12.4% (target 11%)</td>
<td>14.3% (target 13%)</td>
<td>23% (709) (target 23%)</td>
<td># referred provided as opposed to # enrolled for CM Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pacific</td>
<td>20.9% (target 17%)</td>
<td>16.7% (target 22%)</td>
<td>33% (991) (target 32%)</td>
<td></td>
</tr>
<tr>
<td>Implement the National Healthy Food and Drink Policy in DHB-owned sites</td>
<td>Jul-18, Jul-19</td>
<td>50% compliant</td>
<td></td>
<td>75% Compliant</td>
<td>75% Compliant</td>
<td>57% Compliant</td>
<td>ADHB/WDHB: Compliance figures are an estimation based on the April’18 audit and subsequent improvements made since then. All red items removed from sale. Working towards full compliance by Aug ’19. CM Health: Paper to ELT Jan ’19 seeking endorsement of recommendation to advise all retailers to ensure all red items removed by April ’19</td>
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<tr>
<td>Baseline audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ADHB/WDHB: Compliance figures are an estimation based on the April’18 audit and subsequent improvements made since then. All red items removed from sale. Working towards full compliance by Aug ’19. CM Health: Paper to ELT Jan ’19 seeking endorsement of recommendation to advise all retailers to ensure all red items removed by April ’19</td>
</tr>
<tr>
<td>Follow-up audits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ADHB/WDHB: Compliance figures are an estimation based on the April’18 audit and subsequent improvements made since then. All red items removed from sale. Working towards full compliance by Aug ’19. CM Health: Paper to ELT Jan ’19 seeking endorsement of recommendation to advise all retailers to ensure all red items removed by April ’19</td>
</tr>
<tr>
<td>Work with ARPHS and Healthy Families NZ through Healthy Auckland Together (HAT) to implement the National Healthy Food and Drink Policy for Organisations in the community.</td>
<td>Dec-18</td>
<td># of organisations who have begun implementing the Policy</td>
<td>Dec-18</td>
<td>n=1 implemen tation across whole site</td>
<td>See notes</td>
<td>Some HAT organisations have begun implementation across all 3 DHB catchment areas (n=3). This implementation is however partial, i.e. across 'some' of the organisation’s sites. There has been no change since the last reporting period.</td>
<td></td>
</tr>
<tr>
<td>Work with DHB contracted providers to support implementation of aligned healthy food and drink policies</td>
<td>Dec-18</td>
<td># of providers who have the Policy in their contract</td>
<td></td>
<td>179 (Last reporting period: 97)</td>
<td>151 (Last reporting period: 114)</td>
<td>&gt;95% of all local contracts had the policy</td>
<td>ADHB/WDHB: Note: the number of contracts increased during the last reporting period, hence the large increase</td>
</tr>
</tbody>
</table>
### Pregnant Women

<table>
<thead>
<tr>
<th>Actions</th>
<th>Time-frame</th>
<th>Measures</th>
<th>Priority Popn</th>
<th>ADHB</th>
<th>WDHB</th>
<th>CMDHB</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure culturally appropriate antenatal education available to promote and support breastfeeding</td>
<td>On-going</td>
<td>Deliver contracted volumes of breastfeeding related programmes with 80% of services delivered to the priority populations (Māori, Pacific and Quintile 5)</td>
<td>Māori</td>
<td>On Track</td>
<td>On Track</td>
<td>Achieved/Complete</td>
<td>ADHB/WDHB: Culturally appropriate antenatal education is available which supports and promotes breastfeeding. Prioritisation of delivery to these identified groups is on-going. Healthy Babies, Healthy Futures groups also continue to provide this support to targeted groups postnatally. <strong>CM Health:</strong> 89% of participants at Pregnancy and Parenting Education were priority populations. 80% of women enrolled with Te Rito Ora Breastfeeding Support were priority populations. Between Jul-Dec ’18, 231 women received in-home antenatal breastfeeding education.</td>
</tr>
<tr>
<td>Providing women and their families with key breastfeeding messages through textMATCH messaging, community promotion, and teaching practical skills for better nutrition and increased physical activity</td>
<td>On-going</td>
<td>% of 6-monthly target (450) and of people receiving textMATCH service</td>
<td>Jul-Dec ’18: 114% (n=512) 2017-18: 93.6%</td>
<td>Data not reported per DHB. HBHF is looking into this in 2019. Note: 6 month reporting period this reporting cycle compared to 12 month reporting previous cycle.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Working with partners to engage with specific vulnerable community groups (Māori, Pacific, Asian, and South Asian)</td>
<td>Jun-18</td>
<td>% of 6-monthly target (400) and of mothers engaged in healthy conversations</td>
<td>Māori</td>
<td>Jul-Dec ’18: 114% 2017-18: 102%</td>
<td>Pacific</td>
<td>Jul-Dec ’18: 113% 2017-18: 136%</td>
<td>Asian</td>
</tr>
<tr>
<td>Action</td>
<td>Target Date</td>
<td>Specific Details</td>
<td></td>
<td></td>
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<tr>
<td>Further strengthen HBHF connections with maternity services, Kohanga reo, Churches and ECEs to increase access to the HBHF programme</td>
<td>Dec-17</td>
<td># of Community Learning Programme (CLP) groups held within community settings (6-monthly target: 24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Promoting HBHF to pregnant mothers at the earliest possible stage when engaging with DHB services</td>
<td>Dec-17</td>
<td>% of 6-monthly target (600) and of mothers given the opportunity to engage with a HBHF provider</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Continue the development of Te Rito Ora service and B4 baby services which engage with women in antenatal period to support breastfeeding</td>
<td>Jun-18</td>
<td>70% women accessing the service will be fully/exclusive breastfeeding at 6 weeks (aligned to the WCTO indicator targets)</td>
<td></td>
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</tr>
<tr>
<td>Incorporate referrals to Green Prescription and healthy weight gain in pregnancy conversations into existing Auckland Regional Health Pathways</td>
<td>Dec-18</td>
<td>Health Pathways updated to include referral options for pregnant women, e.g. Green Prescription (Y/N)</td>
<td></td>
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</tr>
<tr>
<td>Establish a baseline[1] and increase[2] referrals of pregnant women into Green Prescription for healthy weight management</td>
<td>Dec-18</td>
<td># pregnant women enrolled in Green Prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop Pathway for management of pregnant women with high BMI</td>
<td>Dec-18</td>
<td>Pathway developed and implemented (Y/N)</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Notes:**
- **Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19**
- **Further strengthen HBHF connections with maternity services, Kohanga reo, Churches and ECEs to increase access to the HBHF programme**
- **Dec-17**
  - # of Community Learning Programme (CLP) groups held within community settings (6-monthly target: 24)
- **Jul-Dec '18: 35 2017-18: 13**
- **Promoting HBHF to pregnant mothers at the earliest possible stage when engaging with DHB services**
- **Dec-17**
  - % of 6-monthly target (600) and of mothers given the opportunity to engage with a HBHF provider
- **Jul-Dec '18: 172% (1034) 2017-18: 98%**
- **Continue the development of Te Rito Ora service and B4 baby services which engage with women in antenatal period to support breastfeeding**
- **Jun-18**
  - 70% women accessing the service will be fully/exclusive breastfeeding at 6 weeks (aligned to the WCTO indicator targets)
- **Achieved 67% breastfeeding rate at 6 weeks for women enrolled in Te Rito Ora antenatally, compared to the overall rate of 58% across the CM Health region (WCTO data set)**
- **Incorporate referrals to Green Prescription and healthy weight gain in pregnancy conversations into existing Auckland Regional Health Pathways**
- **Dec-18**
  - Health Pathways updated to include referral options for pregnant women, e.g. Green Prescription (Y/N)
- **Partially achieved**
- **Partially achieved**
- **Partially achieved**
- **The first iteration of changes has been made with the healthy weight changes in pregnancy resources now live on the Health Pathways website. Further changes regarding Green Prescription referral has been submitted to Clinical Editors for consideration**
- **Establish a baseline[1] and increase[2] referrals of pregnant women into Green Prescription for healthy weight management**
- **Dec-18**
  - # pregnant women enrolled in Green Prescription
- **Jul-Dec '18: 11 2017-18: n=52 Baseline ('16-'17) n=24**
- **Jul-Dec '18: 5 2017-18: n=13 Baseline ('16-'17) n=3**
- **Partially achieved CM Health: 9 referrals, however these are referrals with GDM only. We will continue to work with the provider to improve reporting. This has been led with implementation of a new reporting template for Q2. Note: 6 month reporting period this reporting cycle compared to 12 month reporting previous cycle.**
- **Develop Pathway for management of pregnant women with high BMI**
- **Dec-18**
  - Pathway developed and implemented (Y/N)
- **Achieved As per previous update, a guideline for the management of obesity in place. This guideline is currently being reviewed and updated and is expected to be completed by Feb '19. At this point it is not on Auckland Regional Health Pathways, however is being integrated into MCIS.**
**TARGET** is a multi-site randomised controlled trial investigating how gestational diabetes mellitus (GDM) should be treated

**GEMS** is a multi-site randomised controlled trial investigating how GDM should be diagnosed

**HUMBA** is a trial of dietary education and probiotics in overweight in South Auckland with the aim of reducing pregnancy weight gain

### Infancy

<table>
<thead>
<tr>
<th>Actions</th>
<th>Time-frame</th>
<th>Measures</th>
<th>Priority Popn</th>
<th>ADHB</th>
<th>WDHB</th>
<th>CMDHB</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance the pregnancy and parenting education smartphone app and website to encourage all women, particularly Māori, Pacific and Asian, to breastfeeding for at least the first 6 months of their baby’s life</td>
<td>Jun-18</td>
<td>% of Māori and Pacific women who breastfeed at 3 months (Target of 70% of babies are exclusively or fully breastfed at 3 months)</td>
<td>Māori</td>
<td>On Track</td>
<td>On Track</td>
<td>PP37. Note: website and app available, good feedback regarding utilisation from target groups for website. However, content and promotion of resource due for review.</td>
<td></td>
</tr>
<tr>
<td>Postnatal support through Titifaitama and Wahakura Wananga including peer support and breastfeeding support groups</td>
<td></td>
<td># who attend support groups</td>
<td>Māori</td>
<td>Achieved</td>
<td>Achieved</td>
<td>PP37.</td>
<td></td>
</tr>
<tr>
<td>Intensive post-natal support through Te Rito Ora service including peer support and home visits</td>
<td>Jun-18, Dec-18, 6-monthly report</td>
<td># of visits in 6 month period (Target - Kaitipu Ora Workers will engage with clients a minimum of 3x in Week 1 postnatally, and then weekly until Week 12)</td>
<td></td>
<td></td>
<td></td>
<td>745 Lactation consultant visits = 149; Kaitipu Ora visits = 596</td>
<td></td>
</tr>
<tr>
<td>Project Description</td>
<td>Start Date</td>
<td>Key Milestone</td>
<td>Status</td>
<td>Notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate effectiveness of Auckland DHB breastfeeding community clinic and home visiting approach and integrate learnings into future efforts.</td>
<td>Mar-18</td>
<td>Build findings from evaluation into contract for the 17/18 financial year (Y/N)</td>
<td>Achieved/Complete</td>
<td>Note: programme was discontinued as did not successfully reach target population.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community cooking courses to support pregnant woman and parents and whānau of 0-2 year olds to make healthy, affordable and culturally appropriate meals which meet the nutrition needs of pregnant women and infants and toddlers</td>
<td>Ongoing</td>
<td># of participants that complete the course</td>
<td>26</td>
<td>26 women completed the full course and of these 92% were priority populations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhance the training plan for GPs, nurses and other relevant health professionals to increase their confidence in having culturally appropriate conversations about child weight and healthy lifestyles with families.</td>
<td>Ongoing</td>
<td>90% of participants who identified an increase in confidence with having conversations about healthy weight following the sessions</td>
<td>Achieved</td>
<td>CM Health: Between pre- and post-training, the overall % of health professionals who were quite or very confident increased from 82% to 97%, with 55% of health professionals reporting increased levels of confidence. Importantly, health professionals who were least confident pre-training were the most likely to report increased confidence. ADHB/WDHB: 98% of participants (up from 95% at last reporting) identified an increase in confidence with having conversations about healthy weight following the Raising Healthy Kids training sessions. Feedback from health professionals indicated that the most useful aspects of the training were the resources, BMI calculator, tips on how to start the conversation and goal setting.</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
</tbody>
</table>
### Pre-School and School-Aged Children and Adolescents

<table>
<thead>
<tr>
<th>Actions</th>
<th>Time-frame</th>
<th>Measures</th>
<th>Priority</th>
<th>ADHB</th>
<th>WDHB</th>
<th>CMDHB</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen support for schools to implement healthy food and beverage policies by achieving an 80% adherence</td>
<td>Dec-19</td>
<td>WDHB/ADHB: 80% of contracted schools have a healthy food and drink policy. CM Health: Introduce a healthy food and drink policy in Mana Kids schools</td>
<td>On Track</td>
<td>On Track</td>
<td>On Track</td>
<td>ADHB/WDHB: WDHB: 83% of Enhanced School Based Health Services (ESBHS) schools have healthy food and beverage policies in place. The Nurse Educator is working with the remaining school to ensure an appropriate policy is put into place this year. ADHB: 50% of ESBHS schools have healthy food and beverage policies in place. The Nurse Educator and Youth Health Programme Manager are working with the remaining five schools to ensure appropriate policies are put into place this year. Next steps: review all school food / beverage policies, where possible, to ensure quality / adherence to MoH guidelines, including schools new to the Programme in 2019. CM Health: Planning is underway to introduce healthy food and drink policies across all schools by Dec '19.</td>
<td></td>
</tr>
<tr>
<td>In collaboration with HAT and Healthy Families NZ, engage intersectorally to support a gap analysis of healthy food environments in and around Kohanga reo, Pacific Language nests and ECEs to determine areas for future DHB support</td>
<td>Jun-18</td>
<td>Gap analysis complete</td>
<td>Achieved/ Complete</td>
<td>Achieved/ Complete</td>
<td>Achieved/ Complete</td>
<td>ADHB/WDHB: A dietitian has now been contracted to work on some of the recommended improvements identified in the gap analysis. CM Health: Continuing to work to establish relationship with Healthy Families.</td>
<td></td>
</tr>
</tbody>
</table>
### Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19

Utilise INFORMAS survey results, along with information from the Heart Foundation, ARPHS and Healthy Families NZ sites to engage with high-priority ECEs and schools to support development and implementation of food policies and healthy food environments.

<table>
<thead>
<tr>
<th>Action</th>
<th>Target Group</th>
<th>Milestone 1</th>
<th>Milestone 2</th>
<th>Milestone 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract a provider to deliver a whānau-focused physical activity, nutrition and parenting programme for pre-school children identified as being 298th centile, including a psychological component and development of specific approaches for Māori and Pacific populations</td>
<td>Māori</td>
<td>Achieved/Complete</td>
<td>Achieved/Complete</td>
<td>Achieved/Complete</td>
</tr>
<tr>
<td>Undertake communication activities to promote and familiarise primary care / WCTO partners with target</td>
<td></td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

**On-going**

By December 2017, 95% of obese children identified in the B4SC programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

**ADHB/WDHb**: Both DHBs have been exceeding the health target with 100% of children identified as obese being referred to a health professional. The bottom indicator of this section "develop consistent health promotion messages..." will be part of communication activities.
<table>
<thead>
<tr>
<th>Ensure referral process for referrals from B4 school provider to primary care for children with BMI&gt;98th centile is in place and all obese children are referred to primary care and that referral is acknowledged (electronic referral process in CM Health, paper based in ADHB/WDHB).</th>
<th>On-going</th>
<th>Percentage of declined referrals to primary care programmes</th>
<th>Māori</th>
<th>19%</th>
<th>17%</th>
<th>38%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific</td>
<td>8%</td>
<td>7%</td>
<td>19%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There has been a decrease in the % declines since the last reporting period, for both Māori and Pacific families in ADHB (was 31% and 10%) and for Pacific in WDHB (was 11% for both Māori and Pacific) and in CMDHB (was 31% for Māori and 23% for Pacific). Work will continue in the next quarter to reduce the number of families declining a referral, with a particular focus on Māori and Pacific. Total % declines for CM Health was 29%. Source: B4SC monthly report to end of Dec ‘18.

<table>
<thead>
<tr>
<th>Provide community, primary and secondary care training by dietitian on use of Be Smarter brief intervention and goal setting healthy lifestyles tool and other resources so health professionals are confident to initiate conversations with families and talk about healthy weight to enable families to be as healthy as they can be</th>
<th>On-going</th>
<th># of training sessions delivered</th>
<th>Jul-18 to Dec-18: 85 people trained. Jan-18 to Jul-18: 31 people trained. Jul-16 to Jul-18: 83/138 GP practices received training</th>
<th>Jul-18 to Dec-18: 148 people trained. Jan-18 to Jul-18: 42 people trained. Jul-16 to Jul-18: 74/107 GP practices received training</th>
<th>1 Jul 18 - 31 Dec 18: 60 people trained. 1 Jul-17 to 31 Jun-18: 369 people trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff trained include: GPs, primary care nurses, Well Child Tamariki Ora staff, healthcare workers, Starship community staff (public health nurses), practice managers, Active Futures coordinators and clinical assistants. Note: 6 month reporting period this reporting cycle compared to 12 month reporting cycle previous cycle ADHB/WDHB: Feedback from participants indicated training was a helpful starting point for childhood obesity management in primary care. In addition to this work more support is being provided to practices, including: regular updates on new resources, tools, information and MoH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Design and implement an evaluation of families and health professional engagement with Raising Healthy Kids referral pathway.</td>
<td>Dec-18</td>
<td>Evaluation plan complete with recommendations (Y/N)</td>
<td>On Track</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>Support the implementation of the regional growth chart solution for use in secondary care in metro Auckland DHBs</td>
<td>Dec-18</td>
<td>An electronic growth chart is implemented in the metro Auckland DHBs</td>
<td>On Track</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>Work with ARDS and the Northern Region DHBs to develop consistent health promotion messages using the common risk factor approach for obesity and oral health</td>
<td>Jun-18</td>
<td>Message alignment complete with 5 key messages agreed upon. Priority languages identified and translation services costed.</td>
<td>On Track</td>
<td>On Track</td>
<td>On Track</td>
</tr>
</tbody>
</table>
Scope the feasibility for a pilot to assess measuring weight and height at the year eight dental check. The aim is to facilitate collection of data for population level monitoring of trends and to feedback to parents information on their child’s weight and growth. This pilot could potentially assess:
- Consenting of children
- Impacts on clinic flow and staffing
- Scalability
- Data collection requirements and utility
- Communication of outcomes to parents
- Staff and consumer perspectives
- Identification of any adverse or unexpected outcomes
This would inform the assessment of whether this could be implemented across the region and the trade-off of costs compared to the potential impact of the information gained for children, their families and the sector as a whole.

<table>
<thead>
<tr>
<th>Dec-18</th>
<th>Pilot complete</th>
<th>At Risk</th>
<th>Pilot has not been scoped due to other issues being worked through with ARDS and prioritisation of other pieces of work this reporting period</th>
</tr>
</thead>
</table>

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19
4.2 Community Based Diabetes Care Programme Update

Recommendation:

That the report be received.

Prepared by: Eirean Gamble (Programme Manager, Primary Care), Jagpal Benipal (Senior Programme Manager, Primary Care), Joy Christison (Project Manager, Primary Care).

Endorsed by: Tim Wood (Deputy Director Funding)

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE</td>
<td>Angiotensin converting enzyme</td>
</tr>
<tr>
<td>ADC</td>
<td>Auckland Diabetes Centre</td>
</tr>
<tr>
<td>AHA</td>
<td>Alliance Health Plus (Auckland DHB)</td>
</tr>
<tr>
<td>AHW</td>
<td>Alliance Health Plus (Waitemata DHB)</td>
</tr>
<tr>
<td>AKL</td>
<td>Auckland PHO (Auckland DHB)</td>
</tr>
<tr>
<td>ALT</td>
<td>Alliance Leadership Team</td>
</tr>
<tr>
<td>ARB</td>
<td>Angiotensin receptor blocker</td>
</tr>
<tr>
<td>CCW</td>
<td>Comprehensive Care Limited (Waitemata DHB)</td>
</tr>
<tr>
<td>CPHAC</td>
<td>Community and Public Health Advisory Committee</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>DCIP</td>
<td>Diabetes Care Improvement Package</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>DSLA</td>
<td>Diabetes Service Level Alliance</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>KM</td>
<td>Kaimanaaki-whānau</td>
</tr>
<tr>
<td>MACGF</td>
<td>Metro Auckland Clinical Governance Forum</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NHC</td>
<td>National Hauora Coalition</td>
</tr>
<tr>
<td>NHS</td>
<td>National Hauora Coalition (Waitemata DHB)</td>
</tr>
<tr>
<td>PCA</td>
<td>Procare Networks Ltd (Auckland DHB)</td>
</tr>
<tr>
<td>PCW</td>
<td>Procare Networks Ltd (Waitemata DHB)</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>SMO</td>
<td>Senior Medical Officer</td>
</tr>
<tr>
<td>THA</td>
<td>Total Healthcare (Auckland DHB)</td>
</tr>
<tr>
<td>THW</td>
<td>Total Healthcare (Waitemata DHB)</td>
</tr>
</tbody>
</table>

1. Executive summary

At the request of the Committee, this paper provides a detailed update on the work programme underway to improve diabetes outcomes across the catchment areas of both Auckland and Waitematā District Health Boards.

There are approximately 50,000 people with diabetes across the two districts; 40% of these have poor control of their diabetes. Uncontrolled diabetes can lead to serious complications. Māori and Pacific are disproportionately affected by diabetes related complications.
The current work programme, led by the Diabetes Service Level Alliance (DSLA), is an informed, strategic approach to the task of effecting a transformation in the way that diabetes care is provided. The objective is to attain equity of health outcomes and improved health outcomes for people living with diabetes.

Resting on a substantial foundation of earlier exploratory work and decision making, a roadmap was devised by the DSLA in 2018 to prioritise and monitor the medium term projects for the sector. The following five projects have been given the highest priority:

1. use co-design processes to design and trial a system of diabetes care that improves outcomes for people living with diabetes
2. transform retinal screening services
3. lift the standard of foot care services
4. repurpose diabetes care improvement package (DCIP) funding
5. establish a programme of text based support for people living with diabetes.

Implementation is underway for each of these high priority projects, and progress is regularly reported to the DSLA.

Progress towards improved equity and improved health outcomes is monitored quarterly using the metro Auckland Clinical Governance Forum (MACGF) agreed five priority diabetes and cardiovascular disease (CVD) clinical indicators:

- glycaemic control (increasing the proportion of people with diabetes with good glycaemic control)
- blood pressure control (increasing the proportion of people with diabetes with systolic blood pressure <140mmHg)
- microalbuminuria management (improving the management of those with microalbuminuria)
- secondary CVD prevention (increasing the proportion of people with diabetes who have known CVD and are on triple therapy)
- primary CVD prevention (increasing the proportion of people with diabetes who have a CVD risk >20% and are on dual therapy).

2. Background

2.1. Prevalence

There are two main sources of information that can be used to estimate the prevalence of diabetes: the PHO registers of people with diabetes and the Ministry of Health (MoH) virtual diabetes register (VDR). Each source comes with its own respective limitations and estimates obtained from each source vary slightly. However, as a result of the coding and data cleaning work associated with the MACGF diabetes clinical indicators, the gap between the VDR and PHO registers is narrowing.

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1 PHO estimated diabetes population is based on data generated from practice management system. This provides estimates of diabetes prevalence based on the location of the practice.

2 The VDR estimates the diabetes population based on an algorithm using data extracted from inpatient, outpatient, laboratory test and pharmaceutical dispensing data collections. In 2016 the algorithm was updated, resulting in a significant improvement in the accuracy of the VDR population estimates. The VDR provides estimates of diabetes prevalence for a given geographical area based on the patient’s domicile.
It is estimated that there are between 49,433 and 52,759 people with diabetes living in Auckland and Waitemata DHBs. The breakdown by ethnicity and DHB is presented in Table 1, below.

Table 1. Estimated prevalence of diabetes, by DHB and ethnicity

<table>
<thead>
<tr>
<th>DHB of domicile</th>
<th>Ethnicity</th>
<th>People with diabetes, 2017 VDR, enrolled with a PHO</th>
<th>People with diabetes, PHO register 31 December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>Māori</td>
<td>1,802</td>
<td>1,935</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>5,991</td>
<td>8,652</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>16,793</td>
<td>17,660</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>24,586</td>
<td>28,247</td>
</tr>
<tr>
<td>Waitemata</td>
<td>Māori</td>
<td>2,341</td>
<td>2,104</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>3,993</td>
<td>3,004</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>21,839</td>
<td>16,078</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>28,173</td>
<td>21,186</td>
</tr>
</tbody>
</table>

The prevalence of diabetes is higher than it was in 2010, but, as shown in Figure 1 below, over the past three years prevalence, as calculated by comparing the VDR for each year with the Stats NZ population projection for each year, has been relatively stable.

![Figure 1. Crude rate of diabetes for residents of large DHBs, 2010-2017](image)

As shown in Figure 2, diabetes prevalence across the catchments of Auckland and Waitemata DHBs has a strong relationship with geography, and with the gradient of socio-economic deprivation.
The geographical distribution pattern varies significantly for specific ethnicities. Figures 3-6, below, for example, show that the geography of Māori living with diabetes is more dispersed and encompasses rural locations to a far greater degree than the geography of Pacific people living with diabetes.
2.2. Policy Context

The work programme for improving diabetes outcomes at Auckland and Waitematā DHBs is underpinned by the broader direction set by the Ministry of Health’s Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015-2020. The plan identifies six priority areas for action:

1. Prevent high-risk people from developing type 2 diabetes
2. Enable effective self-management
3. Improve quality of services
4. Detect diabetes early and reduce the risk of complications
5. Provide integrated care
6. Meet the needs of children and adults with type 1 diabetes

This update focuses on community based diabetes care, corresponding with priorities two to six. In addition, there are separate work streams within both DHBs that address priority one and priority six.

3. The work programme

Auckland and Waitematā DHBs, under the Alliance Leadership Team (ALT), have a substantive programme of work which focuses on improving diabetes outcomes. This work has a particular focus on improving diabetes care and outcomes for Māori and Pacific people with diabetes for whom outcomes are often poorest. The work programme is overseen by the DSLA which is a partnership involving people with diabetes, Primary Health Organisations (PHOs), Non-Government Organisations (NGOs) and the DHBs.

The DSLA is taking a staged and informed approach to improving diabetes care. The approach has a focus on working with high needs patients, through focus groups, one to one interviews, or co-design approaches to develop and implement service change that is responsive to their needs. In each area there is strong focus on collecting evidence of the interventions being successful or not. The flagship project involves co-design processes which take significant upfront engagement with people living with...
diabetes and clinicians to identify barriers/issues and co-designing possible solutions which will then be trialled and tested. Once tested and proven, expansion to cover the entire population can progress. The rationale is to ensure we develop effective interventions rather than roll out an untested model that may or may not deliver improved outcomes. Change processes are resource intensive and time consuming, so having a proven model developed collaboratively with service users and providers that can be implemented widely is proposed as the best use of the limited resources.

Stakeholder engagement and oversight for the work programme is facilitated by the following groups:
- Auckland Waitemata Alliance Leadership Team (formed in 2014)
- Diabetes Service Level Alliance (DSLA) (formed in 2015)
- Metro Auckland Clinical Governance Forum (formed in 2014)
- Northern Region Diabetes Retinal Screening Governance (formed in 2017)

3.1. Foundations for the current work programme
The focus of the main body of this paper is on work undertaken in 2018. However, this work is supported by an extensive foundation laid down in previous years. Salient aspects of the earlier work programme are summarised below.

1. A stocktake of current activity and investment in diabetes care in Auckland and Waitemata was updated in 2016 and supplemented by separate reviews of foot care services and the retinal screening services in both DHBs.

2. A Performance and Quality Framework was developed. This framework includes 22 indicators, of which five high priority clinical indicators are now routinely measured and reported on. Counties Manukau DHB subsequently adopted this framework. This comprehensive data reporting framework, unique in New Zealand, is a significant enabler for enlivening change processes and measuring diabetes outcomes. Data are reported at an individual practitioner level. Individual practitioners can receive, via their PHO, a patient by patient profile. PHOs and practices are using this information to target improvement activities. Progress is monitored by the MACGF and summary reporting is presented quarterly to CPHAC.

3. Three quality improvement pilots were commissioned to identify the impacts and effectiveness of quality improvement initiatives on the clinical management and health outcomes for people with diabetes. The learning from these quality improvement pilots has been incorporated into work programme and into business as usual for PHOs and secondary diabetes services.

4. Preparatory co-design work centred on the experience of people living with diabetes established a good understanding of patient views and experiences while using the current diabetes services. This process focused on people who were not fully engaged with the current diabetes services. Overall, it highlighted a high level of patient dissatisfaction with the way diabetes services were currently being provided and the following themes/issues were identified:
   - current service models lead to a lot of health appointments and waiting for people and supporters
   - what health professionals want is often not the same as what people living with diabetes want
   - performance managing people with diabetes can lead to shame or whakamā
   - the current model of general practice does not effectively meet the needs of many people living with diabetes
   - the complexity and cultural importance of food is not well understood or recognised.
The exploratory work outlined above led to the following decision papers being developed and endorsed:

- Diabetes Service Level Alliance proposed framework to achieve the regionally agreed clinical indicators for diabetes
- Diabetes Service Level Alliance prioritised implementation plan
- Business case: Improving podiatry services
- Business case: Improving outcomes for people with diabetes (co-design approach)

3.2. Transforming Diabetes Care Roadmap

Building on the platform established in earlier years, the DSLA developed a roadmap in 2018. A major transformation is envisaged, supported by the contributions of all stakeholders.

The Roadmap Vision

The vision for the future diabetes system of care is articulated by the DSLA as follows:

Across all ethnic groups, people living with diabetes and their whānau are empowered by knowledge about what helps people with diabetes to stay well and remain as contributing members of their communities. Communication between health providers, people living with diabetes, and their whānau is working well. People living with diabetes and their whānau have a good understanding of the actions they can take on a daily basis to manage diabetes and prevent diabetes related complications. They have the right tools to take these actions and they feel supported on their own terms.

Funders and providers have stopped doing the things that don’t deliver results, and shifted their focus and resources to the things that reliably produce good outcomes for people with diabetes. The result is a fit for purpose, sustainable system of diabetes care. A single system is operating seamlessly across primary and secondary care, and across both district health boards.

Services are configured around the needs of people with diabetes. They are flexible enough to be tailored to the needs of individuals. Systems and processes have changed and in some cases service locations have changed and/or the workforce mix has changed so that services are genuinely oriented around meeting the needs of people with diabetes and their whānau in a way that is respectful, culturally appropriate, and effective.

As an ecosystem (people with diabetes, whanau, service organisations, clinicians, funders, and policy makers) we have “turned the curve” on trend data for diabetes. The clinical indicator targets have been met, not only for the population as a whole, but also for Māori and Pacific populations.
The Roadmap work programme

DSLA endorsed the following work programme in May 2018.

<table>
<thead>
<tr>
<th>Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use co-design processes to transform the diabetes system of care into a person and whānau centred service with optimal and equitable outcomes. Identify and recommend improvements to the funding model to assist with the attainment of this goal. Summarise the learning from the three quality improvement pilots and Mana Tū into a synthesised, reader friendly format. Refine the draft of this document through feedback from DSLA, then distribute to general practices via PHOs. Implement workforce development initiatives that are strongly aligned to the learning from the co-design process, the three quality improvement projects, and Mana Tū. Use a co-design process to transform the way diabetes self-management education is provided.</td>
</tr>
<tr>
<td>Repurpose Diabetes Care Improvement Package (DCIP) funding and PHO flexible funding to provide scaled up support for people with poorly controlled diabetes and drive equity of outcomes. Optimise the general practice clinical management of people with diabetes (e.g. consistent and comprehensive diabetes annual reviews; optimal medication titration). Implement workforce development initiatives to support this aim.</td>
</tr>
</tbody>
</table>

| Lift the standard of foot care services for people with diabetes. Improve primary care clinical management and referral practices. Establish quality standards and a credentialing framework for community podiatrists. Provide podiatry clinical leadership and support. |
| Engage clinical leadership and use contracting and/or procurement levers to transform the way retinal screening services are provided for people with diabetes. |
| Review the needs of people living with diabetes for dietetic and psychology services. Ensure learning from the co-design project underpins any emerging actions. |

<table>
<thead>
<tr>
<th>Quality improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the quality of the local diabetes clinical dataset so that it can be relied on to: 1) drive decisions about transforming care 2) monitor overall progress and equity milestones.</td>
</tr>
<tr>
<td>Identify and implement opportunities in secondary services to: 1) better meet the needs of people with diabetes 2) improve consistency of service provision across the two DHBs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the use of text reminders to assist with self-management for people living with diabetes.</td>
</tr>
<tr>
<td>Implement a central diabetes registry for the Northern region.</td>
</tr>
<tr>
<td>Implement the use of shared care platforms for people with diabetes and all providers of diabetes care.</td>
</tr>
<tr>
<td>Explore how SMART technology can support diabetes care.</td>
</tr>
</tbody>
</table>

The following five projects have been prioritised for early completion:

1. use co-design processes to design and trial a system of diabetes care that improves outcomes for people living with diabetes
2. transform retinal screening services
3. lift the standard of foot care services
4. repurpose diabetes care improvement package (DCIP) funding
5. establish a programme of text based support for people living with diabetes.
4. Progress against the five priority projects

4.1. Flagship project – improve outcomes through co-design

The flagship project for the Transforming Diabetes Care Roadmap is the task of *improving outcomes for people with diabetes through a co-design approach*.

This project aims to transform care for a group of high risk/need people with type 2 diabetes. The initial implementation involves up to six general practices, with high numbers of Māori and Pacific people living with diabetes, in each DHB. The co-design process will involve a broad range of stakeholders, as shown in Figure 7, below. This transformed care will:

- improve relationships between people with diabetes and health providers
- change the culture both within general practice and specialist care to support and empower a partnership and coordinated team approach to care in a way that meets the needs of people with diabetes
- improve relationships between health providers (general practice, PHO, secondary services, NGOs etc) to better support people with diabetes
- improve integration across sectors (ie health and social services)
- improve outcomes for people with diabetes as measured by the MACGF diabetes and CVD clinical indicators.

The impact of this co-design system of diabetes care will be measured using both qualitative and quantitative evaluation methods that incorporate perspectives from all stakeholders. The qualitative evaluation will measure the experiences of both health professionals and those with diabetes using the new system of diabetes care. The quantitative evaluation will measure statistically significant changes in diabetes outcomes as measured by the MACGF diabetes and CVD clinical indicators.

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Figure 7. Stakeholders who will be involved in the co-design process
High level milestones

- Undertake preparatory consumer focused co-design project
- Secure approval for the co-design business case
- Produce document summarising learning from current and previous Quality Improvement projects
- Recruit co-design facilitators
- Recruit general practices (beginning with an initial four (two in each DHB)
- Develop the co-designed new system of care
- Validate the co-designed new system of care (by rolling it out to the next eight practices)
- Evaluate the new system of care
- Implement workforce development initiatives strongly aligned to what we have learnt
- Roll out new system of care so that it becomes business as usual across all providers

4.2. Transform diabetes retinal screening services

Anyone with diabetes is at risk of developing diabetic retinopathy (damage to the retina). Continued damage can lead to blindness. Fortunately, diabetic retinopathy can be detected through community screening. Once diabetic retinopathy is detected, early intervention can prevent or reduce vision loss. Therefore, the MoH expect that at least 90% of the population with diabetes will be screened.

Current screening rates in Auckland and Waitemata are below this target at approximately 60% and the current models of retinal screening employed across Auckland DHB and Waitematā DHB are no longer fit for purpose. A regional clinical governance group, with accountability to oversee retinal screening performance, has been established. A standard model of care for diabetic retinal screening has been developed with significant engagement with Māori and Pacific people with diabetes to ensure the future model would be responsive to their needs. The future model will incorporate the following 12 components:

1. The new service model will offer diabetes retinal screening at a significantly expanded range of screening locations than is the case under the current service model. Service users requiring a primary screen will have the option of attending any primary screening site that is convenient to them.
2. Primary screening will be offered at locations that take into account ease of access and travel time for service users, as well as the availability of public transport and free parking.
3. The service model will include screening locations regarded as trusted, familiar, and easily accessible to Māori. This may include, for example, general practices with a high proportion of Māori enrolees, Māori health providers, and marae.
4. The service model will include screening locations regarded as trusted, familiar, and easily accessible to Pacific people. This may include, for example, general practices with a high proportion of Pacific enrolees, Pacific health providers, and churches.
5. Where general practices with a high proportion of South Asian enrolees are amenable to having a visiting diabetes retinal screening clinic at the practice, the service model will facilitate this. The service model will also facilitate screening at mosques and temples where practicable.
6. Primary screening will be offered at locations that take into account the distribution of diabetes prevalence across the catchment area.
7. A travelling service will cover prison clinics and selected locations, such as rural locations and venues that have high value as culturally accessible sites, where fixed sites are not feasible. (Screeners and equipment will be transported to these sites to enable the set-up of temporary screening clinics.)
8. The service model will include the offer of appointment times in evenings and weekends.
9. The governance group for the Auckland and Waitemata diabetes retinal screening service will include Māori and Pacific representatives (which may be consumers, health professionals, or health administrators).
10. Where general practices with a high proportion of Māori, Pacific, or South Asian enrolees are willing to assist with the invitation and booking process for their enrolees, the service model will facilitate this involvement.
11. Where general practices with a high proportion of Māori, Pacific, or South Asian enrolees are willing to assist with communicating a screening result of mild retinopathy to their enrolees, the service model will facilitate this involvement.
12. Whilst the image capture component of the screening test will be offered at a significantly expanded range of locations, a central administration hub will have responsibility for the oversight of grading for all images.

The Auckland and Waitematā funder is now in an advanced stage of developing an implementation plan to implement this new model. A business case and procurement plan will be submitted to both DHB Boards in the first half of 2019.

Section 5.1 outlines work undertaken to improve retinal screening coverage in the interim.

**High level milestones**
- Undertake a review of retinal screening service provision across Auckland and Waitemata DHB
- Establish clinical governance oversight group for retinal screening
- Define the essential components of a high quality comprehensive retinal screening service for the populations of Auckland and and Waitemata DHB
- Complete the service specifications
- Determine the preferred the procurement/contacting route to establish the redesigned retinal screening service
- Secure approval to proceed with the preferred procurement/contacting route
- Complete the procurement process (through to contract execution)
- Complete the establishment phase for the redesigned service

**4.3. Lift the standard of foot care services**
To reduce the risk and rates of diabetes-related foot ulcers and lower limb amputations, an investment of $202,027 over 15 months, has been made by each DHB. This is being invested in:
- Building the capability of primary care to undertake foot screening and risk assessment for all people with diabetes. This will help identify risk earlier and allow for early treatment and management of risk.
- Building the capability of community podiatry services to provide appropriate care for people with moderate to high risk of diabetes-related foot disease.
- Meeting the unmet podiatry needs of people with healed ulcers to be monitored and managed appropriately in the community setting.
- Developing quality standards, a credentialing framework, and clinical oversight and support for primary care and community podiatrists.
An audit of lower limb amputations is also being undertaken. Early results indicate that Māori are more likely to have lower limb amputations than other parts of the population. This finding is being used to inform the podiatry work plan.

**High level milestones**
- Undertake a review of foot care services
- Secure approval for the business case
- Execute Service Level Agreements with secondary services to recruit the Podiatry Professional Clinical Leader and interim podiatrists
- Recruit Podiatry Professional Clinical Leader and interim podiatrists
- Develop quality standards for community podiatrists
- Develop a credentialing framework for community podiatrists
- Develop and implement clinical referral pathways for diabetes-related foot disease
- Build capability of primary care to undertake accurate and appropriate foot screening and risk assessment for all people with diabetes

### 4.4. Re-purpose Diabetes Care Improvement Package funding

This historical funding had been provided to PHOs to improve diabetes care, with limited evidence of a good return on this investment. Following a workshop with a broad range of stakeholders, this funding has been repurposed to provide scaled up support for people with poorly controlled diabetes and to drive equity of outcomes.

There is a focus on tracking progress against clinical indicator targets separately for Māori, Pacific and Other population groups within individual practices, identifying what is working well in individual practices to achieve each of these targets, and sharing the learning with other practices.

We are beginning to see evidence of the ways in which this repurposed funding is driving a data informed and thorough approach to population health management within individual practices. Examples of this are showcased in section 4.

**High level milestones**
- Hold workshop to discuss repurposing DCIP and PHO flexible funding to provide scaled up support for people with poorly controlled diabetes/newly diagnosed with diabetes
- Capture the emergent service model and payment mechanisms in a document
- Secure (Auckland and Waitemata DHBs, and PHO) approval to proceed with new service model and payment mechanisms
- Execute contracts to formalise the new service model and payment mechanisms
- Embed the new service model in business as usual

### 4.5. Text based support

The Auckland and Waitemata funder, in collaboration with the National Institute of Health Innovation, ran a Health Research Council funded trial on a text to remind programme for people with diabetes. A business case is in development for Board consideration on the implementation of this programme. This intervention is designed to address the seven key self-management behaviours identified by the Association of American Diabetes Educators:

1. healthy eating
2. being active
3. monitoring
4. taking medication
5. problem solving
6. reducing risks
7. healthy coping.

The programme is tailored to the needs and goals of individuals, taking into account demographic factors. As well as core motivational and support messages (in Māori, Pacific, or non-Māori/Pacific cultural versions), recipients can opt to receive additional modules on the following topics: insulin, young adult, smoking cessation, lifestyle behaviour (exercise, healthy eating or stress/mood management), and foot care. Recipients can choose to receive blood glucose monitoring reminders which they can reply to by sending in their result by text message. Participants can view their blood glucose results graphically via a password protected website.

High level milestones
- Secure approval for the business case
- Select the provider
- Execute the contract
- Launch the service within the co-design cohort
- Roll out the service across Auckland and Waitemata DHBs

5. Additional activities undertaken to improve diabetes outcomes

5.1. Interim catch up programme for diabetes retinal screening
A number of measures are being undertaken to improve retinal screening coverage in the current model of care (pending a longer term solution through the new model of care described above).

Regional retinal screening data match
Auckland, Waitemata, and Counties Manukau DHBs have agreed to undertake a regional data match to improve retinal screening coverage. This will involve matching Auckland, Waitemata, and Counties Manukau DHB retinal screening data with the HealthSafe diabetic dataset (ie people enrolled with metro Auckland PHOs and coded as diabetic whose data are uploaded for quarterly diabetes indicator reporting). The retinal screening data match will be undertaken using the Metro Auckland Data Sharing Framework. The project includes two stages; stage 1 is expected to commence in February 2019.

Stage 1: Understand the quantum of people who are not known to retinal screening services
Stage 1 will describe the quantum and characteristics (eg age group, ethnicity, HbA1c, PHO) of people with diabetes enrolled with metro Auckland PHOs who are not known to retinal screening or relevant ophthalmology services. This data will inform service planning to ensure services have capacity to screen and if needed treat the unscreened population. Data from stage 1 will also provide a baseline to monitor retinal screening coverage over time, including by ethnicity.

Stage 2: Identify, prioritise and refer individuals for retinal screening
Stage 2 will generate lists for each PHO of patients who are coded as diabetic and not known to retinal screening or relevant ophthalmology services (ie people who should be offered a referral for screening).
Lists will be provided to PHOs from HealthSafe and will be prioritised by ethnicity and clinical risk factors to ensure a strong focus on clinical risk and equity.

**Other measures to improve retinal screening coverage**

**IT enablers**

An upgrade of the retinal screening patient management system OptoMize is being undertaken. This upgrade will address OptoMize limitations identified in previous reviews and will support improved data collection required for MoH reporting.

A project to implement retinal screening e-referrals for Waitemata DHB is underway and due for completion in March 2019; retinal screening e-referrals have already been implemented for Auckland DHB.

**New screening locations**

Regular retinal screening clinics have been reinstated at The Fono Medical Centre. This is in response to consumer feedback received during interviews conducted in October 2018.

**5.2. Regional standing orders for oral hypoglycaemic agents and insulin**

The Metro Auckland Standing Order Steering group has recently developed and endorsed metro Auckland standardised standing orders for nurses for insulin and oral hypoglycaemic initiation and titration for people with type 2 diabetes. These metro Auckland standing orders are the first such standing orders developed in New Zealand. They have been developed to enable nurses to more ably, safely and legally provide medicines management for the people with type 2 diabetes. These standing orders have been released on the Auckland Regional HealthPathways platform.

**6. Service and activity highlights**

Many general practices across the districts of Auckland DHB and Waitematā DHB are bringing a stronger focus to monitoring and improving diabetes related outcomes for the individuals on their practice registers. Strategic direction from the DSLA is also effecting a stronger practice level focus on outcomes for Māori and Pacific people. Practices are supported in this work by PHO support with data analysis and workforce development, and DHB provider arm support in the form of education, advice, and mentoring.

Where PHOs and general practices are:

- using the clinical indicator data reports to get better practice systems in place so that they can drive improved outcomes for individuals
- trialling new approaches to support self-management (such as health coaches or support workers)
- offering improved diabetes group education sessions
- upskilling their workforce to offer timely interventions (eg insulin starts)
- offering flexible modes of service delivery (eg, home and workplace visits)

we are starting to see concrete improvements in outcomes at the practice level. These improvements include:

- a reduction in the number of people with poor glycaemic control
- a reduction in the number of people with systolic blood pressure below 140 mmHg

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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19
• a reduction in the number of people with microalbuminaria who are not on an angiotensin converting enzyme inhibitor or an angiotensin receptor blocker
• a reduction in the frequency of GP visits prompted by ill health.

See appendix 1 for detailed examples of service and activity highlights.

6. Priority clinical indicators

In January 2017, MACGF finalised the five prioritised diabetes and CVD clinical indicators. It was agreed that all Metro Auckland PHOs would report on the five priority indicators from quarter four 2016-17. The seventh quarterly report was presented to MACGF in November 2018. This information was then summarised in the quarter one 2018/19 CPHAC update. The section below highlights and discusses these five clinical indicators. The full set of tables and graphs for the period 1 October 2017 to 30 September 2018 is provided in Appendix 2.

6.1 Clinical Indicator 1 – glycaemic control

One of the key goals of diabetes management is keeping blood glucose levels within an acceptable range and is monitored using the HbA1c test which reflect the average plasma glucose level over the previous 8 to 12 weeks.

The numerator and denominator for the MACGF Clinical Indicator 1 (glycaemic control) are specified as follows:

| Numerator | number of enrolled diabetic patients (aged 15-74 years) with HbA1c ≤ 64 mmol/mol |
| Denominator | number of enrolled diabetic patients (aged 15-74 years) with HbA1c recorded in the last 15 months |

The MACGF clinical indicator data collections facilitate close analysis of the work required by DHBs, PHOs, and practices to lift achievement to the target. Table 2, below, for example, shows that good glycaemic control has been achieved for a smaller proportion of the Māori and Pacific population than is the case for the remainder of the population.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieved</td>
<td>Shortfall*</td>
<td>Achieved</td>
<td>Shortfall</td>
<td>Achieved</td>
</tr>
<tr>
<td>Auckland</td>
<td>52%</td>
<td>478</td>
<td>50%</td>
<td>2,247</td>
</tr>
<tr>
<td>Waitemata</td>
<td>52%</td>
<td>481</td>
<td>52%</td>
<td>720</td>
</tr>
</tbody>
</table>

*Number needed to achieve the 80% target.
As shown in Figure 8, below, funnel plots displaying the achievement of individual practices demonstrate that the target of 80% is attainable for the population as a whole. In addition, practice level reporting under the repurposed DCIP funding contracts demonstrates that attainment of the target is achievable for priority populations. The next step is for PHOs to transfer the learning from successful practices to other practices.

Figure 8. Glycaemic control – Auckland DHB

The funnel plot display allows PHOs to see where a particular focus is required to raise the attainment of individual practices, by, for example, exploring the reasons for the low performance of two outlying practices in Figure 9, below.

Figure 9. Glycaemic control – Waitemata DHB

3 A funnel plot is a type of scatter plot that helps viewers to visualise the spread of performance against clinical indicator targets and to spot outliers (practices with a performance level that is significantly different from the others). Outliers fall outside of the upper and lower control lines, which are a set distance from the average performance level.

The vertical axis indicates the performance level (expressed as a percentage), while the horizontal axis indicates the practice size. Individual practices are represented by dots which are colour coded according to which PHO they belong to. The legend at the bottom of each funnel plot matches the colours to PHO abbreviations. PHO abbreviations are explained in full in the abbreviations table at the front of this paper.
6.2 Clinical Indicator 2 – blood pressure control

People who have both diabetes and hypertension are more susceptible to complications such as renal disease, ischaemic heart disease, retinopathy, and neuropathy.

The numerator and denominator for Clinical Indicator 2 (blood pressure control) are specified as follows:

<table>
<thead>
<tr>
<th>Numerator</th>
<th>number of enrolled people with diabetes (aged 15-74 years) whose latest systolic BP recorded within the last 15 months is below 140 mmHg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>number of enrolled people with diabetes aged (15-74 years)</td>
</tr>
</tbody>
</table>

As shown in Table 3, this goal has not yet been attained. However, using the example of Auckland DHB, a practice by practice breakdown (shown in Figure 10, below) demonstrates that several practices have achieved or surpassed target, or are on the cusp of achieving the target. The new service specification for the repurposed DCIP funding focuses PHOs on identifying their star practices (separately identified for attainment of the target for Māori, Pacific, and other populations within individual practices). The objective is to facilitate the transfer of learning from successful practices.

Table 3. Blood pressure control in those with diabetes - achievement against target (80%) (based on data submitted)

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td>Auckland</td>
<td>60%</td>
<td>331</td>
<td>61%</td>
<td>1,384</td>
</tr>
<tr>
<td>Waitemata</td>
<td>63%</td>
<td>298</td>
<td>65%</td>
<td>382</td>
</tr>
</tbody>
</table>

*Number needed to achieve the 80% target.

![Blood pressure control chart](image)

**Figure 10. Blood pressure control – Auckland DHB**

6.3 Clinical Indicator 3 – microalbuminuria management

Microalbuminuria (increased albumin in the urine) is most often an early sign of kidney damage from diabetes and is treated with an ACE inhibitor or ARB which slow the rate of progression to renal failure.
Microalbuminuria has also been identified as an independent risk factor for cardiovascular complications. Its presence is therefore a pointer to the need for more rigorous management of all CVD risk factors.

The numerator and denominator for Clinical Indicator 3 (microalbuminuria management) are specified as follows:

<table>
<thead>
<tr>
<th>Numerator</th>
<th>number of enrolled people with diabetes (aged 15-74 years) with a raised albumin to creatinine ratio on the most recent measurement in the last 18 months who have been prescribed an ACE inhibitor or ARB in the last 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>number of enrolled people with diabetes (aged 15-74 years) with a raised albumin to creatinine ratio on the most recent measurement in the last 18 months</td>
</tr>
</tbody>
</table>

As shown in Table 4, below, for the microalbuminuria management target to be reached for Māori, prescriptions of ACE inhibitors or ARBs are required for a further 95 people in Auckland and a further 98 people in Waitemata. Refining data to this level helps the DSLA to strategize for early wins and monitor progress against equity goals.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori Achieved</th>
<th>Māori Shortfall*</th>
<th>Pacific Achieved</th>
<th>Pacific Shortfall</th>
<th>Other Achieved</th>
<th>Other Shortfall</th>
<th>Total Achieved</th>
<th>Total Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>73%</td>
<td>95</td>
<td>78%</td>
<td>315</td>
<td>76%</td>
<td>425</td>
<td>77%</td>
<td>835</td>
</tr>
<tr>
<td>Waitemata</td>
<td>72%</td>
<td>98</td>
<td>74%</td>
<td>150</td>
<td>67%</td>
<td>566</td>
<td>70%</td>
<td>814</td>
</tr>
</tbody>
</table>

*Number needed to achieve the 90% target.

Funnel plots displaying the achievement of individual practices (colour coded by PHO) provide insight into where learning can usefully be transferred between practices and between PHOs. For example, the PHO clusters in Figure 11 below, indicate that learning could be transferred from ProCare practices to Comprehensive Care practices in Waitemata DHB to assist with the attainment of the microalbuminuria management goal.

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4 See the abbreviations table at the front of this paper for an explanation of PHO abbreviations.
6.4 Clinical indicator 4 – CVD secondary prevention

The goal of this indicator is to maximise the use of triple therapy (statin + blood pressure lowering agent + antiplatelet/anticoagulant) to minimise the risk of further cardiac events for people with known CVD.

**Numerator**
Number of enrolled patients with known CVD who are on triple therapy (statin + blood pressure lowering agent + antiplatelet/anticoagulant)

**Denominator**
Number of enrolled patients with known CVD

Regular data uploads enable recognition and celebration of achievements. As shown in Table 5, below, the CVD secondary prevention target has been reached across both DHBs for all ethnicities.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall*</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td>Auckland</td>
<td>71%</td>
<td>Achieved</td>
<td>76%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Waitemata</td>
<td>73%</td>
<td>Achieved</td>
<td>76%</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

*Number needed to achieve the 70% target.

7. Conclusion

It is a significant challenge to achieve equity and improve outcomes for approximately 50,000 people living with diabetes across the catchments of Auckland and Waitemata DHBs. However, there is now a robust framework in place, with all stakeholders working collaboratively to facilitate clinical governance and accountability across the diabetes system of care for Auckland and Waitemata. Contracting and procurement processes are starting to reorient to enable the DSLA vision for the future diabetes system of care, and regular MACGF data uploads are an increasingly powerful tool for data driven improvements at the PHO and practice level. There is considerable appetite for transformational work, where there is confidence that this work will bring about equity and improved health outcomes for people living with diabetes.
Appendix 1. Service and Activity Highlights

1. National Hauora Coalition – Mana Tū

1.1. Overview
The National Hauora Coalition (NHC) secured a substantial National Science Challenge/Health Research Council/MoH grant to undertake Mana Tū, a programme to improve the impact of clinical and lifestyle interventions for whānau living with prediabetes and people with poorly controlled type 2 diabetes (defined as most recent HbA1c >65mmol/mol). Mana Tū deploys skilled and supported case support workers or Kaimanaaki-whānau (KM) in practices. The KMs use a mana whānau approach and work with General Practice teams while being operationally supported by a central hub led by the NHC. The NHC-led hub provides network operational leadership, programme design, ongoing workforce training and development, and quality improvement support within a rich data environment.

1.2. Outcomes
At nine months into the programme there has been an overall reduction of 7.33 mmol/mol in the patients still active on the Mana Tū programme (N = 167). Including patients that have dropped out/disengaged with the Mana Tū programme (N = 33), there has been an overall reduction of 5.33mmol/mol in the Mana Tū group. There has also been an increase of 1.17 mmol/mol in the control group.

Mana Tū interim results

<table>
<thead>
<tr>
<th></th>
<th>Control Baseline</th>
<th>Control Jan 2019</th>
<th>Mana Tū Baseline</th>
<th>Mana Tū Jan 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>167</td>
</tr>
<tr>
<td>Age range (years)</td>
<td>23-81</td>
<td>-</td>
<td>20-83</td>
<td>24-83</td>
</tr>
<tr>
<td>Female: Male (n)</td>
<td>100:100</td>
<td>-</td>
<td>109:91</td>
<td>95:72</td>
</tr>
<tr>
<td>HbA1c (mmol/mol)</td>
<td>81.07</td>
<td>82.24</td>
<td>84.33</td>
<td>77</td>
</tr>
<tr>
<td>average range</td>
<td>65-152</td>
<td>41-151</td>
<td>65-196</td>
<td>37-127</td>
</tr>
<tr>
<td>Change in HbA1c (mmol/mol)</td>
<td>-</td>
<td>+1.17</td>
<td>-</td>
<td>-7.33</td>
</tr>
</tbody>
</table>

2. Total Healthcare PHO

2.1. Self-management education groups
Total Healthcare has been running general health self-management education groups since 2012. These courses are based on the six week Stanford self-management course model. The number of courses Total Healthcare has facilitated over the years has grown steadily, and in 2018 40 courses were
delivered across the greater Auckland region. On average, 8 to 9 people complete each course, and over 80% of people who begin courses complete the course. The vast majority of participants coming through the courses are Pacific and Māori, and along with depression and anxiety, diabetes is one of the most common conditions participants have.

Patients who complete the diabetes specific version of the self-management course see an improvement in diabetes self-efficacy and reduced psychological distress. GP utilisation data shows that people who completed a course in 2016 had significantly more days between visits post course completion (69 days on average) compared to pre-course attendance (46 days).

2.2. Health Coaches
Total Healthcare introduced health coaching\(^5\) for people with diabetes in 2016. The objective of the health coaching clinics is to provide patient centred, tailored support for people with diabetes. The first Auckland DHB trial sites at Wai Health was specifically to support people with an HbA1c of 75 mmol/mol or more. The peer health coaches are an integral part of a ‘teamlet’ model of care, where patients meet a GP and nurse and are also supported by a health coach at the beginning and end of their GP appointment. The primary outcome measures of this trial show a change in HbA1c from baseline, pre intervention, to follow up. An independent analysis in June 2018 showed promising results. The average improvement at Wai Health (n=49) was 5.2%.

3. Procare PHO

The following is an excerpt from a report furnished by a ProCare general practice engaged with the redesigned DCIP programme:

**Background**

In October 2018, we were invited by ProCare to take part in DCIP, which bulk funded our diabetes work. This was aimed at improving the patient’s well-being, and clinical outcomes. The vision is to empower those living with diabetes and their whānau with knowledge about diabetes, and to enjoy a good quality of life. The aim is also to achieve equity of health outcomes for Māori and Pacific people living with diabetes.

**Methods**

Our team worked with Jackie Copp, Product Manager at ProCare. Jackie very kindly supplied us with the data necessary to analyse our gaps and develop appropriate strategies. She also supplied us with support material and resources.

The data supplied by ProCare was analysed. 148 patients were identified as living with diabetes. The list was stratified several different ways: ethnicity; high needs status, HbA1c; BP; smoking status; and by microalbuminuria. 44 patients were identified as having gaps in their diabetes measures that could be closed by our team. There were a few more, but these were all being managed by the teams at the hospitals and we didn’t want to interfere in their management. There were two additional patients who were unfortunately lost to follow up.

\(^5\) Health coaching is a set of skills and processes that help people to be active self-managers and to be more engaged with their health care.
Over four months, the team contacted all 44 patients where gaps were identified and offered them individualised packages of care tailored to each person’s specific needs. Each patient had between 30 minutes to 2 hours with one of the nurses or 15 minutes with one of the doctors where they were offered tailored support. This support included: support material, referrals as appropriate, individual advice, medication adjustment, access to Green Rx, access to classes, etc.

Pre-implementation Data:
- 61 patients of the 148 patients were identified as Māori or Pacific. These were prioritised in our work plan
- 12 were current smokers (3 Māori)
- 47 had an HbA1C over 65mmol/mol
- 36 had a systolic blood pressure over 140mmHg (2 Māori, 3 Pasifika)
- 12 had microalbuminuria but not on an angiotensin converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB) (1 Māori, 1 Pasifika).

Post-Implementation Data
- 44 had an HbA1C over 65mmol/mol – a small improvement over the 3 months
- nine had a systolic BP over 140mmHg – a large improvement with intensive targeting of BPs (0 Māori, 2 Pasifika)
- five had microalbuminuria but not on an ACE inhibitor – (1 Māori, 1 Pasifika) (one we were unable to prescribe an ACE inhibitor for as her renal function was too low, one is young type 1 diabetic under the hospital, the rest declined. All these five patients were offered an ACE inhibitor)
- 11 were still smoking (3 Māori). All were offered smoking cessation.

Discussion
This was a great team effort, and we made excellent use of the funding in identifying those who could benefit from intensive input. The nurses found the work very gratifying, and the patients reported that they appreciated the extra attention.

We have placed auto prompts and red bold notes in the MedTech notes of all the patients where there are still gaps. The whole team is aware of our project to close these gaps and we will continue the work as the patients come for their usual medication review over the next three months.

We plan to re-audit again in April 2019.

4. Alliance Health Plus

The Tongan Health Society, an Alliance Health Plus general practice, provide support to a mainly Pacific cohort of 761 people living with diabetes, many of whom have complex care needs driven by multiple comorbidities (eg diabetes and chronic kidney disease, diabetes and CVD, diabetes and gout, diabetes and asthma/chronic obstructive pulmonary disease, or a combination of three or four of these disease states). These patients are on multiple, sometimes complex medication regimens, and many require insulin in addition to a range of other medications.

The Tongan Health Society understand their population very well and work hard to provide services that are responsive to their needs. This care is provided in a culturally appropriate and holistic manner that
has patients and their families at the centre. The service delivery recognizes the context in which patients and families live and the priorities made within their cultural practices and the resources available to them.

The majority of patients enrolled at Tongan Health Society are of Tongan descent therefore providing services in the Tongan language is critical. Most of the staff working in the clinic are fluent Tongan speakers. This includes the dietitian and Podiatrist who provide services for patients with diabetes and their families.

The Reducing Inequalities contract provides a contribution to the total cost of care required for achieving equitable and effective management of diabetes.

The following excerpt from the diabetes nurse’s most recent quarterly report highlights the holistic approach the Tongan Health Society takes:

Recently, there was a radio talk, in the Tongan language, that our diabetes nurse specialist and Podiatrist participated in.

Home visits and sometimes work-place visits are conducted when appropriate. We have a lot of shift workers, as well as patients that work 12 hour days, six days a week. Some of our enrolled population do not live immediately near one of our clinics, however, they choose to be enrolled here at Langimalie.

In the last quarter there was a significant total overall HbA1c reduction for 146 patients.

Insulin starts continue. These appear to be typically 1-2 per month. Of interest, out of our enrolled 761 patients with diabetes, 531 of them are now on an insulin regimen.

The total number of patients with a BP>130/80 has reduced from 250 to 201.

Constant problem-solving is required, upskilling, and putting our considerable devotion into our beautiful population to improve their lives, minimise their considerable risks and improve outcomes.

5. Auckland PHO

Auckland PHO is taking a population health approach to improving diabetes outcomes and is utilising the MACGF diabetes and CVD clinical indicators to drive this improvement.

Every month the Clinical Director, GP liaison, or Primary Care Nurse Director meets with each general practice to review their diabetes patients. Using real time data, patient lists are provided that stratify patients by the five MACGF diabetes and CVD clinical indicators. This process highlights patients who would benefit from more intensive support to improve their diabetes management. Māori and Pacific patients are prioritised.

The Clinical Director, GP liaison, or Primary Care Nurse Director provide coaching/case review support to help the practice work with the priority patients identified.

As a result of this intensive support Auckland PHO have seen an improvement, at a PHO level, in their performance against the MACGF diabetes and CVD clinical indicators.
6. Comprehensive Care

Comprehensive Care has recently revamped the format of its diabetes self-management education (DSME) group sessions, and as a result has seen a more than five-fold increase in Māori and Pacific attendees.

A one-day course format has been implemented following feedback from attendees that smaller blocks of time spread out over multiple sessions made attendance difficult. One-day courses are offered on Thursdays and Saturdays, to fit around the work commitments of attendees. Course locations include Orewa, Stanmore Bay, Albany, Birkdale, Henderson, Glen Eden and Swanson.

In high need areas, a small bag of seasonal vegetables and fruit is provided for attendees, which provides the base ingredients for one of the featured recipes. Following the course, people with diabetes are invited to attend a small supermarket tour and/or individual consultations with a dietitian. This has proved very popular, and most people will consult with the dietitian at least once. Attendees are also offered follow up support with a psychologist if required.

7. Auckland DHB Diabetes Centre

7.1. Satellite clinics
Auckland DHB Diabetes Centre (ADC) currently runs satellite clinics at Avondale Centre, Grey Lynn, Oranga Community Centre, Glenn Innes (two locations), Mt Roskill, Otahuhu, University of Auckland, and Waiheke Island. These clinics are staffed by specialist diabetes nurses and diabetes dietitians, and two clinics have Senior Medical Officer (SMO) and registrar support. The service added two new clinics in 2018, and recently reviewed attendance rates and utilisation of these clinics. This led to the implementation of a new patient centred booking system ('invite to contact').

7.2. Locality work
The locality programme, established in 2016, provides SMO and specialist nursing support to general practices in specified areas based on postcodes, diabetes prevalence, and deprivation. The clinics are run from within general practices and are aimed at up-skilling, mentoring and supporting practice nurses and GPs. Case discussions between GPs and SMOs are part of this project. This model served as one of the foundations for the co-design and mentorship project, currently initiated with the help of the DSLA.

7.3. Education and training
ADC provides regular education sessions in a variety of different settings. These include practice nurse specialist interest groups, insulin initiation workshops in general practices, SMO lunchtime and evening education sessions, SMO/GP case reviews, GP symposia, mentoring of practice nurses at ADC, and support for practice nurses with e-learning modules for diabetes management (www.healthmentoronline.com).

ADC also delivers diabetes self-management education activities such as regular group education for people with type 2 diabetes and in house specialist education for people with type 1 diabetes (eg the internationally accredited Dose Adjustment for Normal Eating (DAFNE) course).
7.4. Advice and support
ADC provides telephone support via a hotline (two dedicated mobile numbers) for GPs, practice nurses and IP teams. Advanced training registrar and specialist nurses can be reached every workday between 8.30 and 4.30 for advice and support. In addition, frequent informal contact (telephone advice) regarding case management has been a well-established aspect of this service to support primary care teams.

There is a duty nurse providing daily clinic support (eg insulin starts at the time of the 1st visit, if appropriate), but also supporting ‘walk-in patients’ who otherwise have difficulties accessing appropriate care.

ADC recently added a clinical care coordinator to the team with special focus on high needs patients, young adults with type 1 and 2 diabetes, and difficult to reach patients.

8. Te Hononga Oranga Diabetes Service

To improve outcomes for Māori with diabetes the Waitemata DHB Diabetes Service designed and implemented a community-based Māori focused diabetes service. This service, Te Hononga Oranga Diabetes Service, operates under a whānau ora / whānau-centred approach. The service provides multi-disciplinary outpatient specialist diabetes service for those who express a preference to be seen within a kaupapa Māori service.

Between the start of 2016 and the end of 2018, 445 Māori have opted to be seen under this model. During an initial evaluation the majority of service users reported that the service met their cultural needs and they preferred using this service over mainstream diabetes services. One service user commented: “You feel proud of who you are; proud of being Māori.” The majority of service users reported an improvement on their diabetes knowledge and their ability to self-manage their diabetes. Health outcome data showed that 61% of service users experienced a decrease in their HbA1c level after accessing Te Hononga Oranga Diabetes Service.

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6 The terms ‘Whānau Ora approach’ and ‘whānau-centred approach’ refer to a culturally grounded, holistic approach focused on improving the wellbeing of whānau (families) and addressing individual needs within a whānau context (Te Puna Kokiri (2015) Understanding whanau-centred approaches.)
Appendix 2. Clinical indicator data – attainment against targets

Glycaemic control - achievement against target (80%)

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall*</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td>Auckland</td>
<td>52%</td>
<td>478</td>
<td>50%</td>
<td>2,247</td>
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<tr>
<td>Waitemata</td>
<td>52%</td>
<td>481</td>
<td>52%</td>
<td>720</td>
</tr>
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</table>

*Number needed to achieve the 80% target.

Blood pressure control – achievement against target (80%)

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Other</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall*</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td>Auckland</td>
<td>60%</td>
<td>331</td>
<td>61%</td>
<td>1,384</td>
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<tr>
<td>Waitemata</td>
<td>63%</td>
<td>298</td>
<td>65%</td>
<td>382</td>
</tr>
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</table>

*Number needed to achieve the 80% target.

Microalbuminuria management in those with diabetes - achievement against target (90%)

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall*</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td></td>
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<td>Shortfall</td>
</tr>
<tr>
<td>Auckland</td>
<td>73%</td>
<td>95</td>
<td>78%</td>
<td>315</td>
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<tr>
<td>Waitemata</td>
<td>72%</td>
<td>98</td>
<td>74%</td>
<td>150</td>
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</table>

*Number needed to achieve the 90% target.

CVD secondary prevention (diabetes population) - achievement against target (70%)

<table>
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<tr>
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<th>Māori</th>
<th>Pacific</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall*</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td>Auckland</td>
<td>71%</td>
<td>Achieved</td>
<td>76%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Waitemata</td>
<td>73%</td>
<td>Achieved</td>
<td>76%</td>
<td>Achieved</td>
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</table>

*Number needed to achieve the 70% target.

CVD primary prevention – achievement against target (70%)

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<thead>
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<th>Pacific</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall*</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td></td>
<td>Achieved</td>
<td>Shortfall</td>
<td>Achieved</td>
<td>Shortfall</td>
</tr>
<tr>
<td>Auckland</td>
<td>54%</td>
<td>65</td>
<td>55%</td>
<td>227</td>
</tr>
<tr>
<td>Waitemata</td>
<td>61%</td>
<td>32</td>
<td>62%</td>
<td>36</td>
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</tbody>
</table>

*Number needed to achieve the 70% target.
Auckland DHB

1. HbA1c Glycaemic control

2. Blood Pressure control

3. Management of Microalbuminuria

Waitemata DHB

1. HbA1c Glycaemic control

2. Blood Pressure control

3. Management of Microalbuminuria

* differences in 2018 were artefact due to PHOO not uploading their data
HbA1c Glycaemic control: Percentage of enrolled diabetic patients with HbA1c <64 (aged 15 – 74 years) HbA1c recorded in the last 15 months - Auckland DHB - September 2018 (n = 20)

Blood pressure control: Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140 - Auckland DHB - September 2018 (n = 20)

Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker - Auckland DHB - September 2018 (n = 10)
Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140 - Waitemata DHB - September 2018 (n ≥ 20)

Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker - Waitemata DHB - September 2018 (n ≥ 10)

CVD Secondary Prevention: Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant) - DIABETES - Waitemata DHB - September 2018 (n ≥ 10)

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19
CVD Primary Prevention: Percentage of enrolled patients with CVDRA ever recorded >20%, (aged 25 to 74 years, excluding previous CVD event) on dual therapy (statin + BP lowering agent) - DIABETES - Waitemata DHB - September 2018 (n ≥ 10)
4.3 Planning and Funding Māori Health Update

Recommendation:

That the report be received.

Prepared by: Shayne Wijohn (Acting Māori Health Gain Manager, ADHB/WDHB)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Acting Director Health Outcomes)

Glossary

AAA - Abdominal Aortic Aneurysm
ARPHS - Auckland Regional Public Health Service
AH+ - Alliance Health Plus
ARDS - Auckland Regional Dental Service
CPHAC - Community and Public Health Advisory Committee
HNA - Health Needs Assessment
HPV - Human Papilloma Virus
MPDS - Māori Provider Development Scheme
NCSP - National Cervical Screening Programme
PDH - Precision Driven Health
PPAL - Positive Parenting Active Lifestyle
PSAAP - Primary Health Organisation Service Agreement Amendment Protocol Group
RCT - Randomised Controlled Trial

1. Executive Summary

This report provides an update from a Planning and Funding perspective of work occurring within Māori health gain for Auckland and Waitemata DHBs. This update is provided to the Community and Public Health Advisory Committee in the interim ahead of the establishment of the joint Māori health gain advisory committee.

2. Governance and Planning

2.1 Iwi partnerships

In late December 2018 Dr Dale Bramley hosted a hui of governance and executive representatives from Waikato DHB, Counties Manukau DHB, Auckland DHB, Waitemata DHB and Northland DHB, who met at Waitemata DHB with their iwi partners to discuss the future of iwi and DHB relationships and advancing Māori health outcomes.

There was also an agreement that the natural iwi alignment to the DHBs was to form two Māori health committees. These committees, set by the Boards, would be a joint partnership between iwi and their aligned DHBs with the authority to act within their agreed terms of reference. The northern alliance governance partnership would represent Northland, Waitemata and Auckland DHBs with their iwi. The southern governance partnership would combine Counties Manukau DHB and Waikato DHB with Tainui. Further consideration on what form this group will take and its scope is currently in consultation with our Boards and iwi partners. Work will continue in early 2019 to establish the two committees, gain the necessary endorsements (Minister of Health and Boards) and to develop a clear
work programme. The wider collective of five DHBs and iwi partners also agreed to share all available resources as well as to continue to work together into the future.

2.2 Regional Māori Health Plan
We are continuing to work towards the development of a long term (3 or 5 years, as opposed to annual) Māori health plan for metro-Auckland, although the focus of this work may change with the priorities set through the new governance framework. Data is currently being compiled and analysed for consideration within a broader Māori health plan, with measures being included from several different sources – annual plans, previous Māori health plans, System Level Measures and local, regional and national plans and reviews. The current focus is on regional initiatives and major system change projects across priority areas – child and youth health, mental health, and primary health care (prevention and screening), with accompanying targets and accountabilities to be reported to governance should this be agreed.

A proposed consultation plan is also being developed to includes iwi-partner engagement, Māori provider input from across Auckland, and wider sector engagement with key decision making groups (Alliance Leadership Team) and strategic forums.

2.3 Auckland DHB and Waitemata DHB Māori Health Scorecard
Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19

Auckland and Waitemata DHB Performance Scorecard

Health Targets - Auckland DHB

<table>
<thead>
<tr>
<th>Measure</th>
<th>Non-Māori</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital falls resulting in NOF fracture</td>
<td>2.5</td>
<td>1.8</td>
<td>2.5</td>
<td>A</td>
</tr>
<tr>
<td>Rheumatic fever rates</td>
<td>0.92</td>
<td>0.97</td>
<td>0.7</td>
<td>F</td>
</tr>
<tr>
<td>Oral Health - Children caries free at 5yr</td>
<td>58%</td>
<td>46%</td>
<td>5%</td>
<td>F</td>
</tr>
<tr>
<td>Older patients Falls Risk Assessed</td>
<td>79%</td>
<td>70%</td>
<td>10%</td>
<td>F</td>
</tr>
<tr>
<td>Inpatient rated care as very good or excellent</td>
<td>97%</td>
<td>95%</td>
<td>5%</td>
<td>F</td>
</tr>
<tr>
<td>Mental Health Access Rates 20-64 years</td>
<td>62%</td>
<td>65%</td>
<td>3%</td>
<td>F</td>
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<tr>
<td>Mental Health Access Rates 0-19 years</td>
<td>61%</td>
<td>64%</td>
<td>3%</td>
<td>F</td>
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<tr>
<td>Māori other FTE as % of total workforce</td>
<td>9%</td>
<td>5%</td>
<td>4%</td>
<td>F</td>
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<tr>
<td>Māori administrative FTE as % of total workforce</td>
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<td>6%</td>
<td>1%</td>
<td>F</td>
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<tr>
<td>Māori management FTE as % of total workforce</td>
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<td>3%</td>
<td>1%</td>
<td>F</td>
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<tr>
<td>Māori clinical FTE as % of total workforce</td>
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<td>6%</td>
<td>3%</td>
<td>F</td>
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<tr>
<td>Māori admissions seen by cultural service</td>
<td>50%</td>
<td>25%</td>
<td>25%</td>
<td>F</td>
</tr>
<tr>
<td>Māori admissions seen by cultural service</td>
<td>40%</td>
<td>20%</td>
<td>20%</td>
<td>F</td>
</tr>
<tr>
<td>Inpatient mortality (NPO exclusion)</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>Ref</td>
</tr>
<tr>
<td>Oral Health - Children caries free at 5yr</td>
<td>46%</td>
<td>5%</td>
<td>41%</td>
<td>F</td>
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<tr>
<td>Inpatient mortality (NPO exclusion)</td>
<td>3%</td>
<td>3%</td>
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Health Targets - Waitemata DHB

<table>
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<tr>
<th>Measure</th>
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<th>Target</th>
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<td>F</td>
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<tr>
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<td>3%</td>
<td>Ref</td>
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<tr>
<td>Oral Health - Children caries free at 5yr</td>
<td>46%</td>
<td>5%</td>
<td>41%</td>
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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19
3. **Māori Health Providers**

3.1 **Integrated contracting (regional approach to contracting with Māori health providers)**

Alignment of Auckland DHB and Waitemata DHB with Counties Manukau DHB has been progressing regarding engagement and support for metro Auckland Māori health providers, notably providers who operate across the region. Several workshops have been held to determine a regional approach to integrated contracting with these providers that supports a more robust method for contracting for Māori health outcomes.

3.2 **Māori Health Provider Forum**

The Māori Health Provider Forum, chaired and led by Ngāti Whātua, is made up of all Māori health providers funded by Auckland DHB and Waitemata DHB. The Forum has its own work programme supported by our Māori Health Gain Team. Recently, the Forum secured funding from the Ministry of Health to undertake two projects that would benefit all members of the Forum, and support Māori health gain in our districts (detailed below).

   a) **Clinical leadership**

   This project aims to strengthen clinical leadership, safety and quality across all of our Māori providers. The Forum will establish a clinical leadership group with members representing all providers who will review clinical roles and recommend opportunities for development across the network. Key tasks will include: career development plans for all clinicians, minimum training requirements and expectations for clinicians established, and clinical/cultural supervision made available for all clinicians.

   b) **Māori health online**

   The Forum will develop an online resource for the public that promotes Māori health providers and strategies, promotes enrolment and employment opportunities with Māori health providers, and regularly highlights the achievements of the Māori health sector. It will also provide a space in which Māori health providers can demonstrate examples of excellence by showcasing services and people achieving outcomes.

3.3 **Māori Provider Development Scheme Funding**

In partnership with the Ministry of Health, we have assessed proposals to the Ministry’s Māori Provider Development Scheme (MPDS) funding initiative for the Māori health providers in our districts. A total of $588k has been allocated to ten providers across Auckland and Waitemata DHBs.

4. **Targeted Planning Funding and Outcomes (PFO) initiatives**

4.1 **Abdominal Aortic Aneurysm (AAA) research programme**

Both the Māori-specific pilot and extension programme, and the non-Māori Precision Driven Health (PDH) initiative are now complete. The research programme successfully screened approximately 2,500 eligible Māori across Auckland DHB and Waitemata DHB. The programme has been evaluated and a series of patient and whānau interviews has been conducted by an independent Māori researcher (funded by the A+ Trust), including an assessment of potential anxiety generated by the process of AAA screening (an issue raised in the international literature). The report on the programme findings is currently being finalised. A smaller Pacific AAA research project is being developed based on the AAA project learnings.
4.2 Human papilloma virus (HPV) self-sampling research programme

The Feasibility study of Māori women has been completed and a report has been completed and summary findings provided to CPHAC previously. The larger Randomised Controlled Trial (RCT; funded by the Health Research Council and led by Massey University), is underway with approximately half of the recruitment complete in Auckland DHB and Waitemata DHB areas (the larger study includes Māori, Pacific and Asian women and is examining different invitation methods: mail-out, clinic-based and opportunistic offer). A smaller arm in Wellington will commence after July 2019. With Dr Bev Lawton (University of Victoria), the Ministry of Health recently released results of a series of hui with Māori women across the country indicating strong support for self-sampling. The results of Dr Lawton’s subsequent study in Northland DHB, and our research programme, will help to inform the Ministry’s consideration of self-sampling in the future cervical screening programme.

4.3 Raising Healthy Kids Health Target

In response to the Raising Healthy Kids national health target a Positive Parenting Active Lifestyle (PPAL) programme commenced in the 2018/19 in both Auckland DHB and Waitemata DHB. PPAL is a family-based, multicomponent lifestyle weight management service for preschool children and their whānau. The programme incorporates Group Lifestyles Triple P for parents / caregivers and an activity programme for their children. There are two providers covering Waitemata and Auckland DHBs, of which Te whānau o Waipareira is one.

4.4 Oral health data matching project

The focus for oral health continues to be on pre-school enrolment of tamariki with Auckland Regional Dental Service (ARDS). Evidence shows that once enrolled, whānau engagement with oral health care providers and access to treatment increases dramatically.

In 2018, we implemented a data sharing project on Waiheke Island (a non-fluoridation area) between Piritahi Hauora and Auckland Regional Dental Service (ARDS). At the start of this project, Piritahi Hauora had only 26% of their enrolled tamariki registered with ARDS. With a list of not enrolled tamariki matched with ARDS, both organisations were able to directly engage priority whānau through both opportunistic enrolment, and by targeted engagement with priority whānau in the community. As a result, Piritahi have managed to increase their enrolled population to 63% or 234 tamariki now enrolled with ARDS. This project is being presented to other Māori health providers across Auckland and Waitemata DHB, with the aim of rolling out a regional project by March 2019.

5. Māori pipeline projects

The Auckland DHB and Waitemata DHB Māori Health Gain Team and the PFO Health Gain team, sponsored by the CEOs of both Auckland DHB and Waitemata DHB, have established a pipeline of projects. The identified projects address opportunities to accelerate Māori health gain and have been identified through a range of mechanisms – the Māori Life Expectancy Gap Report, the Whānau House Health Needs Assessment (HNA), the Māori Health Plan, the equity re-focussing of the System Level Measures Plan, the DHB and Nga Painga Hauora outcomes frameworks, the review of the integrated contracting processes, work of colleagues and horizon scanning of research, evidence and technologies. The pipeline provides an opportunity to develop a more streamlined process for proposals, project implementation and evaluation. These projects will also test the methodology and approach of using a pipeline approach.
The Māori health pipeline is currently progressing proposal development in a range of areas:

a) **Lung cancer screening**
   Lung cancer is a clearly identified Māori health priority, reinforced by the recent presentations at the national Cancer Conference (Ministry of Health and University of Otago). The development of a full research programme including a trial of lung cancer CT screening will begin with a qualitative research project funded by the A+ Trust, which includes three focus groups and a survey of 300 Māori participants. The learnings from the AAA project and the human papilloma virus (HPV) self-sampling projects have been incorporated into the approach for lung cancer screening; intentionally designing-in equity to the development of the programme. The terms of reference for the project governance are currently being established with leadership from Associate Professor Dr Sue Crengle (University of Otago), and in collaboration with other partners. The work is aligned to the development of the Northern Region cancer equity model which has recently been initiated.

b) **Alternative community cardiac rehabilitation prototype**
   The Whānau House based cardiac rehabilitation prototype is in the final stages with all 18 (5 Māori and 6 Pacific) clients who remained on the programme (2 exited early and managed outside of the Prototype) having had their final Clinical Exercise assessments, and 5 awaiting their final nurse assessment before Christmas. Early clinical measures appear promising with secondary risk factors have improved on average by 30% for each client, which tracks above international benchmarks for similar interventions which sit at 20-25% improvement. Attendance at key face to face meetings was at 90-95% for clients who have completed. This is a marked increase from the average of 60% for the current service.

   WaiResearch conducted the evaluation and they have started interviewing clients (including those two who exited early) about their experience and self-reported outcomes. This will add further context to the Prototype report which will be finalised by March. The Prototype report will likely inform a service change initiative for cardiac rehabilitation and long term condition contracts in the community managed by the Māori Health Gain Team, and a business case is in development.

c) **Alternative community pulmonary rehabilitation model**
   Dr Sandra Hotu is developing a Māori engagement model for respiratory services through her PhD work (nearing completion). One of the findings of her research includes the potential for kapa haka as a health intervention component. The development of a prototype model of the use of kapa haka in pulmonary rehab is a project under the pipeline lead by Dr Hotu. An initial terms of reference and project outline have been agreed and a stakeholder meeting between kapa haka experts and pulmonary rehabilitation clinicians will be held in April to determine the parameters of the prototype.

d) **Northern region breast screening datamatch (‘500 Māori women campaign’)**
   Approximately 500 additional Māori women need to be screened at each of the metro-Auckland DHBs (approximately 100 additional women in Northland) to achieve the breast screening coverage target of 70%. Screening is an important mechanism to improve breast cancer outcomes for Māori women. As there is currently no breast screening population register this project includes the northern region as a demonstration project for a national datamatch between Breast Screen Aotearoa (BSA) and primary care enrolment data, in order to offer women breast screening. This project has undergone a full privacy impact assessment, Māori data sovereignty assessment, approval from the Ministry of Health and the national primary care group (PSAAP) and regional approvals through the Metro Auckland Data Stewardship group and Metro Auckland Clinical Governance. The data extraction is...
currently underway. The three metro Auckland BSA Lead Providers have been fully engaged in the project and the safe use of women’s data has been agreed in standardised processes and data collection, and the Lead Providers are planning for the capacity to contact women from late February.

e) Māori provider and PHO datamatch
The Auckland DHB and Waitemata DHB integrated contract reports indicate that self-reported enrolment with primary care is relatively high, however in previous projects we have shown that self-reported enrolment does not necessarily correlate to actual PHO enrolment (and that this varies by age group). It is also noted that overall DHB level PHO enrolment rates are lower for Māori than non-Māori (10-15% gap). Māori providers report that their reach into the community is greater than the reach of primary care for some groups of clients. From data provided in the Waitemata DHB and Te Whānau o Waipareira joint Whānau House Health Needs Assessment (HNA) in 2016, it was noted that 15% of clients were not recorded as enrolled with a PHO. This project is a proposal for a datamatch between the metro Auckland Māori health providers and PHOs to identify and quantify the group enrolled with the Māori Provider but not enrolled with any PHO.

The datamatch is phase one of the project, which is agreed in principle with nine Māori providers and by the Metro Auckland Data Stewards. There are planned meetings with Māori providers in February and March to discuss Māori Data Sovereignty assessment and appropriate project and data governance. Depending on the results of phase one, phase two would involve the co-development of an offer of service to this group including facilitated PHO enrolment and potentially a range of health checks.

f) Intensive support for women with a history of high grade lesions in cervical screening
Due to the inequities in cervical cancer outcomes for Māori women this project focuses specifically on women who have had incomplete follow up after a high grade cervical smear (this may be related to a non-attendance at colposcopy, incomplete follow up or incomplete test-of-cure). This group of women were identified in the HPV self-sampling project and this project initiated in response. An audit has been undertaken (with team at the National Cervical Screening Programme register (NCSP-R; hosted by Auckland Regional Public Health Service (ARPHS)) to risk assess this cohort of women, and follow up is now underway. A longer term process of quality improvement with primary care and the establishment of systems improvements is in development. A Māori GP who has been active in the Smea your Mea campaign has been invited to the project steering group.

g) Pre-bariatric adult weight management pathway
A recommendation from the Bariatric Service Project was the consideration of a service to provide a culturally, medially and psychologically supported programme to those considering bariatric surgery as one means to address access barriers. This project has been scoped and a proposal is being drafted for further consideration.

Additional areas of work will be included over time.

6. Whānau House Health Needs Assessment - Update on Business Case development

6.1 Enhanced Well Child/Tamariki Ora Service
The Enhanced Well Child/Tamariki Ora Service works with Te Whānau o Waipareira’s Tamariki Ora service to identify and immunise tamariki who are overdue. To date, the service has immunised 20 children, and two mothers, and employs one nurse vaccinator.

6.2  Taitamariki Substance Misuse Service Development
In July, the Waitemata DHB Board supported the second Whānau House Health Needs Assessment (HNA) Business Case – Taitamariki Substance Misuse Service. The Taitamariki Substance Misuse Service is a youth focused and whānau inclusive substance misuse prevention service aimed at complimenting existing services in West Auckland by filling a gap in preventative and whānau focused addiction support, out of school positive messaging and development programmes, packages of care for direct positive youth development, and connecting a range of services operating in this space and locality. The development phase of the service is due to start 1 February 2019 when the provider, Te Whānau o Waipareira, a back to full operation. The second phase, delivery of the service, is due to start 1 July 2019.

6.3  Business Case 3 – Family violence prevention programme
We are currently in discussions with Waipareira to develop a third Business Case linked to the HNA. We are particularly interested in addressing the findings from the HNA about the number of whānau screened for family violence in 2016 (1,700) and the 380 who disclosed instances of violence. There is currently no validated kaupapa Māori family violence programme that these whānau can be referred to, opting instead to receive 2 – 4 whānau counselling sessions by Waipareira counsellors.
5.1 Planning, Funding and Outcomes Update

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Jean-Marie Bush (Senior Portfolio Manager Mental Health and Addiction Services), Ruth Bijl (Funding and Development Manager Child, Youth and Women’s Health), Tim Wood (Funding and Development Manager Primary Care), Kate Sladden (Funding and Development Manager Health of Older People), Shayne Wijohn (Manager Māori Health Gain), Leani Sandford (Acting Manager Pacific Health Gain), and Raj Singh (Project Manager Asian, Migrant and Refugee Health Gain)

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

Glossary

AH+ - Alliance Health Plus
ABC - Ask, Brief Advice and Cessation
ACH - Auckland City Hospital
ACE - Angiotensin-converting-enzyme
AOD - Alcohol and Other Drugs
ARRC - Age Related Residential Care
ARC - Aged Residential Care
ARDS - Auckland Regional Dental Service
ARPHS - Auckland Regional Public Health Service
ARSHS - Auckland Regional Sexual Health Services
ACH - Auckland City Hospital
BP - Blood Pressure
CADS - Community Alcohol and Drug Service
CDA - Combined Dental Agreement
CELT - Commissioning Executive Leadership Team (Auckland DHB)
CHIL - Child Health Information Link
CGG - Clinical Governance Group
CLP - Community Learning Programme
CPHAC - Community and Public Health Advisory Committee
CTO - Community Treatment Orders
CVD - Cardiovascular Disease
CfYH - Centre for Youth Health
DHB - District Health Board
DSLA - Diabetes Service Level Alliance
HBHF - Healthy Babies Healthy Futures
HCSS - Home and Community Support Services
HKO - He Kainga Ora
HPV - Human Papilloma Virus
HVAZ - Healthy Village Action Zones
IPS - Individual Placement and Support
IWas - Intensive Wrap around Service
MACGF - Metro Auckland Clinical Governance Forum
MECA - Multi-Employer Collective Agreement
MEELA - Middle Eastern Latin American African
MHUD - Ministry of Housing and Urban Development
MMR - Mumps, Measles and Rubella
1. **Executive Summary**

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata DHBs’ (DHB) planning and funding activities and areas of priority, since its last meeting on 21 November 2018. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting’s agenda.

**Highlights**

- A significant body of work has been developed and delivered by the Primary Care and Pacific Team – the Pacific Smokefree Community Champions Training. This training already has had an impact beyond the Enua Ola and HVAZ program. The Tongan Methodist Vahefonua (governance) has requested that the DHB provide support to develop and implement a Smokefree Policy for all their Tongan Methodist churches and smoking cessation support for members to quit.
- For the second quarter in a row, Auckland DHB has achieved the Immunisation Health Target with 95% of babies fully vaccinated by eight months of age.
- Paired Up, Youth Peer Support Pilot Service, a peer led pilot support service located within Tamaki College. Early indications show the model has been effective, particularly at engaging Māori and Pacific Island youth who have no contact with other support services.

2. **Planning**

2.1 **Annual Plans**

The 2018/19 Annual Plans were submitted to the Ministry of Health (MoH) on 1 November 2018, as required. The Auckland DHB Annual Plan was agreed to and signed by the Minister and has been published on the Auckland DHB website. The Waitemata DHB Annual Plan is still being finalised and, pending Board approval, will be submitted to the Ministry and the Minister for approval this month.
The 2019/20 DHB Annual Planning package was received on the 20 December 2018, along with the Minister’s Letter of Expectations.

Both ADHB and WDHB Annual Plans are currently under development in line with Ministry guidance and first drafts will be submitted to respective March Board meetings for review.

2.2 Annual Report
Both 2017/18 Annual Reports have been finalised and published on respective websites.

2.3 System Level Measure Improvement Plans
Implementation of activities in the 2018/19 SLM Improvement Plan is ongoing. The Quarter 1 2018/19 SLM report will be presented to March Board meetings. 2019/20 SLM Improvement Plan development has commenced.

2.4 Auckland and Waitemata DHB Quarterly Performance Scorecard
The Auckland and Waitemata DHB CPHAC Scorecard is a standardised tool used to internally review and track performance against a range of measures. The Scorecard below shows indicator performance against target for each DHB for Quarter 2 of the 2018/19 year.
### Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19

#### Auckland and Waitemata DHB Quarterly Performance Scorecard

**Health Targets - Auckland DHB**

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**Health Targets - Waitemata DHB**

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#### Child, Youth and Women - Auckland DHB

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#### Primary Care - Auckland DHB

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#### Health of Older People - Auckland DHB

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### How to read

- **Performance Indicators:**
  - Achieved/Demonstrated through discharge
  - Not Achieved/Discharged

- **Trend Indicators:**
  - Performance depression compared to previous month
  - Performance deterioration compared to previous month

### Key notes

1. Māori and targets are reported for the separate Māori and non-Māori streams.
2. Rates and targets are expressed as the number of people per 100,000 population.
3. Rates are not adjusted for the age structure, but are adjusted for the sex structure of the age group under the age structure of the age group, where relevant.

### Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 20/02/19
3. Primary Care

3.1 Smoking - Pacific Smokefree Community Champions Training – Helping Pacific People to Stop

3.1.1 Introduction
Māori and Pacific are priority groups for both Waitemata and Auckland DHBs for stop smoking services. Approximately 15.5% of adults in New Zealand aged 15+ smoke daily. Māori and Pacific people are more likely to smoke (37 and 23 per cent respectively)\(^1\).

Many Pacific people who smoke within the Auckland and Waitemata DHBs' region may never visit their GP or access other health services, resulting in missed opportunities for DHB funded services to offer help and support them to stop smoking. This priority population needs specifically tailored approaches and services to support them to quit smoking and access stop smoking services. Offering training to the Pacific community and church leaders to become Smokefree champions reduces the barriers of access and broadens the reach of smokefree activities within the Pacific community.

3.1.2 Objective
The objective of this training was to design, develop and facilitate a Stop Smoking Fundamentals Training program using the Ask, Brief Advice and Cessation Support (ABC) approach for the smokefree champions belonging to the Pacific community and church groups. Smokefree champions, who undertook this training, are expected to apply the skills learnt to motivate those in their sphere of influence to make quit attempts; helping to achieve the Smokefree Aotearoa 2025 goal.

3.1.3 Development of Pacific Champions Training package
Smokefree champions are identified as individuals from their local community groups, organisations, churches or businesses, who are interested in advocating or promoting smokefree changes within their environments or settings. There is currently no publicly available smokefree training suitable for non-registered healthcare workers and community. To better understand the training needs of Pacific communities, a questionnaire was undertaken by members of Enua Ola and Healthy Village Action Zone (HVAZ) community and church members. This covered smoking status, methods and beliefs on what motivated Pacific people to stop smoking, and the nature of the support that would be most effective for Pacific people and the results were used to develop the “Pacific Champions Fundamentals” training program.

A total of 200 participants completed a hardcopy of the survey. The majority of the respondents were females (131 respondents) (see Figure 1). The majority of respondents were Samoan (125) followed by Niuean (28), Tongan (17), Tuvaluan (17), Cook Island (4), Fijian (2), Tokelauan (2) and others (5). Slightly more than one-third of respondents were current smokers (73) followed by ex-smokers (65) (see Figure 2).

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\(^1\) MoH New Zealand Health Survey 2013/14
3.1.4 Implementation

Enua Ola and HVAZ Steering Groups were also consulted on how to motivate Pacific people to stop smoking, the role of smokefree champions in the churches/groups and their learning needs.

A registered Smokefree Practitioner trainer, with a Pacific cultural background, was recruited from the National Training Service to help develop and facilitate the training. Both Enua Ola and HVAZ providers and coordinators recruited champions from their community groups.

Four training workshops were held on Saturdays in November 2018: two groups each for HVAZ and Enua Ola groups. Overall, 73 Smokefree champions completed the training, 37 from Enua Ola and 36 from HVAZ. The local stop smoking services – Ready Steady Quit (RSQ) delivered by ProCare PHO and The Fono provided information about their smoking cessation services including the process of referring smokers to the quit services and the DHB-funded incentives program for pregnant women.
At the completion of training, the champions were given a “Smokefree Champion Tool Checklist” including Smokefree Best Practices Principles for each group to implement in their environment. Implementation of this checklist helped the champions to maintain their interest and momentum from the training and increase referrals from churches and community groups. The Enua Ola/HVAZ contracts for 2018-2019 have been varied to require each group to train smokefree champions.

A survey was undertaken at the end of each training session, and the majority of the participants provided positive feedback on the training content and delivery of the training approach.

### 3.1.5 Preliminary results of the training programme

In the month following the completion of the training, two kava groups from the Tongan community have invited RSQ - The Fono smoking cessation practitioners to support the kava groups to become smoke free. Currently The Fono is in the process of customising how they work with, and support, the Pacific champions to provide stop smoking groups to Pacific churches/community within Enua Ola and HVAZ. RSQ – The Fono has agreed to offer 20 group based treatment programmes to Pacific churches/community within Enua Ola and HVAZ and will provide a $500 incentive award to each church/group to organise a seven week, Group Based Treatment quit group for their smokers. This programme may be delivered at a venue of choice and supported by The Fono quit coaches. They have also agreed to offer referral incentives to the 73 smokefree champions at $20 referral fee payment per eligible referral and $30 for the referral of a pregnant woman.

This training already has had an impact beyond the Enua Ola and HVAZ program. The Tongan Methodist Vahefonua (governance) has requested that the DHB provide support to develop and implement a Smokefree Policy for all their Tongan Methodist churches and smoking cessation support for members to quit.

### 4. Child, Youth and Women’s Health

#### 4.1 Immunisation

##### 4.1.1 Immunisation Health Target

For the second quarter in a row, Auckland DHB has achieved the Immunisation Health Target with 95% of babies fully vaccinated by eight months of age. There remains an equity gap, with both Māori and Pacific coverage reducing over this quarter (84% and 94% respectively).

Waitemata DHB coverage remains stable, but did not reach the health target for Q2 2018/19, achieving 92%, however it continues to exceed the national average of 91%. The previous improvement in Pacific coverage has not been sustained, falling to 94% over this quarter. In contrast, the Waitemata DHB coverage for tamariki Māori has been trending upward, now reaching 88.2%. The decline rate for Māori is improving slightly. A Māori focused work programme continues with the aim of eliminating the equity gap. In the co-design project with Te Whānau o Waipareira, consumer testing of concepts for promoting immunisation has been completed. Final changes are now being made.

Following the trial of an outreach immunisation (OIS) collaboration one day per week with Plunket, both Auckland and Waitemata DHB have entered a contract with Plunket for on-going provision. This service started in November 2018 and is in addition to the existing OIS programme hosted by HealthWEST. This combined WCTO health support worker and nurse vaccinator service offers an additional outreach immunisation option alongside well child information for Māori and Pacific whānau who have not yet engaged with OIS.
New Zealand research has demonstrated that early enrolment with a general practice is associated with on-time immunisation. Auckland DHB and Waitemata DHBs continue a programme of work with PHOs to improve early enrolment for infants. The DHB conducted an audit of all babies born in May 2018 – checking PHO enrolment status at 3 months and then at 5 months of age. The results were presented to PHOs and the NIR/OIS in a workshop in December. Geographical analysis has identified some areas of lower enrolment. PHOs are currently seeking appropriate practices in those localities to trial a supported enrolment pathway. The audit findings will inform strategies for refining business processes and follow-up of children.

The Ministry of Health has signalled a move in emphasis expecting that in 2019/20 DHBs will contribute to child wellbeing and healthier populations by establishing innovative solutions to improve and maintain high immunisation rates at all childhood milestones from infancy to age 5 years. The NCHIP programme of work is well placed to enable quality improvements for all infants from 0 to 6 years of age.

4.1.2 Mumps catch up programme
The school based MMR vaccine catch up programme has now been completed across both Auckland and Waitemata (Counties Manukau did not run a school based programme). The programme was taken up by 14 of out 15 low decile schools across Auckland and Waitemata.

The Waitemata programme in 5 high schools operated between October 2017 and May 2018. A total of 1,501 MMR vaccinations were provided, including to alternative education students. Overall 29% of the eligible population in the 5 schools were vaccinated through the programme.

The Auckland DHB programme provided 3,608 MMR vaccinations in 9 high schools during 2018. This resulted in an increase of at least 1 dose of MMR from 28% to 59% of the eligible students. Students still needing the second dose of MMR were referred on to their GP for follow-up.

Lessons learned from the Waitemata DHB programme were invaluable in implementing the Auckland DHB programme and the Auckland MMR catch up programme was a finalist in the Auckland DHB Health Excellence Awards.

4.1.3 Antenatal Immunisation
Auckland DHB has funded a new opportunistic vaccinating nurse role based within the DHB’s antenatal clinic, where a large proportion of attendees are Māori and Pacific women. The service began in Q2 at the Greenlane Clinical Centre site. The team has already immunised over 90 women as well as providing education for mums-to-be on the importance of timely immunisation of their babies. There has been positive feedback from both women and midwives about the service. The service will soon be expanding to provide opportunistic immunisation at the Auckland City Hospital antenatal clinic.

4.1.4 Pertussis
Auckland Regional Public Health Service (ARPHS) data is now showing a second spike in the pertussis outbreak, with cases predominantly linked with Waitemata DHB school localities in the 1-4 year and 5-19 year cohorts. Of more concern, the under 1 year old case numbers have also increased. Primary care and communities have been alerted through ARPHS communication channels.

A DHB funded radio campaign planned for January is well timed to also raise awareness about how to protect against pertussis. The two week campaign on Flava, Niu FM and Mai FM, is designed to promote immunisation to Māori and Pacific families. This will also be supported by a social media post from a Mai FM presenter who has recently had her fourth child.
4.2 NCHIP

The project team is progressing the design phase to implement the National Child Health Information Platform (NCHIP) in the Northern region DHBs. NCHIP will provide a point-of-care view of each child’s progress through the universal health milestones from 0 to 6 years of age.

Consultation is underway with providers of the universal child health milestone services on the Auckland DHB and Waitemata DHB proposal to implement a shared coordination service hosted by the DHB to support the NCHIP platform. Other health professionals and communities are also welcome to provide feedback on the enhanced service model. The proposed name for the coordination service is the Child Health Information Link (CHIL) Hub. Feedback closes early February. The changes required will bring the NIR in-house under DHB management. The DHB is seeking feedback particularly regarding unintended consequences of change.

4.3 National Well Child Tamariki Ora Review

The Ministry of Health advised at the end of 2018 its intention to review Well Child Tamariki Ora (WCTO) services as part of the Prime Minister’s Child Wellbeing Strategy. The Review will look at what is currently meeting the needs of children and their families, identifying what’s working well and what we need to improve. The Ministry intends to co-lead the Review with DHB partners and Māori, to strengthen Tamariki Ora services. The Review will include input from WCTO providers and other agencies, including the Ministry of Education and Oranga Tamariki.

Specifically, the following aspects of the WCTO programme will be assessed and redesigned:

1. WCTO Schedule – opportunities for improving the timing and content of WCTO contacts. This includes the Ministries of Health and Education working to align and integrate services to enhance school readiness.
2. Equity – addressing current access and outcome inequities and looking at opportunities to introduce a more proportionate response to address light to intensive needs while offering more choice when it comes to mode of delivery.
3. Funding and contracting – development of a funding formula to ensure fair allocation of funding across the service, and an outcome-based contracting framework that supports funding transfers between providers based on consumer demand and that can adapt.
4. Data and insights – The Review will look at the development of a national database and collection to include in the Integrated Data Infrastructure.

It is anticipated the Review will be concluded by December 2019 with implementation to follow. Regular updates will be provided as received.

4.4 Oral Health

Waitemata DHB has achieved the 95% enrolment target for children less than two years of age. The result of 103% is likely due to the actual birth population exceeding the census projection estimates. Auckland DHB did not quite achieve the 95% enrolment target. This is likely due to the portion of Auckland babies whose contact details were not available as they are born in Counties Manukau Health facilities. Recent improvements to standardise enrolment processes across the region are expected to improve the end of year result for Auckland DHB babies. Further work is continuing to understand why the Māori enrolment rate is so low.

A data matching process has occurred with two Māori Well Child Tamariki Ora providers, one in Auckland and the other in Waitemata. This has supported Auckland Regional Dental Service (ARDS) to identify many high needs children who were not enrolled with the oral health service. It has also allowed the services to work together to identify current contact details and improve oral health service utilisation. This process will be replicated with the other DHB funded Well Child Tamariki Ora providers.
There is still a significant difference in the utilisation rate for Māori and Pacific children, falling well below other ethnicities. A scorecard has been developed for each locality team leader which provides the opportunity to review the team’s plan and progress, and to provide support to the Team Leaders. Access to the newly-created ARDS Qlik Sense database has proven helpful for this exercise.

Planning for the implementation of the maternal oral health service in Tāmaki continues with the service expected to be implemented from 1 April 2019.

4.5 Youth Health
Regionally, Auckland DHB, Waitemata DHB and Counties Manukau DHB and provider partners have collaborated to develop a youth sexual health training package for DHB funded school nurses. This has been delivered for the first time this month.

The Ministry of Health confirmed funding for an increase in health services into decile 4 secondary schools during 2018. Work continues to achieve service commencement during the 2019 calendar year. In Auckland DHB, the teacher training component of an evidence-based mindfulness and resilience programme for pre-teens (intermediate school age) has been rolled out in January 2019. The group programme for students will be rolled out during term time this year.

4.6 Transgender Healthcare
The Planning, Funding and Outcomes (PFO) team hosted a project focused on improving access to gender affirming healthcare for transgender peoples for the northern region DHBs. The main body of project work is near completion, and moving into business as usual activities from January 2019. Highlights from the project include development of health pathways with e-referral and a central referral point for Metro Auckland, provider education, development of clinical guidelines, celebration of Transgender Awareness Week, establishment of services for youth (provided by the Centre for Youth Health (CfYH)) and improved specificity regarding services provided by Auckland Regional Sexual Health Services (ARSHS). A Peer Support Service for the Northern Region goes out to tender on 1 February 2019, with the intent to enter a contract for service delivery from 1 July 2019.

As the work moves to business as usual, the Advisory Group has been replaced by a Clinical Governance Group (CGG) led jointly by CfYH and ARSHS. The group will continue to have consumer representation, as well as plastics, mental health, and endocrine. Secretariat support and contact for the CGG is through Counties Manukau Health (CMH), with reporting to CMH CMO. The group is expected to consider and address issues such as equity of access, quality and consumer satisfaction with services. Planning and Funding representatives from both CMH and PFO will continue to have input.

For the 2017/18 FY year (1 July 2017 to 30 June 2018) a total of 269 initial assessments were completed at either Centre for Youth Health or Auckland Regional Sexual Health Service for Hauora Tāhine in Metro Auckland.

It is estimated that about 300 people per year will be referred to the Hauora Tāhine services in Metro Auckland, and 30 people per year to services in Northland.

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2 Initial assessments, rather than referrals, are used as a dataset that is most consistent and comparable between services.
This represents a continued rapid growth of referrals into the youth and adult services – in line with expectations, and with what has been observed in services. The ethnicity of patients is comparable to the population of the wider Auckland region.

Notes:
^Youth data represents total active cases for WDHB and ADHB only. CMH youth data is not included.
^Population Average is the average for the Auckland Region, Stats NZ, 2013 census. Respondants could indicate more than one ethnicity.

4.7 Maternity Services
Changes at maternity services at Auckland City Hospital have not resulted in a significant increase in post-natal transfers to Birthcare. The impact of changes will continue to be monitored.

The funder is working collaboratively with the communications team and the provider arm around developing an information campaign for women in pregnancy, SMILE. The key messages target third trimester care. Consumer testing of resources has been positive. SMILE’s key messages are Smoke and Alcohol Free, Mental health matters, Immunise, Lie on your side, Exercise and Eat Healthily.
4.8 Maternal and Infant Well-being Assessment and Proto-typing of an Intensive Wrap Around Service

Auckland DHB Commissioning Executive Leadership Team (CELT) approved seed funding for development of an electronic tool to support routine enquiry across a range of domains. Pregnant women and new mothers should routinely be asked about a range of psycho-social factors known to negatively impact on mothers’ and babies’ health and well-being.

A set of validated questions has been developed. Finalisation of the questions has been agreed between a stakeholder group from the Northern Region. Further development is required on a small sub-set of questions where validated tools do not currently exist. The questions will form the basis of the electronic tool, and the same questions will be implemented across other platforms (such as through an advanced form on MedTech) in order to achieve consistency. Responses to questions on the tool will support clinicians to identify appropriate levels of service, and highlight unmet need.

4.9 Healthy Housing

The Kāinga Ora (Healthy Housing) service has a priority focus on pregnant women and those with young babies. As at December 31 2018, Auckland and Waitemata DHBs have received 1,413 referrals to Kainga Ora. 5,872 family members have had access to healthier home interventions. Of the referrals received 438 were for families where there was a newborn baby or hapu woman. As part of the social work interventions, these women may be referred to smoking cessation services or immunisation, amongst other interventions such as entitlements available through the Ministry of Social Development. Kāinga Ora is contributing data for the national HHI evaluation which is being conducted by He Kainga Oranga research unit of Otago University and has been commissioned by the Ministry of Health, Housing New Zealand and the Ministry of Housing and Urban Development.

4.10 Cervical and Breast Screening

An initiative to invite women to enrol in the Breast Screening programme is in progress as part of the Māori Health Pipeline. Sharing information from primary care to systematically invite women into the Breast Screen service within their DHB will be trialled as a regional demonstration project to inform national learnings. Protocols for the trial have been agreed with the three Lead Providers in preparation for implementing the data match. Learning from the success of the initiative will inform future processes for improving systematic invitation to Breast Screening Aotearoa and can provide valuable information to the Ministry of Health for future development of a Breast Screen population register. The key focus of the programme is to improve enrolment and screening coverage for Māori women.

Our cervical screening coordination service supported two outreach cervical screening clinics in Helensville and Wellsford late last year. These partnership events focused on inviting Māori women to come and participate in cervical screening. Very positive feedback was gained from the partnering organisations and participants and engagement with women was very positive. Continuing to support this work in the Kaipara area is an ongoing objective of the service.

There is strong interest in the February cervical screening update at Alliance Health Plus, with 40 nurses registered. Collaboration from the National Cervical Screening Programme and DHB colposcopy services and others at these events is highly valued.
5. Health of Older People

5.1 Age Residential Care (ARC)
When DHBs negotiated the national Age Related Residential Care Agreement for 2018/19 it was confirmed with the sector that should the DHB New Zealand Nurses Organisation (NZNO) Multi-Employment Collective Agreement (MECA) settlement significantly exceed the 2% Aged Residential Care (ARC) price increase for 2018/19, then the parties would come back to the table to discuss how the flow on effects of MECA settlement could be managed for the ARC sector.

Based on the outcome of the MECA settlement these discussions have now taken place and DHBs have agreed to a further 0.43% price increase. This increase will be back dated to 1 July 2018 with a one-off lump payment calculated and paid to each ARC provider for the period 1 July 2018 till 28 February 2019. ARC prices will formally increase on 1 March 2019 and the maximum contribution rate paid by private payers will also increase at this time. It is noted that this increase is a partial contribution only to the impact and does not fully reinstate pre-settlement relativities. Notwithstanding the sector has indicated support for the 0.43% increase.

ARC providers in both Auckland DHB and Waitemata DHB have raised concerns about the significant challenges they are facing in recruiting and retaining registered nurses. The price increase will help to mitigate this issue but it is acknowledged that there are other factors also affecting the current shortage of registered nurses in the sector. Planning and Funding will continue to closely monitor this area.

5.2 Aged Residential Care Audits
The table below has the audits undertaken in quarter 1 and 2 of 2018/19 and the resulting corrective actions.

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<th>Quarter 1</th>
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<td>WDHB</td>
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<td>Average number of corrective actions / audit</td>
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<td>3</td>
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*audit report not yet received for 1/19 facilities
*audit reports not yet received for 3/14 facilities

Note: * 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)
To fully understand the current population receiving HCSS at Waitemata DHB and inform the development of the new model of care, data analysis has been undertaken. This includes data by ethnicity, age, average hours of service per week for the four current levels of need (low, medium, high, very high) and interRAI assessments. This information will be critical for the procurement documents when describing the population to future service providers.
The review of the cost model for the Auckland DHB HCSS case mix is near completion. The University of Auckland (Department of Accounting & Finance) has reviewed the costings submitted by providers for each level of the cost model:

1. Facility level – activities related to the infrastructure of the HCSS provider eg senior management, IT systems, payroll
2. Product sustaining level – activities including training, general management of service provision, quality control, contract invoicing
3. Batch level – activities including three monthly review of clients and coordination of support workers providing the service
4. Unit level – the costs of the support workers who provide the care.

Benchmarking (anonymised) of these costings across the four HCSS providers was discussed at workshop in January.

6. Mental Health and Addictions

6.1 Mental Health and Addictions Support Worker Pay Equity
The Mental Health and Addiction Support Workers (Pay Equity) Settlement Agreement (2018) was approved by Cabinet on 18 June 2018. Through 2018 the MoH Pay Equity team worked with DHBs, Funders and Providers nationally to determine worker eligibility for Pay Equity, to calculate Pay Equity payment for all eligible providers, and to incorporate pay equity into contracts. The MoH, on behalf of DHBs, made pay equity payments to eligible providers for the period 1 July 2017 to 30 November 2018.

As of 1 December 2018, all Auckland and Waitemata DHB contracts which were eligible for pay equity were varied to incorporate pay equity and contract price uplift, using what was described as a ‘bespoke’ contracting method. One of the consequences of this is that because pay equity was added into price, there are now inconsistent prices across providers within each DHB, for the same purchase units.

The next immediate stage of work, also led by the MoH, supported by a Technical Working Group, is to develop a reconciliation method to backdate contracts to 1 July 2018, to ensure correct contract price uplift is applied.

Future work groups will include a Devolution Steering Group (to devolve pay equity to DHBs) and a Phase 2 Working group led by DHBs, to address national consistency of price and service specifications.

6.2 Individual Placement Support (IPS) Waitemata DHB
IPS is an evidence-based practice that integrates employment and mental health services to support people with severe mental health conditions to find and stay in work. The Government’s 2017 Budget (through the joint initiative Oranga Mahi with the Ministry of Social Development and Treasury) provided funding to purchase up to 500 IPS places over four years to be provided by the Adult Mental Health Services at Waitemata DHB. We began a nine month prototype in June 2018 which runs through to February 2019, supporting up to 50 people aged 18-35 with severe mental health conditions (including schizoaffective disorders, and bipolar affective disorders) accessing community mental healthcare with Waitemata DHB.

While the evaluations of this prototype and its fidelity to the model are not due until March, early indications are that the Prototype has been successful. Consequently a competitive procurement process is underway to widen the initial Prototype to a full trial from 01 July 2019. The full trial will
expand IPS delivery across Waitemata, increasing client access to this employment support from 50 to 500 people over the coming 3-4 years.

6.3 Paired Up, Youth Peer Support Pilot Service
Paired Up is a peer led pilot support service located within Tamaki College, a decile 1 school in an area of high need. Following two suicides at the school in 2017, Auckland District Health Board commissioned the pilot service to increase resilience and coping skills of youth at the school. The pilot was initially commissioned for one year and included an evaluation as part of service delivery. This evaluation is due to be delivered in February. Early indications show the model has been effective, particularly at engaging Māori and Pacific Island youth who have no contact with other support services. As such, further funding has been agreed by the DHB to continue Paired Up delivery for a second year. This will allow additional time for evaluation at the same time as ensuring consistency of support to a highly marginalised cohort of the Auckland community who are not presently engaged with other services.

6.4 Integrated Detox Services with Community Alcohol and Drug Service (CADS) and Auckland City Mission
Mission HomeGround, the Auckland City Mission rebuild initiative in Hobson Street, is progressing to plan with demolition of the existing building completed, and detailed design and building consent lodgement processes nearing completion. From October 2020, the upgraded complex will provide:

- Social (15 beds) and medical detox services (10 beds) in conjunction with Auckland and Waitemata DHBs, increasing the service in Auckland by 50%
- 80 affordable homes that are safe and secure with 24-hour support
- Integrated social services with a fit-for-purpose crisis care facility, allowing for physical and mental healthcare, social services and dental care to be delivered under one roof
- A new community commercial kitchen
- A public space for activities including art, carving and drama classes with therapeutic effect as well as social events, conference facilities and social enterprise opportunities.

In early February, key Auckland City Mission personnel are scheduled to meet with key Waitemata DHB personnel to begin planning for the shared operational and change management activity to be carried out prior to the new building’s opening to ensure streamlined service integration between the providers. This is a significant piece of work. The master plan produced at this workshop will identify the necessary workstreams and working groups, and prioritise delivery to ensure the October 2020 go live date can be met.

In addition to this, the Northern Regional Alliance (NRA) has been engaged to review the Auckland region’s current end to end detoxification service – from acute through to home-based care. This work has three key delivery phases:

- A literature review to identify what best practice recommends for the region
- A gap analysis to identify where the service currently falls short of best practice
- Working with the service to identify how the gaps can be closed and where the refreshed services should be located

The project continues to keep communication channels open with impacted CADS staff and their union delegates.

7. Māori Health Gain
A standalone update paper has been provided in this agenda.
8. Pacific Health Gain

8.1 PHAP Priority 1 – Children are safe and well and families are free of violence
The Pacific Team and Child Health Team are working closely with Wai Health and AH+PHO to improve family engagement in the Positive Parenting and Active Lifestyle for children programme and to build our collective knowledge about what works well for the families.

8.2 PHAP Priority 2 – Pacific People are smoke-free
The Pacific and Primary Care Teams organised and implemented Four Community Champions Smokefree Training sessions in November 2018. The Ready Steady Quit Teams from Procare and The Fono presented at each session. A total of 73 community representatives from HVAZ and Enua ola completed the training. A positive outcome of the training was an agreed action plan which is to be completed by the representatives in 2018/2019. (Please refer to the Primary Care team update for a full briefing of the training).

8.3 Priority 3 – Pacific people are active and eat healthy
The New Zealand Institute of Sport Personal Trainer Level 4 course is now complete. The 14 community members from HVAZ & Enua Ola who attended the programme are now delivering community fitness programmes in council parks, such as Cornwall Park, Mangere Bridge Park, community, and church halls. These sessions are open to the public. Some community members are working with other church denominations that are not part of HVAZ and Enua Ola programmes that have asked for support. The programmes are developed and tailored according to the need and health conditions of participants. The Pacific language and cultural skills of the community members has enabled them to work with different individuals and groups of people.

8.4 PHAP Priority 4 – People seek medical and other help early
Three workforce development workshops for Parish community nurses has been organised for March, April and June 2019. The Pacific Team is working together with Abel Smith and Celeste Gilmer (Primary Health Care Nursing Development Team WHDB) and providers (AH+, Procare, Langimalie, The Fono) to implement the recommendations from the inaugural workshop held in October 2018.

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
Continue to work on the actions from the Asian, migrant and refugee health plan 2017-2019 which include raising awareness about the NZ Health and Disability System by working closely with our key stakeholders and tertiary education providers (orientation days).

We are partnering with The Asian Network Incorporated (TANI) to have a Health Stand at the 2019 Chinese New Year festival and Market Day at ASB Show grounds (Saturday, 2 February). It is a major event for the Chinese, South East Asian and migrant communities. Information will be made available for participants to familiarise themselves with local health services and PHO enrolment.

We are working with the ADHB Participation and Experience Team supporting their ‘Whānau Room Re-design Project’ across the ADHB facilities to better engage with and encourage Asian, new migrant and former refugee communities to participate in the consultation process.

We are supporting Mercy Hospice setting up a steering group of interested parties to advise on creating Palliative Care information resources for the Asian, former refugee and new migrant communities.
The Hon. Jenny Salesa, Associate Health Minister and Minister for Ethnic Communities visited Waitemata DHB and had a special meeting with the PFO Asian, Migrant and Refugee Health Gain and WDHB Asian Health Services representatives on 21 Nov 2018.

We delivered a presentation on Waitemata DHB’s responsiveness towards Asian, migrant and ethnic communities. Waitemata DHB has the largest Asian health service and the Minister acknowledged our unique and comprehensive service delivery model. The Minister was also impressed by the improvement of Asian women’s breast screening rates over the years. The Office of Ethnic Communities (OEC) and Asian Health Services have been working together to share ethnic specific information and to promote health and wellbeing to ethnic communities.

The cervical screening coverage rate is 51.6% as at September 2018. We invited Well Women and Family Trust to present to the Auckland Regional Asian and MELAA Primary Care Working Group at the October meeting. This provided an opportunity to better understand the challenges and barriers as to why we are seeing low levels of participation in this programme by Asian women however we note that although there is low coverage there is no current outcome inequity (cervical cancer incidence) for this group: Asian women have the lowest cancer incidence of all ethnic groups.

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

The third Refugee Health Forum to primary care health professionals in 2018 was recently held on 1 November on the topic: ‘Family Harm’ — looking at ways professionals can address these issues in their daily work and provide culturally safe support. We invited subject matter experts to talk about Family Harm and share case studies. Speakers included Senior Sergeant Sharon Price from Counties Manukau Police, Zoya Kara and Shehana Hassan from Sahaayta Counselling and Support Services and Arpita Das from Shakti Community Council. Around 60 people attended the Forum. Feedback was positive and encouraging. The Auckland Regional Refugee Health Network Executive Network is meeting on 19 February to plan the 2019 Forums.