Community and Public Health Advisory Committees Meeting

Wednesday 15 May 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.
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

Board chairs:
Judy McGregor – Ex-officio as WDHB Board Chair
Pat Snedden – Ex-officio as ADHB Board Chair

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

Apologies:

AGENDA

Karakia

Acknowledgements

Disclosure of Interests
- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that might give rise to a conflict of interest with a matter on the agenda?

Items to be considered in public meeting

1. AGENDA ORDER AND TIMING

2. CONFIRMATION OF MINUTES

10.00am 2.1 Confirmation of Minutes of the meeting held on 20/02/19
Actions Arising from previous meetings

3. DECISION PAPER

4. INFORMATION PAPER

10.10am 4.1 Auckland Regional Public Health Service Update
10.25am 4.2 Pacific Health Update
10.40am 4.3 Pacific Health Snapshot in the Auckland Region

5. STANDARD REPORTS

10.55am 5.1 Planning, Funding and Outcomes Update
- Executive Summary
- Planning
- Primary Care
- Child, Youth and Women
- Health of Older People
- Mental Health and Addictions
- Māori Health Gain
- Pacific Health Gain
- Asian, Migrant and Refugee Health Gain

6. GENERAL BUSINESS

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 15/05/19
## Auckland and Waitemata District Health Boards
### Community and Public Health Committees
#### Member Attendance Schedule 2019

<table>
<thead>
<tr>
<th>NAME</th>
<th>February</th>
<th>May</th>
<th>August</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharon Shea</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max Abbott</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Judith Bassett</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edward Benson Cooper</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoe Brownlie</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandra Coney</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warren Flaunty</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matire Harwood</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lee Mathias</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robyn Northey</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allison Roe</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### REGISTER OF INTERESTS

<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
</tr>
</thead>
</table>
| Max Abbott       | Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology  
Patron - Raeburn House  
Advisor - Health Workforce New Zealand  
Board Member, AUT Millennium Ownership Trust  
Chair - Social Services Online Trust  
Board member - Rotary National Science and Technology Forum Trust | 19/03/14     |
| Judith Bassett   | Shareholder - Fisher and Paykel Healthcare  
Shareholder - Westpac Banking Corporation  
Husband - Fletcher Building  
Husband - shareholder of Westpac Banking Corporation  
Granddaughter - shareholder of Westpac Corporation | 20/02/19     |
| Edward Benson-Cooper | Chiropractor - Milford, Auckland (with private practice commitments)  
Edward has three (different) family members who hold the following positions:  
Family member; Radiology registrar in Auckland Radiology Regional Training Scheme.  
Family member; FANZCA FCICM. Intensive Care specialist at the Department of Critical Care Medicine and Anaesthetist at Mercy Hospital. | 25/03/19     |
| Zoe Brownlie     | 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 | 26/06/18     |
| Sandra Coney     | Member - Waitakere Ranges Local Board, Auckland Council  
Patron - Women’s Health Action Trust  
Member - Portage Licensing Trust  
Member - West Auckland Trusts Services | 15/12/16     |
| Warren Flaunty   | Member - Henderson-Massey Local Board Auckland Council  
Trustee (Vice President) - Waitakere Licensing Trust  
Shareholder - EBOS Group  
Shareholder - Green Cross Health  
Director - Life Pharmacy Northwest  
Chair - Three Harbours Health Foundation  
Director - Trusts Community Foundation Ltd  
Trustee - Hospice West Auckland (past role)  
Shareholder – Genesis Energy | 12/09/18     |
| Dr Matire Harwood | 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 | 10/05/18     |
| Lee Mathias      | Chair - Health Innovation Hub (until the end of the Viclink contract in line with the director appointment)  
Chair - Medicines New Zealand | 20/02/19     |
<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
</tr>
</thead>
</table>
| Robyn Northey    | 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)  
Chair - Collective Hospitality Group  
Director - Orakei Estates Limited  
Shareholder of Fisher & Paykel Healthcare  
Shareholder of Oceania  
Husband - member Waitemata Local Board  
Husband - shareholder of Fisher & Paykel Healthcare  
Husband - shareholder of Fletcher Building  
Husband - Chair, Problem Gambling Foundation  
Husband - Chair, Community Housing Foundation | 05/07/17 |
| Sharon Shea      | Chair - Maori Expert Advisory Group, Health and Disability Systems Review  
Principal - Shea Pita Associates Ltd  
Provider - Maori Integrated contracts for Auckland and Waitemata DHBs  
Provider - Hapai Te Hauora  
Board member - Alliance Health Plus  
Iwi Affiliations: Ngati Ranginui, Ngati Hine, Ngati Hako and Ngati Haua  
Sub-contractor - Te Ha Oranga/Te Runanga o Ngati Whatua  
Director - Healthcare Applications Ltd  
The Moko Foundation – contractor for a youth mentoring project  
Impact Research Ltd – contractor for health and social service research projects  
Director Manawaroa Ltd – a company that specialises in tamariki, youth and whanau resilience building  
Husband - Part owner Turuki Pharmacy Ltd, Auckland  
Husband - Board member - Waitemata DHB  
Husband - Director Healthcare Applications Ltd | 20/02/19 |
| Allison Roe      | Chairperson - Matakana Coast Trail Trust  
Member - Rodney Local Board, Auckland Council  
Member - Wilson Home Committee of Management (past role) | 22/08/18 |
| Judy McGregor    | Associate Dean Post Graduate - Faculty of Culture and Society, AUT  
Member - AUT’S Academic board  
New Zealand Law Foundation Fund Recipient  
Consultant - Asia Pacific Forum of National Human Rights Institutions  
Media Commentator - NZ Herald  
Patron - Auckland Women’s Centre  
Life Member - Hauturu Little Barrier Island Supporters’ Trust | 28/03/19 |
| Pat Snedden      | Director and Shareholder - Snedden Publishing & Management Consultants Limited  
Director and Shareholder - Ayers Contracting Services Limited  
Director and Shareholder - Data Publishing Limited  
Trustee - Recovery Solutions Trust  
Director - Recovery Solutions Services Limited  
Director - Emerge Aotearoa Limited and Subsidiaries  
Director - Mind and Body consultants Ltd  
Director - Mind and Body Learning & Development Ltd  
Shareholder - Ayers Snedden Consultants Ltd  
Executive Chair - Manaiakalani Education Trust | 09/10/18 |
<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chair - National Science Challenge Programme – A Better Start</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chair - The Big Idea – Not-for-profit-trust</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director - Te Urungi o Ngati Kuri Ltd</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director - Wharekapua Ltd</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director - Te Paki Ltd</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director - Ngati Kuri Tourism Ltd</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director - Waimarama Orchards Ltd</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chair - Auckland District Health Board</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director - Ports of Auckland Ltd</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Board member - Counties Manukau DHB</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chair - Counties Manukau Audit, Risk and Finance Committee</td>
<td></td>
</tr>
</tbody>
</table>
Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act 2000, a member of a DHB Board who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member’s knowledge, disclose the nature of the interest to the Board.

A Board member is interested in a transaction of a DHB if the member is:

- a party to, or will derive a financial benefit from, the transaction; or
- has a financial interest in another party to the transaction; or
- is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is (i) the Crown; or (ii) a publicly-owned health and disability organisation; or (iii) a body that is wholly owned by 1 or more publicly-owned health and disability organisations; or
- is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or
- is otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out responsibilities, then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

A board member who makes a disclosure as outlined above must not:

- take part in any deliberation or decision of the Board relating to the transaction; or
- be included in the quorum required for any such deliberation or decision; or
- sign any document relating to the entry into a transaction or the initiation of the transaction.

The disclosure must be recorded in the minutes of the next meeting and entered into the interest register.

The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if a majority of other members of the Board permit the member to do so. If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

Board members are expected to avoid using their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducement and which could compromise the Board’s integrity.

IMPORTANT

Note that the best course, when there is any doubt, is to raise such matters of interest in the first instance with the Chair who will determine an appropriate course of action.

Ensure the nature of the interest is disclosed, not just the existence of the interest.

Note: This sheet provides summary information only.
2.1 Minutes of the Community and Public Health Advisory Committees meeting held on 20 February 2019

Recommendation:

That the Minutes of the Community and Public Health Advisory Committees held on 20 February 2019 be approved.
Draft Minutes of the Meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 20 February 2019

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 10.00a.m.

Items considered in Public Meeting

COMMITTEE MEMBERS:

Sharon Shea (Committee Chair - ADHB Board member)
Max Abbott (WDHB Board member) (present from 10.05 a.m.)
Judith Bassett (ADHB Board member)
Edward Benson-Cooper (WDHB Board member)
Zoe Brownlie (ADHB Board member)
Sandra Coney (WDHB Board member) (present from 10.17a.m.)
Warren Flaunty (Committee Deputy Chair - WDHB Board member)
Lee Mathias (ADHB Board member)
Robyn Northey (ADHB Board member)
Allison Roe (WDHB Board member)
Judy McGregor (WDHB Board Chair) (ex-officio) (present 10.18 a.m. - 11.45 a.m.)

ALSO PRESENT:

Dale Bramley (WDHB Chief Executive Officer) (present 10.18 a.m. - 11.45 a.m.)
Ailsa Claire (ADHB Chief Executive Officer)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Karen Bartholomew (ADHB and WDHB, Acting Director Health Outcomes)
Tim Wood (ADHB and WDHB, Deputy Director Funding)
Meg Poutasi (ADHB Chief Strategy, Participation and Improvement)
Stuart Jenkins (ADHB and WDHB, Clinical Director, Primary Care)
Shayne Wijohn (Maori Health Gain Manager)
Joy Christison (Project Manager, Primary Care)
Paul Garbett (WDHB Acting 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:

Sue Claridge (Co-ordinator, Auckland Women’s Health Council)
Tracy McIntyre (Waitakere Health Link)
Kirsty Gover (Health Link North)
Mark Vella (Total Health Care)
Kate Moodabe (Total Health Care)
Gaylene Sharman (Whanau Ora Manager, HealthWest)

KARAKIA:

The Committee Chair opened the meeting with the karakia.
WELCOME:
The Committee Chair welcomed those in attendance to the first CPHAC meeting of the year. Public representatives and staff attending were introduced to the Committee.

APOLOGY:
Apologies were received from Matire Harwood and from Max Abbott and Sandra Coney for late arrival.

DISCLOSURE OF INTERESTS:
In regard to the Register of Interests:

- Lee Mathias advised that she was no longer Chair of the Health Promotion Agency.
- Judith Bassett advised that she was no longer a Trustee of the A+ Charitable Trust and that her daughter was no longer employed by Auckland DHB.
- Sharon Shea had recently advised of the following new interests for the Register:
  1. The Moko Foundation – contractor for a youth mentoring project.
  2. Impact Research Ltd. – contractor for health and social service research projects.
  3. Director Manawaroa Ltd – a company that specialises in tamariki, youth and whanau resilience building.
- Judy McGregor had recently advised of the following changes for the register. She was no longer Head of School of Social Sciences and Public Policy, Auckland University of Technology (remains Associate Dean Post Graduate, Faculty of Culture and Society). A new interest to be added to the Register is Director of Health Partnerships Ltd.

ACKNOWLEDGEMENTS:
The Committee Chair acknowledged Matire Harwood’s appointment as Associate Professor.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 21 November 2018 (agenda pages 7-18)

Resolution (Moved Zoe Brownlie/Seconded Allison Roe)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 21 November 2018 be approved.

Carried

Matters Arising (agenda page 19) The schedule was noted.
In answer to a question re Healthy Families, Tim Wood advised that Healthy Families is managed and funded directly by the Ministry of Health. Planning and Funding have good relationships with Healthy Families and try to be cognisant of the work they do. Rebecca McCarroll noted that Healthy Families are a key stakeholder in the Healthy Auckland Together (HAT) alliance and that there were close working relationships on key areas of commonality such as in the area of child obesity and the promotion of water in schools and communities.

3. DECISION PAPERS

There were no decision papers.

4. INFORMATION ITEM


Rebecca McCarroll (Public Health Dietician) was present for this item and introduced the report. Matters that Rebecca highlighted included:

- In a related area that the Committee had previously expressed an interest in, the Wai Auckland project had now surveyed all of the drinking fountains around Auckland. They had found 96 fountains of which three were vandalised, 70% drinkable and 66% clean. An addition to the Council app had been prepared based on the information gathered. The Wai Auckland team is now working with Auckland Council and local boards on infrastructure improvements.
- The implementation plan for three Auckland metro DHBs for the National Healthy Food and Drink Policy is on track and going well and is a national exemplar.
- Work has been done to address the gap identified with healthy food environments in and around early childhood centres, with a dietitian contracted to improve their food environments. They are supporting kohanga reo as well.

Matters covered in discussion and response to questions included:

- Rebecca McCarroll advised that with nutrition, there is a good connection with Healthy Families. They are working with them on a number of programmes and providing support. For example, for events like the Pasifica Festival, they are helping them to change the type of food provided.
- With implementing the National Healthy Food and Drink Policy, they are working towards 80% of schools having a policy, however going forward they would like to reach 100%. The objective of 80% had only been set one year previously, but they had made significant progress. The best method is to get an advocate within the school and then build a relationship with that person. The emphasis is on Decile 1 to 4 schools.
- Max Abbott noted a general frustration he had (not related specifically to this report) about some targets that are set by the Ministry for which it would not be too difficult to do final outcome studies to see if they had achieved what was anticipated.
- As noted in the report, after training on having conversations with families with overweight children, 98% of health professionals trained had identified an increase in confidence. Rebecca noted that there had been a lot of misunderstanding in this group of health professionals about nutrition previously.
Ailsa Claire commented that it feels like that this is a programme that is starting to work and that it was important to build on the gains.

10.17a.m. – Sandra Coney present.
10.18a.m. – Judy McGregor and Dale Bramley present.

- With the Enhanced School Based Health Services (ESBHS) schools, dieticians are working with the schools to design workshops. These schools had large numbers of Maori and/or Pacific students and were low decile. This work is funded until the end of June.
- Karen Bartholomew commented that the joint bariatric service project had been in place for a number of years. Auckland DHB had undertaken a change process based on patient experience and analysis of key steps in the pathway through the service. Preliminary data for the last 12 months suggests that there is no longer inequity in terms of completion of surgery by ethnicity. Waitemata DHB was looking at the service changes made and where alignments could be made. Ailsa Claire advised that at Auckland DHB they had been looking at how the service achieved that outcome as there should be learnings for the rest of the organisation. Learnings from the achievement are of immense interest to the rest of the organisation. Karen Bartholomew, the service and others involved were congratulated on the Auckland DHB outcome.
- With regard to the comment in the conclusion of the report “… it is important to recognise that broader societal and environmental factors need to be harnessed to shift the population as a whole to a healthier weight”, Rebecca McCarroll noted that some exciting things are happening nationally in terms of healthy food policy and they were hoping for more national leadership. In the meantime they would continue work to improve the environment as laid out in the implementation plan.
- The importance of being more proactive pushing public health policy issues such as sugar, fast food and how these things were advertised was emphasised. Examples such as advertising during children’s television programmes were discussed. It was noted that the problem with complaints to the Advertising Standards Authority was that they were usually “after the horse has bolted”. It was agreed that for its report to the next CPHAC meeting, ARPHS be asked to update the Committee on this issue and bring forward a recommendation. It was also noted that attempts to date to get radio and television channels to sign up to standards on this had been knocked back, but it might be worthwhile contacting social media influencers.
- It was also agreed that for its report to the next CPHAC meeting ARPHS be asked to comment on the Auckland Council partnership and what might be achievable through that in terms of the Healthy Weight Action Plan.

Rebecca McCarroll was thanked.

The report was received.

4.2 Community Based Diabetes Care Programme Update (agenda pages 34-65)

Tim Wood, Eirean Gamble (Programme Manager, Primary Care) and Joy Christison (Project Manager, Primary Care) presented this item.

Tim Wood introduced the report. Matters that he highlighted included:
• The programme is very much a collaborative effort involving clinical teams, general practitioners, nurses, programme managers and administrators, DHBs and PHOs. The programme has a strong equity focus.

• The programme has five key components as listed on page 35 of the agenda.

• Firstly, there is the use of co-design processes to design and trial a system of diabetes care that improves outcomes for people living with diabetes. As a trial they are trying to find ways (initially in four general practices) to better engage people in diabetes care. If it is successful, the challenge will be how to spread the approach throughout primary care.

• Secondly, there is the Retinal Screening Programme. This had been delivered differently by the two DHBs. Waitemata DHB worked through two PHOs and one NGO to deliver a community service. Auckland DHB had a Provider Arm delivery service. Both approaches achieved about 60% coverage, but the need is to get to 90%. The new service model is detailed on pages 43-44 of the agenda and the Auckland and Waitemata Funder is now in an advanced stage of developing an implementation plan to deliver this new model. A key component is to provide the service at locations regarded as trusted, familiar and accessible to Maori and Pacific people. Part of the new approach involved stratifying high risk patients. Strong clinical governance is being set up overseen by ophthalmologists.

• Thirdly, there is the initiative to lift the standard of foot care services for those people with diabetes. They had found that at GP level, there is a gap in nursing knowledge to provide this service. Podiatrists also don’t have a continuing education programme and have variable skill sets. They have employed a senior podiatrist to develop a programme to try and get general practice teams and community podiatrists to up-skill.

• Fourthly, there is the work to repurpose diabetes care improvement package (DCIP) funding. Time had been spent with the PHOs revamping how this money is targeted so that it aligns with the broader diabetes programme. The PHOs present their plans to the diabetes service alliance, for review and feedback. The key point is that there is reporting back on performance and activity.

• Fifthly, Waitemata DHB has partnered with Auckland University to do a large trial of a text based service for people with diabetes; to see if that can help in better managing their conditions. Patients can opt to receive those modules that they consider will be of most benefit to them. The service has had positive impact and been well received. Messaging had been available in Maori, Pacific or non-Maori/Pacific cultural versions. They were in the final stages of preparing a business case for Waitemata DHB and Auckland DHB.

• With regard to the diabetes performance framework, the first five indicators were up and running and routinely recorded across most groups. They were also entering into discussions with the Provider Arm services to understand what indicators would be useful to determine specific areas of performance.

Matters covered in discussion and response to questions included:

• PHOs are funded to send diabetes patients to a selected number of podiatrists (not to any podiatrist).

• In answer to a question about disconnect between patient view and health professional view, Tim Wood advised that there had been a lot of feedback from Maori and Pacific diabetes patients that they had not really been listened to, for example there was a lack of recognition of what food means in Pacific culture. They were told to lose weight, exercise etc. but practitioners were not listening to what was important for the patient and what might work for them.
• Edward Benson-Cooper asked that in reports, when cultural misunderstanding is referred to, examples be provided to help those reading to properly understand what is being referred to. This was supported. Meg Poutasi gave an example of the importance of breaking bread as part of hospitality in Samoan culture. Gaylene Sharman talked of the importance of kai in Maori culture; sharing of food shows your mana and it does matter what type of food. Later in the meeting Lee Mathias advised that there was a good paper in Pacific Beats explaining the relationship between food and culture. (A copy will be obtained for members’ information and included in the Diligent Boardbooks Resources section.)

• In answer to a question, it was noted that generally Asian health is amongst the best in the region however there is an issue with type 2 diabetes and gestational diabetes for Chinese and Indian populations.

• With regard to the gap between the Ministry of Health virtual diabetes register (VDR) and the PHOs’ register of people with diabetes, the gap has closed quite a bit. PHO figures are based on numbers going to GPs and there is now a strategy to engage with those not enrolled. The PHOs have been asked to consider how they can close the enrolment gap, by making going to a GP more attractive. Ailsa Claire said they are trying to look at how when anyone comes into contact with the health system, enrolment with a GP could be facilitated.

• Tim Wood advised that with rest homes, many of the GPs providing services do enrol those patients; a small proportion don’t. They are reasonably confident that the rest home population is covered.

• Mark Vella (Total Health Care) suggested that to increase enrolment, there may be a need to look at steps to incentivise, including lower fees, extended hours and other ways to encourage access.

• Judy McGregor advised that at a meeting with DHB Chairs and CEOs, the Minister of Health had criticised diabetes management at Auckland and Waitemata DHBs. The Committee agreed to her suggestion that a letter be sent to the Minister enclosing this report. Tim Wood also advised that a team from the Ministry is visiting in March when they would go through the diabetes programme with them.

• New technology enabling continuous glucose monitoring was raised by Lee Mathias. There had been a trial in Canterbury, that had raised expectations for those involved, but they could only continue if they self-fund, which many patients could not afford. Tim Wood advised that he understood this was for type 1 diabetes, but that he would look into it. It was noted that Pharmac fund medical devices including glucose test equipment nationally.

• Lee Mathias referred to an article the previous week in NZ Doctor where diabetes specialist Rick Cutfield had referred to good results from several medicines not available in New Zealand. Tim Wood noted that medicines access is a Pharmac decision making process, but that he would clarify the points raised by Rick Cutfield.

• With regard to co-design, Tim Wood advised that the co-design process (outlined on pages 38-39 of the agenda) is very robust.

• Dale Bramley expressed his appreciation to the team and primary care for delivering some of the work that he had been hoping to see for many years, and that this report highlighted the nationally leading approach including the use of funnel plots to understand variation and take a quality improvement approach. It is important to identify those people with diabetes who are doing really well and understand what has happened to them. Likewise to identify those who are struggling and need support most. It should be highlighted from the indicators at
the back of the report that in this field, inequity for Maori and Pacific had been largely eliminated in several of the indicators. He acknowledged Primary Care colleagues for a huge amount of work.

- The Committee Chair asked that for the next time there was a report on diabetes thought be given as to whether they had got the accountability measures right.

The report was received.

4.3 Planning and Funding Maori Health Update (agenda pages 66-73)

Shayne Wijohn was welcomed to his first CPHAC meeting as interim Maori Health Gain Manager.

Shane introduced the report. He highlighted Section 2.1 of the report – the hui held in December 2018 and the agreement on the formation of a northern governance partnership and a southern governance partnership (detailed on pages 66-67 of the agenda). The conversation in December included looking at defining what partnership means from an iwi perspective. Around the country such partnerships had generally been advisory; now there is an opportunity to look at capacity for partnership to make decisions on Maori Health Gain. The next stage in the process is engagement with iwi on the terms of reference and membership. For the northern partnership a further meeting will be held in early March.

Other matters that Shane Wijohn highlighted included:

- Work on the Regional (metro Auckland) Maori Health Plan (page 67 of the agenda). The Ministry of Health no longer provides guidance on what it wants to see in the Plan and so there is an opportunity to look at new priorities.
- Growing Maori health providers is a key project. One aspect of this is a clinical leadership group looking at improving recruitment and retention (detailed on page 69 of the agenda).

Matters covered in discussion and response to questions included:

- Judy McGregor noted the priorities for child health and mental health in the Minister of Health’s Letter of Expectations. She asked how it would be determined that as a result of increased funding that child health had improved. The aligned work on this currently being undertaken by the Office of Prime Minister and Cabinet, the Well Child Tamariki Ora review, the Mental Health Enquiry and the Families Commission was noted.
- There was a discussion about family violence programmes related to item 6.3 including the importance of this as a health issue and screening and referrals processes. Debbie Holdsworth commented that Waipareira is a MOU partner and that a range of service development was being co-developed on the basis of the joint Health Needs Analysis which is still in progress. The reference in the paper was not a complete picture and further detail would be provided to CPHAC.
- Mark Vella commented that Total Healthcare PHO offers three facilities to assist with family violence issues, concentrating on early intervention work and preventing family harm. 1,500 families had gone through the programme and there had been 90% non-recidivism. Funding had been provided by ACC. He was open to sharing the learnings. (This is being followed up with Mark by Debbie Holdsworth.)
Shayne Wijohn was thanked for the report.

5. STANDARD REPORT

5.1 Planning, Funding and Outcomes Update (agenda pages 74-90)

Debbie Holdsworth referred to the highlights in the Executive Summary on page 75 of the agenda. She also advised that the Minister’s Letter of Expectations would be put on the Boardbooks Resource Centre for members’ information.

Karen Bartholomew updated the report by advising that ARPHS is working on producing a submission and media release on Auckland Transport’s proposal for a bylaw change reducing urban traffic speeds.

Ruth Bijl was asked to comment on the discontinuation of the Auckland DHB breastfeeding community clinic and home visiting approach mentioned earlier in the agenda (page 23). Ruth advised that the problem had been that the programme had not effectively engaged with the Maori and Pacific population and the investment was being redeveloped to ensure benefits to those populations.

Ruth Bijl referred to the equity gap for Maori and Pacific for immunisation (detailed on page 80-81 of the agenda) and the ongoing focus and further measures being taken to try and address that.

In response to a question, Ruth Bijl advised that with the National Well Child Tamariki Ora review (page 82 of the agenda), the Ministry is trying to ensure that clinicians are feeding into the consultation process at a clinical level.

11.45a.m – Judy McGregor and Dale Bramley retired from the meeting.

Leani Sandford (Acting Manager Pacific Health Gain) was introduced to the meeting. Debbie Holdsworth advised that Lita Foliaki had retired. Lita’s work for Pacific Health over many years was acknowledged.

Leani Sandford advised that there is still work to do on the Pacific Health Action Plan, on which she would like to provide a fuller briefing to the next meeting. It was realised that the Pacific population is evolving and there is a need to dig deeper and look at how DHBs can respond in a different way. The Team is keen to work on this.

Auckland DHB was acknowledged for being the first DHB in New Zealand to be awarded the Rainbow Tick and the Accessibility Tick.

The meeting concluded at 11:52 a.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS’ COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 20 FEBRUARY 2019

_________________________ CHAIR
### Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 09 May 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>20/2/19</td>
<td>4.1</td>
<td>Healthy Weight Action Plan: Requests to ARPHS for its report to May CPHAC meeting: - Update on specific activities on advertising unhealthy food to children and discuss what further action on this issue could be developed. - Comment on Auckland Council partnership in HAT and activities related to the DHB activities under the Child Healthy Weight Action Plan.</td>
<td>Karen Bartholomew</td>
<td>CPHAC 15/5/19</td>
<td>See agenda item 4.1.</td>
</tr>
<tr>
<td>20/02/19</td>
<td>4.2</td>
<td>Cultural Understanding Obtain article in Pacific Beats explaining the relationship between food and culture, for members’ information and include in the Diligent Boardbooks Resource section.</td>
<td>Committee Secretary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20/02/19</td>
<td>4.2</td>
<td>Community Based Diabetes Care Programme - Letter with copy of agenda report to be sent to the Minister of Health. - Follow up with Canterbury researchers regarding the continuous monitoring device trial.</td>
<td>Tim Wood</td>
<td></td>
<td>Associate Professor Ben Wheeler, Paediatric Endocrinologist and member of the Edgar Diabetes and Obesity Research Centre has commenced a trial to assess the real-world effectiveness of flash glucose monitors (there is only one flash glucose monitor manufactured at the moment and this is called the Freestyle Libre) in adolescents (aged 13-18 years) with type 1 diabetes and a history of suboptimal glycaemic control. Consequently, this product is not ready for wide spread use.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Discuss recent report with diabetes specialist Rick Cutfield.</td>
<td></td>
<td>The recent report in the NZ doctor can be found at: <a href="https://www.nzdoctor.co.nz/hosted-content/dr-rick-">https://www.nzdoctor.co.nz/hosted-content/dr-rick-</a></td>
<td></td>
</tr>
<tr>
<td>Meeting</td>
<td>Agenda Ref</td>
<td>Topic</td>
<td>Person Responsible</td>
<td>Expected Report Back</td>
<td>Comment</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
<td>-------</td>
<td>--------------------</td>
<td>----------------------</td>
<td>---------</td>
</tr>
</tbody>
</table>
| 20/2/19 | 4.3        | Maori Health Update  
Update on broader family violence programme including approach with Maori providers. | Shayne Wijohn  
Ruth Bijl | | cutfield-oral-agents-type-2-diabetes  
This continuing education article and associated video discusses good diabetes management and touches on some new medications that are not currently funded. Dr Cutfield in the article and/or video does not call on PHARMAC to fund these new agents and acknowledges that they will provide benefit in a limited number of situations. |
4.1 Auckland Regional Public Health Service update

Recommendation:

That the Community and Public Health Advisory Committees:

   a) Receive this update from Auckland Regional Public Health Service.
   b) Note the key pieces of work that are underway and/or completed since the last update in November 2018, through to mid-April 2019.
   c) Note the additional information provided in Appendix 1: Overview of ARPHS and its role.

Prepared and submitted by: Jane McEntee (General Manager, Auckland Regional Public Health Service)
Endorsed by: Dr Margaret Wilsher (Auckland DHB Chief Medical Officer)

Purpose

Auckland Regional Public Health Service (ARPHS) is providing this update to Waitematā DHB and Auckland DHB CPHAC on key pieces of work that are underway or have been completed since the last update in November 2018 through to mid-April 2019. The report contains the following updates:

1. Disease notifications and management
2. BCG vaccine update
3. Ill traveller exercise
4. Drinking water standards
5. Speed management bylaw
6. Healthy Auckland Together (HAT)
7. Wai Auckland update
8. Smokefree
9. Alcohol
10. Local board health planning
11. Refugee health

1. Disease notifications and management

Auckland Regional Public Health Service (ARPHS) receives notifications of 48 infectious diseases as defined under the Health Act, 1958. ARPHS role includes receiving the disease notifications and ensuring appropriate public health management is undertaken, daily and weekly monitoring and surveillance of these diseases, and investigation and follow up of any disease outbreaks. Below is a summary of disease notifications received which have varied from the normal disease pattern with accompanying tables showing confirmed, probable and suspected cases (red), cases under investigation (yellow) compared with the historical three yearly average for that week (grey shaded bar).

1.1 Measles

ARPHS is managing an increase in measles cases across the Auckland region. As at 16 April 2019, there have been 17 confirmed measles cases in this calendar year. The 17 cases have generated over 1,500 contacts which require individual follow up and management. Of the 17 cases, three are overseas acquired, one is a sporadic case and the rest are confirmed or suspected links to existing cases. Of the 2019 cases, seven are in Waitemata DHB, eight in Auckland DHB and one in Counties Manukau Health. The table below provides a summary of the situation.
Status of measles cases as at 16/04/19, 0830 hours:

<table>
<thead>
<tr>
<th>Case type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed</td>
<td>17</td>
</tr>
<tr>
<td>Under active management</td>
<td>7</td>
</tr>
<tr>
<td>Under investigation</td>
<td>17</td>
</tr>
<tr>
<td>Awaiting serology</td>
<td>29</td>
</tr>
<tr>
<td>Currently hospitalised</td>
<td>0</td>
</tr>
<tr>
<td>Hospitalised YTD</td>
<td>8</td>
</tr>
<tr>
<td>Current contacts under active management</td>
<td>1513</td>
</tr>
<tr>
<td>Current contacts under quarantine</td>
<td>57</td>
</tr>
<tr>
<td>Fatalities</td>
<td>0</td>
</tr>
</tbody>
</table>

Confirmed measles cases by week (February – April 2019)

In 2018 there were five confirmed cases in Auckland, all overseas acquired. The last large scale outbreak with sustained person to person transmission in Auckland was in 2014 with 112 confirmed cases and 26 hospitalised.

Measles is a serious disease, notifiable under the Health Act 1958. There are currently outbreaks of measles in different parts of the world and in Christchurch. The best protection from measles is immunisation with the combined Measles, Mumps, Rubella vaccine (MMR) – but current coverage levels are lower than the 95% considered necessary to prevent community spread.

Current response management

The operational response to measles cases is resource intensive therefore ARPHS has established an internal incident management structure to ensure a coordinated approach. ARPHS’ current approach is intensive management of cases and contacts to prevent further cases (known as the ‘stamp it out’ response phase). Key activities include:

- assessment and management of suspected cases (ie isolation and contact management); according to likely risk of case being confirmed
- advice on isolation and public health management of confirmed cases
- advice on quarantine, treatment and management (including immunisation) of contacts
- monitoring and surveillance
- advice to laboratories and clinical services to notify all measles cases on suspicion
- advice to facilities such as emergency departments, early childhood education centres, schools, urgent care centres, and general practices where cases have been during the infectious period
- public information messaging especially in regard to symptoms, advance notice when attending medical facilities and immunisation advice
- weekly stakeholder updates.

ARPHS is working closely with clinical services, Pacific Health, DHBs’ Funding and Planning teams and the Ministry of Health to provide updates and inform future activities.

1.2 Meningococcal
The Ministry of Health issued a national advisory on 6 November 2018 regarding a significant increase in *Neisseria meningitidis* serogroup W (MenW) in New Zealand since mid-2017. MenW can present atypically with gastro-intestinal symptoms, as well as pneumonia, septic arthritis, endocarditis or epi/supraglottitis. The advisory identified Northland as the region most affected in 2018. A targeted vaccination programme was subsequently implemented in Northland. ARPHS provided some public health nursing and communications resources to support Northland DHB.

While the total number of meningococcal cases in the Auckland region has remained relatively stable over 2017 and 2018 (42 and 38 cases respectively), the proportion of these cases identified as MenW has markedly increased over this time from 7% to 29%. In 2019, the Auckland region has had a total of five meningococcal cases as at 31 March, which is typical for this time of the year. Of these five cases, four were identified as serogroup B and one was MenW.

The overall rates of meningococcal disease and MenW disease in the Auckland region are consistent with national figures, unlike Northland where higher rates have been observed. A targeted vaccination programme in the Auckland region is not considered necessary at this stage. However, ARPHS is conducting ongoing surveillance of this issue based on regional and national data, as well as continuing to provide public health management of meningococcal cases and their contacts.

1.3 Syphilis outbreak
As at 31 March 2019, 87 syphilis cases have been reported to Auckland Regional Sexual Health Services (ARSHS) for this calendar year. Although cumulatively lower than last year, the six weeks (mid-February to end of March) has seen an increase in cases similar to this period in 2018. ARPHS and ARSHS are working in partnership to manage the outbreak. A strategy and outbreak management plan has been developed, along with a communications plan. These have been shared with the Public Health Clinical Network.

Auckland and Waitematā DHBs Community and Public Health Advisory Committee Meeting 15/05/19
Key activities in place include:
- an enhanced surveillance system and reporting
- prioritisation of case finding and management
- enhanced contact tracing of sexual partners who have been diagnosed with syphilis
- increased initial health screening in prisons
- increased opportunistic testing in high risk primary care settings such as mission health and community alcohol and drug services.

1.4 Mumps
The mumps epidemic has significantly reduced over the last six months from 100 - 200 cases per month to an average of four cases per month.

1.5 Invasive pneumococcal disease
Invasive pneumococcal disease (IPD) is a seasonal disease with the 2019 notifications similar to the same period last year (2018).
1.6 Pertussis

There was a second wave of pertussis in Spring 2018 after tailing off gradually over last winter. This has been a biphasic outbreak with 447 cases in October 2017 - February 2018 compared with 353 during October 2018 – February 2019. The proportion of pertussis cases aged under one year has decreased from 17% in 2009 to 8% in 2018, suggesting the focused strategy of protecting the under one year old infants is working despite nearly 1,200 notifications over the past two years.

1.7 Dengue fever

During the months of summer 2018-19 there were 19 dengue cases compared with 197 in 2017-18. These were all overseas acquired from Fiji [5], India [3] and Indonesia [3] with the remaining cases from South East Asia.
1.8 Campylobacteriosis
The Auckland region experienced an increase in campylobacteriosis over the summer. Rates increased over the five month period from October 2018 - February 2019 with 1,210 notifications compared with 928 during October 2017- February 2018. An increase in notifications is normally expected during this period but generally not of this scale. There were no risk factor(s) identified that could support a dispersed common source outbreak. In response to the increase, ARPHS actively promoted public health advice in social media, focussing on how to hygienically prepare, cook and store food.

![Campylobacteriosis Graph](https://via.placeholder.com/150)

1.9 Salmonellosis
Rates of salmonellosis in 2019 have increased 31% compared to the same period in 2018. This was largely attributable to Salmonella Typhimurium phage type 108/170 of which there were 23 cases. Case investigation found a range of risk factors and serotypes. ARPHS informed and liaised with ESR and Ministry for Primary Industries who is responsible for leading investigation in food related outbreaks to undertake further analysis of potential causes related to specific foods.

![Salmonellosis Graph](https://via.placeholder.com/150)

1.10 Shigellosis
Rates of shigellosis decreased for the period October 2018 – February 2019 from 73 to 64 cases. Two thirds of cases were overseas acquired; Tonga [25%], India [25%], Samoa [19%], Indonesia [9%] and Fiji [4%]. Of the locally acquired cases consumption of raw fish was a common risk factor. Relevant public health messaging and advice has been circulated.
1.11 **Verocytotoxin producing Escherichia coli**
There were no changes in Verocytotoxin- or Shiga toxin-producing Escherichia coli (VTEC/STEC) notifications between October 2018 - February 2019 (100) compared to the same period in 2017-18 (101).

There has, however, been a revision to the response to cases of confirmed VTEC in line with the revision of the Ministry of Health’s Communicable Disease Control Manual. ARPHS has implemented a change in the response to confirmed cases of VTEC by reducing the level at which people cannot attend childcare or return to work, for both cases and close contacts. The new exclusion recommendation reflects the evidence which shows that while the illness has the potential to be very serious (especially in children under five), there is very little person-to-person transmission. This change provides a better balance between the previously known and often significant burden to cases/contacts from public health interventions, versus the risk to public health from the spread of disease.

1.12 **Tuberculosis**
Tuberculosis (TB) notifications increased approximately 20% in October 2018 – February 2019 compared to the same period in 2017-18. Of the 155 cases notified in 2018, 129 (83%) of new TB cases were born outside of New Zealand. The probable source countries were India (43%), China (13%), Philippines (8%), Tonga (5%), South Africa and Samoa (4%) and Fiji (3%). The average duration of time between arrival in NZ and onset date was 12 years.

1.13 **Acute rheumatic fever**
Acute rheumatic fever notifications are stable compared with the same period last year. The largest burden of disease in 2018 was in the Counties Manukau DHB region with very high rates in Pacific children under the age of 19. Of all acute rheumatic fever cases, 84% occurred in Auckland’s most deprived areas (NZDEP 8, 9, 10).
Weekly rheumatic fever counts by DHB (Auckland metro area)

1.14 Legionellosis
Legionellosis notifications increased 48% (25 to 37) during the October 2018 - February 2019 reporting period compared with the same period in 2017-18. The predominant serotype for 2018 was *L. pneumophila* serogroup 1 (54%), which is typically associated with aerosolised water and man-made warm water systems, especially cooling towers. The second was *L. longbeachae* (29%), typically associated with soil and landscaping products. In February, Auckland Council following a request from ARPHS, asked owners of all known cooling towers to proactively shock dose (i.e. disinfect) their installations, in anticipation of the usual autumnal increase of *L. pneumophila* notifications. The results of the additional dosing and any changes to legionella statistics are yet to be confirmed.
2. Update on Bacille Calmette Guerin vaccine

The Bacille Calmette Guerin (BCG) programme (free to eligible children under five years to protect them from TB) re-commenced in August 2018. The demand for the vaccine has exceeded expectations. For the seven months from August 2018 to February 2019, over 170 clinics have been held and around 3,700 children vaccinated. Currently around 2,100 children are waiting for clinic appointments. Children aged six months and under are being prioritised on this waitlist with an average wait time of approximately one month. Additional clinics have been set up to manage the demand.

In early December, following consultation with Immunisation Advisory Centre (IMAC) and Ministry of Health, a change in approach to mantoux testing was implemented. Previously all children under six months old required mantoux testing and clinics were jointly conducted by ARPHS PHNs and Labtests staff in community clinics. The requirement now is only children who may have been exposed to TB should be offered this test. Mantoux testing for BCG is now undertaken at Labtests community laboratories. This change has assisted ARPHS to increase the clinics offered to children requiring BCG vaccinations.

3. Ill traveller exercise

A full-scale ill air traveller exercise was held at Royal New Zealand Air Force Base at Whenuapai on 23 November 2018. The ARPHS Emergency Management team was involved in exercise planning with the RNZAF. The exercise scenario was based on civilians being evacuated from a country with a circulating communicable disease of concern and involved passengers who were asymptomatic, moderately unwell, severely unwell, as well as a death. The exercise was led by an ARPHS Medical Officer of Health in collaboration with the RNZAF and other partners such as St John, and NZ Police. The exercise highlighted the importance of a coordinated response in which all partner agencies utilised the Coordinated Incident Management System (CIMS).

4. Drinking Water Standards

Revisions approved in 2018 to New Zealand drinking water standards came into effect on 1 March 2019. These standards now require water suppliers to monitor an additional indicator ‘total coliforms’, and conduct enumeration testing for E.coli and total coliforms. “Enumeration” means that the bacterial colonies are counted rather than just reported on a presence/absence basis. Monitoring total coliforms may provide an early indication to water suppliers that water quality is changing to give an early warning of potential contamination events. Adverse results would alert suppliers to consider further testing and assessment, and if necessary, to implement follow up actions in their water safety plans.

The new standards mean there is a need for ARPHS drinking water assessors to carry out more in-depth risk assessment when determining drinking water standard compliance and when responding to notifications.

Other changes as a result of the revisions are:
- changed protozoal (giardia and cryptosporidium) treatment requirements for surface water sources
- deletion of the section on tankered drinking water carriers
- removal of requirements relating to rural agricultural drinking water supplies.
Further review of the Standards is underway, led by an independent Drinking-Water Advisory Committee reporting to the Minister of Health. The proposed changes are expected to be released for consultation in mid-2019.

4.1 Three Waters Review
The Government is currently reviewing how to improve the regulation and supply arrangements of drinking water, wastewater and stormwater (three waters). The review was prompted by the Havelock North drinking water contamination incident but “three waters” recognises that there are interactions between these different water streams.

Policy work is underway on the shape and form of proposed new regulatory arrangements to ensure drinking water safety has been identified as an immediate priority, along with improved environmental performance of wastewater and stormwater systems. The review is being led by the Minister of Local Government with a review team including representatives from the Ministry of Health, the Ministry for the Environment and the Department of Internal Affairs. A targeted engagement process is underway on high-level policy proposals which ARPHS is participating in.

5. Speed Management Bylaw
Reducing speed limits is an important public health issue because slowing traffic significantly reduces traffic crashes, serious injuries, and deaths. In 2017, 64 people died and 771 more were seriously injured on Auckland’s roads. As well as injury prevention, there are also potential co-benefits through reduced harm from air pollution, noise pollution and greenhouse gas emissions. Lower speeds also increase perceptions of safety and the likelihood that adults and children will cycle, walk or take public transport.

Auckland Transport (AT) has been working on the implementation of a Safe Speeds programme and has been consulting on its Draft Speed Limits Bylaw 2019 during March. If successful, AT will reduce speed in the Auckland CBD to 30km/h first, and then introduce new limits in some town centres and on 770km of high-risk rural and urban roads.

ARPHS has been working proactively with AT in this area in the lead up to, and following, the release of the draft bylaw by:
- sharing ARPHS submission and brief of evidence with key stakeholders on the impacts of speed limit reduction on road crashes, injuries and deaths, road safety risk in Auckland, the impact on sustainable transport modes and other public health co-benefits
- providing a media spokesperson, Medical Officer of Health Dr Michael Hale, and contributing opinion pieces and media releases, and posts on social media
- participating in a panel discussion on speed management organised by AT at Auckland City Hospital, which was followed up by Auckland Council with an article outlining the link between public health and speed, published on the Our Auckland – Auckland Council news website
- co-ordinating with the Auckland DHB Communications team and Safekids to offer public statements and spokespeople on the harm from Auckland road accidents, including DHB trauma specialists and Starship clinical staff. Children, especially those in high deprivation areas, are disproportionately killed or injured as a result of current speed limits.
- presenting on the ARPHS SpeedLimits Bylaw 2019 submission at the public hearings in April 2019.
Healthy Auckland Together (HAT) is a coalition of 27 partners committed to making it easier for Aucklanders to eat better, be physically active and maintain a healthy weight. HAT partners include health entities, local government, iwi-based organisations and non-governmental organisations. During November 2018 - March 2019, HAT has undertaken the following:

6.1 Meeting with Minister Genter
The Hon Julie Anne Genter asked to meet with HAT to better understand how the coalition works. At the 18 December meeting ARPHS represented HAT, joined by Auckland DHB Board Chair Pat Snedden and CE Ailsa Claire. HAT talked with the Minister about what policy change might be possible in transport planning and in the food environment around advertising of unhealthy food and zoning of fast food outlets. The Minister expressed support for the coalition’s work, encouraging the public health voice to be heard in the debate around cycling and active transport.

6.2 Marketing to children
HAT is submitting complaints to the Advertising Standards Authority (ASA) to identify inconsistencies with the way the current self-regulatory code is being considered. Complaints that are upheld help create a new standard for the industry, whereas complaints that are not upheld help build the case for policy/regulatory changes. HAT is also role modelling and encouraging communities to make complaints. HAT has lodged two recent complaints with the ASA.

- one complaint related to a Kinder Surprise Advertisement. This has not been upheld. Although the ASA panel determined that Kinder Surprise is an occasional food and the advertisement was aimed at children, the panel ruled that a significant proportion of children would not see it, as the advertisement was not shown in children’s YouTube content
- the second complaint was on a digital advertisement by Cookie Time due to breaches of the general Advertising Standards Code and the Children and Young People’s Code. The advertisement promotes the consumption of a large quantity of cookies as a breakfast meal through the image of milk and cookies in bowls, as well as the corresponding wording of the post. HAT is awaiting the complaint decision from the ASA board.

The HAT marketing to children working group has revised its action plan, with priorities for the next 12 months including:

- developing a unified and clear set of recommendations for policy and regulatory changes in relation to marketing of unhealthy food and beverages
- continuing to reframe the conversation and build and demonstrate public support for restricting the marketing of unhealthy food and beverages by developing and promoting communication/advocacy tools.

6.3 Food Environments
The ‘Good Food Kai Pai’ initiative to strengthen healthy food environments at events has been extended beyond Auckland Tourism, Events and Economic Development major cultural festivals (Lantern, Pasifika, Diwali) to include Auckland Council events such as Pacific in the Park, Christmas in the Park and Waitangi Day events, and most recently Polyfest. ARPHS has made significant progress in working with events teams to implement no-sugary drink policies at events and workshops with stallholders. HAT partners Healthy Families Waitakere and Healthy Families South worked with local boards in the south and west Auckland areas to mandate the ‘Good Food Kai Pai’ guidelines at their funded events.

HAT has continued to support the implementation of the National Food and Drink Policy at the Auckland metropolitan DHBs via chairing the metropolitan DHBs network, participating in national
teleconferences and supporting evaluation of policy implementation. A joint workshop is planned for May 2019 with the Ministry of Health, Heart Foundation and Health Promotion Agency, to create national resources and guidelines to support workplaces to implement the Food and Drink Policy for Organisations.

6.4 Research, Monitoring & Evaluation
A successful research event was hosted by the University of Auckland in October 2019 to highlight progress and develop shared research agendas between HAT partners and the University. This included looking at ways research can be used and translated in policy, and developing evaluation skills that can be used by HAT partners. A debrief was conducted and next steps were identified for the research platform, including exploring tools and a format to keep researchers and stakeholders connected.

The 2019 HAT monitoring report is under development, with contributions from partners from University of Auckland, Waitematā DHB, Auckland DHB, Counties Manukau Health, Aktive and Hapai te Hauora. The report is expected to be released in June.

6.5 Nutrition and Physical Activity
HAT and the Heart Foundation co-hosted a meeting for school providers including frontline staff who deliver nutritional and physical support in Auckland schools to increase the opportunities for collaboration. The meeting concluded with a presentation of Wai Auckland.

7. Wai Auckland

The “Wai Auckland” programme aims to displace sugar sweetened beverage with tap water. The programme includes the Auckland DHB, Counties Manukau Health, ARPHS, Auckland Council, Auckland Transport and Watercare. This programme will include increased access to public drinking water fountains.

A University of Auckland summer student has completed an audit of a large sample of public drinking fountains to assess their quality, including features, accessibility and cleanliness. 282 fountains were sampled. This included 17 new fountains found during the field survey. The survey results included the following:

- 96% of fountains sampled were functioning
- only 70% all fountains were drinkable (this takes in account flow of water, water height enough to drink, and also accessibility to the fountain)
- only 62% fountains were classed as clean (no significant discolouration or mould within 1 cm of the spout and no rubbish found in the fountain).
- there were three fountains with vandalism which was very minor
- a number of public areas did not have water fountains.

Key partners (Auckland Council and Auckland Transport) are addressing the identified cleanliness and drinkability issues and the findings will be used to inform future infrastructure activities. An overall baseline evaluation report for the project is also being finalised with the University.
8. Smokefree update

A Smokefree court hearing against The Longroom in Ponsonby took place on 25 February 2019. ARPHS compliance officers had observed the premises allowing smoking in an area which was assessed as an ‘internal area’ by ARPHS compliance officers, as defined under the Smokefree Environments Act. ARPHS compliance officers gave evidence at the hearing, with technical support from Professor Nick Wilson, a second hand smoke expert. There are multiple factors that must be considered in defining an internal vs outdoor area where smoking may be permitted. Due to these factors and in considering the design of the premises, the judge decided that he could not prove beyond reasonable doubt that the premises was an internal area, and therefore acquitted the defendant. The judgement on this case will provide a useful example for the Ministry of Health when reviewing the Smokefree Environments Act later this year.

On 9 April 2019 ARPHS made a public submission to the Auckland Council Environment and Community Committee meeting on the Auahi Kore Hapori Whanui Action Plan — a plan that derives from Auckland Council’s smokefree policy ARPHS has previously advocated for. ARPHS’ submission recommended that the action plan be strongly connected to the wider council smokefree implementation plan and that both receive sufficient implementation funding. This was to support a systems approach to achieving the goal of a Smokefree Auckland by 2025. ARPHS requested the plan be amended so that vaping was promoted as one of a suite of smoking cessation tools, rather than the main cessation method, and this was adopted. ARPHS offered expertise to further collaborate with Council on the development of the detailed activities.

8.1 Vaping regulation

In November 2018 the Government announced its intention to amend the Smoke-free Environments Act 1990 to improve smokers’ access to quality vaping and smokeless tobacco products, while protecting children and young people from the risks associated with them.

In summary the Government has agreed to:

- Regulate all nicotine and nicotine-free vaping liquid, devices and components
- Regulate flavours and colours
- Prohibit vaping in legislated smokefree areas (indoor workplaces, early childhood centres, schools)
- Agree to exempt notified specialist R18 retailers from the prohibition on vaping indoors.

ARPHS considers that the proposed approach largely manages the balance of concerns between allowing the use of vaping as a cessation option and potential risks to vulnerable populations. It is anticipated that Government will call for submissions on the proposed amendments to the Smokefree Environments Act to support these intentions in June or July 2019. The Government has asked the Health Promotion Agency to work with the Ministry of Health to develop a website and media campaign to support smokers to switch successfully to vaping – go live mid-2019. ARPHS will link to this information for Aucklanders seeking advice on vaping or cessation support.

The Ministry of Health position statement on vaping can be found here: https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/vaping-and-smokeless-tobacco
9. Alcohol update

9.1 Judicial Review of the Provisional Local Alcohol Policy
On behalf of the Medical Officer of Health, ARPHS has led the submission for the Judicial Review of the Provisional Local Alcohol Policy (PLAP). Early indications suggest that the appellants may lose the appeal on the Judicial Review at the High Court hearing held on 20 February 2019. If this is the case, only the Council would have the right to appeal due to ARPHS appearing only as an interested party.

9.2 ADHB Health Excellence Awards
In November, the ARPHS Alcohol team won the ADHB Health Excellence Team Living our Values Award for their collaborative work with the Māori Wardens Ki Otara Trust. This work has enabled the Māori community to have more voice in the alcohol licence process.

9.5 West Auckland Trusts
On 3 December 2019 ARPHS met with the West Auckland Action group in regards to their posting of misleading information in the debate for removing the Trust’s monopoly. It was agreed the post would be removed. On 11 December ARPHS met with the West Auckland Trusts CEO to communicate ARPHS priorities in alcohol licensing and conveyed the density level at which ARPHS would oppose new alcohol outlets within the Trusts area. The Trusts had indicated they were interested to do more to be a good community enterprise so ARPHS provided information on the WHO Alcohol Best Buys strategies to reduce alcohol harm.

10. Local Board Health Planning
Auckland Council’s 21 local boards produce plans every three years that set out each Board’s strategic direction and priorities. As a Healthy Auckland Together (HAT) partner, ARPHS has worked with Council to seek opportunities for wellbeing promotion at the local board level. In 2017, Puketāpapa Local Board committed to a new priority, the Healthy Puketāpapa Action Plan, which the local board will work with other agencies and the community to develop. The plan will identify ways to promote access to water, healthy food and active transport like walking and cycling.

An ARPHS employee has been seconded by Auckland Council to coordinate the Plan, which will be supported by Wai Auckland and HAT. It is anticipated that the Healthy Puketāpapa Action Plan will model work that can be replicated by other local boards in the 2020 planning cycle. Puketāpapa also serves as a demonstration project to showcase some of the wellbeing outcomes that might be achieved through the Government’s commitment to a broad agenda of wellbeing and specifically the focus on wellbeing in Budget 2019.

11. Refugee Health
From June 2020 New Zealand’s refugee quota will increase from 1,000 to 1,500 people per year and the time newly arrived refugees spend at the Mangere Refugee Resettlement Centre (MRCC) will be reduced from six weeks to five weeks. In preparation for this, Ministry of Business, Innovation and Employment and Ministry of Health are leading a project to develop a new model of care for refugee health services. ARPHS and Counties Manukau Health are represented on the project steering group.

Under the new model of care health screening will be completed off shore and only refugees identified with high health needs will be seen at MRCC. A continuum of care will be provided by primary care on resettlement in the regions. Due to the change in focus at MRCC it is unlikely ARPHS will be providing the screening service from 1 July 2020.
12. Policy Submissions

ARPHS has completed and submitted seven policy submissions between November 2018 - April 2019.

<table>
<thead>
<tr>
<th>Date</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 December</td>
<td>Public Safety and Nuisance Bylaw 2013 review</td>
</tr>
<tr>
<td></td>
<td>Auckland Council proposed changes to its Public Safety and</td>
</tr>
<tr>
<td></td>
<td>Nuisance Bylaw 2013, which seeks to protect people from</td>
</tr>
<tr>
<td></td>
<td>nuisance or unsafe behaviours and activities in public places.</td>
</tr>
<tr>
<td></td>
<td>ARPHS recommended the insertion of a smokefree provision in</td>
</tr>
<tr>
<td></td>
<td>the bylaw to strengthen existing smokefree policies for Council</td>
</tr>
<tr>
<td></td>
<td>run events and public transport hubs. ARPHS also recommended</td>
</tr>
<tr>
<td></td>
<td>that the existing public health purpose of the bylaw be</td>
</tr>
<tr>
<td></td>
<td>retained.</td>
</tr>
<tr>
<td>7 December</td>
<td>Child and Youth Wellbeing Strategy</td>
</tr>
<tr>
<td></td>
<td>A key requirement of the child poverty reduction legislation,</td>
</tr>
<tr>
<td></td>
<td>passed in 2018, is the creation of New Zealand's first Child</td>
</tr>
<tr>
<td></td>
<td>and Youth Wellbeing Strategy. It is proposed that the Strategy</td>
</tr>
<tr>
<td></td>
<td>will provide a framework to drive government policy and action</td>
</tr>
<tr>
<td></td>
<td>on child wellbeing.</td>
</tr>
<tr>
<td></td>
<td>ARPHS supported the framework’s principles and provided the</td>
</tr>
<tr>
<td></td>
<td>following considerations:</td>
</tr>
<tr>
<td></td>
<td>● strengthening the emphasis on Te Tiriti o Waitangi and Te Ao</td>
</tr>
<tr>
<td></td>
<td>● increased emphasis on the drivers and determinants of</td>
</tr>
<tr>
<td></td>
<td>● the inclusion of a systems approach;</td>
</tr>
<tr>
<td></td>
<td>● co-designing the Strategy’s indicators with Māori;</td>
</tr>
<tr>
<td></td>
<td>● inclusion of a strength based approach;</td>
</tr>
<tr>
<td></td>
<td>● focus on addressing inequities in the justice system;</td>
</tr>
<tr>
<td></td>
<td>● strengthening of the data collection and information</td>
</tr>
<tr>
<td></td>
<td>● investment in the Māori and Pacific workforce;</td>
</tr>
<tr>
<td></td>
<td>● the Strategy to come with a full implementation plan to</td>
</tr>
<tr>
<td></td>
<td>maximise its impact.</td>
</tr>
<tr>
<td>13 December</td>
<td>Submission on the Regional Public Transport Plan</td>
</tr>
<tr>
<td></td>
<td>The Regional Public Transport Plan (RPTP) describes the public</td>
</tr>
<tr>
<td></td>
<td>transport network that Auckland Transport (AT) proposes for</td>
</tr>
<tr>
<td></td>
<td>the Auckland region, identifies the services that are integral</td>
</tr>
<tr>
<td></td>
<td>to that network over a 10-year period, and sets out the</td>
</tr>
<tr>
<td></td>
<td>policies and procedures that apply to those services. Two</td>
</tr>
<tr>
<td></td>
<td>focus areas in the plan relevant to public health are:</td>
</tr>
<tr>
<td></td>
<td>● expanding and enhancing the Rapid and Frequent Networks;</td>
</tr>
<tr>
<td></td>
<td>● improving customer access to public transport (walking,</td>
</tr>
<tr>
<td></td>
<td>cycling, park and ride)</td>
</tr>
<tr>
<td></td>
<td>ARPHS supported the actions in the RPTP that create a shift</td>
</tr>
<tr>
<td></td>
<td>towards public and active transport modes.</td>
</tr>
<tr>
<td>Date</td>
<td>Subject</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>20 December</td>
<td>Submission on Health (Drinking Water) Amendment Bill</td>
</tr>
<tr>
<td></td>
<td>The Amendment Bill follows the Government’s Havelock North Drinking Water Inquiry – Stage 2 report with the objectives of improving the effectiveness and efficiency of Part 2A of the Health Act 1956, without materially affecting any party or imposing new or additional costs. The proposed amendments will have a direct impact on the operation of Auckland’s Drinking Water Assessment Unit (DWAU).</td>
</tr>
<tr>
<td></td>
<td>ARPHS supported the policy objectives of the Bill noting a number of areas that could be strengthened.</td>
</tr>
<tr>
<td></td>
<td>ARPHS also supported the Public Health Clinical Network Submission on Health (Drinking Water) Amendment Bill</td>
</tr>
<tr>
<td></td>
<td>In December 2018, ARPHS led the development of a joint submission on the Health (Drinking Water) Amendment Bill, on behalf of the Public Health Clinical Network (PHCN). The PHCN submission supported the policy objectives of the Bill noting that the Bill could be strengthened in a number of areas including strengthening of the provision around Water Safety Plans through management and control of critical points, the provision of an alternative national quality management system, inclusion of an additional section which requires specified self-suppliers to comply with the Drinking Water Standards, and the strengthening of Water Safety Plans implementation and compliance processes.</td>
</tr>
<tr>
<td>5 February</td>
<td>MARPOL Annex VI: treaty to reduce air pollution in ports and harbours</td>
</tr>
<tr>
<td></td>
<td>This International Maritime Organisation treaty, Annex VI of the International Convention for the Prevention of Pollution from Ships (MARPOL), regulates emissions that are harmful to public health, deplete the ozone layer and contribute to climate change. This has not been regulated in the past. Sulphur emissions from ships at the Auckland port drift across the central city, and Auckland Council data shows elevated sulphur levels around the port area.</td>
</tr>
<tr>
<td></td>
<td>ARPHS supported New Zealand’s accession to Annex VI.</td>
</tr>
<tr>
<td>8 March</td>
<td>Submission on Watercare Services Limited application: Army Bay Wastewater Treatment Reconsenting Project</td>
</tr>
<tr>
<td></td>
<td>Watercare Services Limited are seeking resource consent to discharge contaminants to the Coastal Marine Area in the Whangaparaoa Passage (Tiri Channel) and to discharge contaminants to air from the Army Bay wastewater treatment plant to enable future upgrades of the wastewater treatment plant (and increased capacity required for future growth).</td>
</tr>
<tr>
<td></td>
<td>ARPHS submitted in support of the reconsenting project and made a number of general comments on effluent quality, volume and impact; treatment plant design and capacity; population pressures and the need to respond; disease transmission risk and prevention; and plant resilience and emergency management risks.</td>
</tr>
<tr>
<td></td>
<td>ARPHS subsequently met with Watercare representatives to discuss the matters raised in its submission. Additional information was provided by Watercare, including the proposed consent conditions and the draft receiving environment monitoring plan.</td>
</tr>
<tr>
<td>11 March</td>
<td>Submission on Speed Limits Bylaw 2019</td>
</tr>
<tr>
<td></td>
<td>ARPHS made a submission in support of the draft bylaw – see item 5 in the report for more information.</td>
</tr>
</tbody>
</table>
Appendix 1: Overview of ARPHS and its role

ARPHS is one of New Zealand’s 12 public health unit’s (PHU). ARPHS provides regional public health services to people residing in Counties Manukau, Waitematā and Auckland District Health Boards (DHBs) through health protection and promotion, and disease prevention. A key role for ARPHS is provision of regulatory public health services and work to improve population health outcomes for the people of Tamaki Makaurau. ARPHS is funded via a direct contract from the Ministry of Health to ADHB.

ARPHS’ vision is Te Ora ō Tāmaki Makaurau. ARPHS’ strategic long term outcomes are:
- People are protected from the harm of notifiable infectious disease
- People are protected from the impact of environmental hazard
- People live free from the harms associated with harmful commodities
- The environments in which people live, learn, work and play promote health and wellbeing.

ARPHS strategic priorities include:
1. Reduce the harm of notifiable infectious diseases, in particular:
   - Reduce the spread of Tuberculosis through TB case and contact management
   - Actively manage infectious diseases and pursue an ‘up stream’ approach to infectious disease prevention
2. Build healthy and resilient environments and communities, in particular:
   - Early identification and active management of enteric diseases
   - Active support and management of waters and wastes
3. Reduce obesity, improve nutrition and physical activity
4. Support Smokefree 2025
5. Enhance surveillance of communicable and non-communicable diseases and risk factors for public health action and reporting
6. Enhance and build stakeholder relationships with organisations and communities to continuously improve public health for Tāmaki Makaurau.

The work of ARPHS

ARPHS’ work includes management of notifiable infectious and environmental diseases, including operational management of the regional tuberculosis control programme. ARPHS provides advice and support on actual/potential environmental hazards such as drinking and recreational water quality, air quality, border health protection, and hazardous substances. Much of ARPHS work involves working with other agencies, including work on liquor licensing, smokefree, emergency response, physical activity and nutrition and obesity prevention activities. These other agencies include central government agencies, Auckland Council, non-government organisations and workplaces. ARPHS is also responsible for refugee health screening undertaken at the Māngere Refugee Resettlement Centre.
Intersections between the work of ARPHS and the three Auckland metro DHB

Key points of intersection for ARPHS with DHB activities are interfaces with primary and secondary services in sharing surveillance information, managing communicable disease outbreaks, policy engagement and submissions and improving physical and social environments to support reduced harm from tobacco, alcohol and unhealthy food. For example ARPHS provides the backbone support team for the Healthy Auckland Together (HAT) coalition, of which the three DHBs are partners. The recent measles cases is an example of where strong collaboration between ARPHS and DHBs is critical.

Challenges

A key risk for ARPHS is managing service demands and ongoing financial sustainability. The lack of an annual funding increase being applied to the public health appropriation means ARPHS needs to review its ability to manage the day to day demands on the service, as well as operational priorities, whilst responding to reactive work including outbreaks. The ongoing financial uncertainty means ARPHS has been unable to afford to recruit to additional positions to support the public health demands that are experienced with the increase in size and complexity of Auckland’s population. This funding uncertainty also leads to challenges in maintaining and upgrading current infrastructure. ARPHS, with the support of ADHB’s CEO and CMO, is negotiating a funding increase with the Ministry of Health.
4.2 Pacific Health Update

Recommendation:

That the Community and Public Health Advisory Committees:

1. Note the Pacific Health Snapshot report, which is an accompanying paper.

2. Note Auckland and Waitematā District Health Boards (DHBs) have an ongoing Pacific Health Action Plan developed with Pacific communities and reflective of community priorities.

3. Note that the current Pacific Health Action Plan covers the period 2016-2020 and sets out eight priorities for Pacific health. Work to refresh the Plan for a further 5 years is underway.

4. Note the broader range of work underway relevant to Pacific Health in Planning Funding and Outcomes, as well as Integrated contracts and Pacific provider development, the Pacific Pipeline and workforce initiatives.

5. Note the Pacific Alliance Leadership Team has been set up to oversee Pacific workforce initiatives, which includes the Pacific Health Science Academies, a partnership between Auckland region DHBs and high schools to support students to enter health-related tertiary courses.

Prepared by: Corina Grey (Public Health Physician), Leani Sandford (Acting Pacific Health Gain Manager), Pulotu Bruce Levi (Pacific General Manager)
Endorsed by: Debbie Holdsworth (Director Funding) and Karen Bartholomew (Director Health Outcomes)

Glossary

ARDs - Auckland Regional Dental Service
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
DNA - Did not attend
DSME/SME - Diabetes and other chronic disease Self-Management Education
ECE - Early childhood centre
Enua Ola - A Pacific church- and community-based health promotion programme based at Waitematā DHB
FTE - Full Time Equivalent
HVAZ - Healthy Village Action Zones (a Pacific church-based health promotion programme based at Auckland DHB)
MMH - Maternal Mental Health
MMR - Measles Mumps Rubella vaccination
NCEA - National Certificate of Educational Achievement
PALT - Pacific Alliance Leadership Team
PFO - Planning, Funding and Outcomes
PHAP - Pacific Health Action Plan
PHSA - Pacific Health Science Academies
1. Executive Summary

This information paper gives an update of activities to improve Pacific health in the Auckland and Waitematā DHB regions. The last substantive update to CPHAC was for the updated Pacific Health Plan in mid-2017. This paper should be read in conjunction with the accompanying report A Snapshot of Pacific Health in the Auckland Region.

Pacific health priorities for Auckland DHB and Waitematā DHB are outlined by a joint Pacific Health Action Plan (PHAP), which was developed by the Pacific Health Gain Team in partnership with the Pacific community. The current PHAP, which sets out eight priorities for Pacific health, is a second iteration of the original 2013 plan, and covers the period 2016-2020. This paper includes a summary of activities from PHAP that are ongoing, achieved, or off-track. Work to refresh the Plan for a further five years is underway.

The Pacific Health Gain team within Planning, Funding and Outcomes (PFO) currently funds two major initiatives within the community and primary care at Auckland and Waitematā DHBs: (i) the church and community group-based programmes Health Village Action Zones (HVAZ) and Enua Ola and (ii) the Integrated Services/Fanau Ola programme in primary care to address the health and social needs of Pacific families with complex needs.

There are also health initiatives to specifically address the needs of Pacific people across the breadth of PFO activity, these include:

- Mental Health: a review of Maternal Mental Health Services and the Awhi Ora programme to address the health and social needs of people with mild to moderate mental distress in primary care, particularly Māori, Pacific and youth.
- Child Health: the Kainga Ora Healthy Housing programme, an oral health fluoride varnish outreach programme in Pacific Language Nests, and an on-time immunisation advertising radio campaign aimed at increasing awareness of immunisation in Māori and Pacific communities.
- Primary Care: targeted approaches to Pacific engagement in the Green Prescription programme, the diabetes work programme including diabetes co-design and improvements to retinal screening with a focus on Māori and Pacific people, and smokefree initiatives.
- Health Gain: a Pacific abdominal aortic aneurysm screening pilot at Auckland DHB.

Finally, there are also Auckland regional initiatives to accelerate Pacific health gain (via specific projects in the Pacific Health Pipeline) and increase the supply, recruitment and retention of the Pacific health workforce (overseen by the Pacific Alliance Leadership Team).

2. Strategic Alignment

<table>
<thead>
<tr>
<th>Community, whānau and patient centred model of care</th>
<th>The Pacific team maintains strong links with the Pacific communities through the HVAZ/Enua Ola programmes, which represent a partnership between the community, DHBs and providers. Successive PHAPs have been developed in partnership with these communities, reflecting their needs and priorities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasis and investment on both treatment and keeping people healthy</td>
<td>The Pacific team’s two major programmes HVAZ/Enua and Integrated Services/Fanau Ola have been developed with Pacific peoples’ worldviews and social and health needs in mind. Their focus is on prevention, wellbeing and optimal management of disease in those with chronic conditions.</td>
</tr>
</tbody>
</table>
Service integration and/or consolidation | The Integrated Services/Fanau Ola programme is focused on addressing the health and social needs of intergenerational families or households using a multidisciplinary team and ‘one stop shop’ approach.

Intelligence and insight | Ensuring that data is reported by ethnicity is important to ensure accurate monitoring of health inequities. See accompanying Pacific Snapshot Report.

Evidence informed decision making and practice | All existing initiatives require regular reporting of activities and outcomes.

3. Pacific Health Action Plan update

Waitematā DHB and Auckland DHB have long recognised the need to address Pacific health equity, and the first joint Pacific Health Action Plan (PHAP) for these DHBs was approved in May 2014 for the period 2013-2016 with the vision ‘Pacific families live longer and healthier lives’. The PHAP reflects a partnership approach between Pacific communities, Waitematā and Auckland DHBs and Pacific and other health providers, and was developed after wide consultation with Pacific churches and community groups.

The first PHAP had six priorities, based on what Pacific community members had said was important to them. These six priorities were kept in the second PHAP (2016-2020), with the addition of another two after further consultation in 2016. CPHAC supported the draft 2016-2020 PHAP at a meeting on 29 March 2017.

The eight priorities of the current PHAP include:

1. Children are well and safe and families are free of violence
2. Pacific people are smoke-free
3. Pacific people eat healthy and stay active
4. Pacific people get help early
5. Pacific people use hospital services when needed
6. Our families live in warm healthy houses that are not overcrowded
7. Pacific people will experience optimal mind health and wellbeing
8. Pacific elders are valued and experience optimal health and wellbeing

The PHAP is positively framed and action-oriented. Each of the eight priorities included a number of specific activities that would be provided over the five-year period 2016-2020. A summary of the progress of these activities is provided in Table 1.
Table 1. Status of activities from PHAP 2016-2020

<table>
<thead>
<tr>
<th>Priority</th>
<th>Activities that are on-track and ongoing</th>
<th>Activities that have been completed</th>
<th>Activities that are off-track</th>
</tr>
</thead>
</table>
| 1. Children are well and safe & families are free of violence | • Healthy Babies Healthy Futures programme for pregnant women & their families.  
• Work with providers to ensure that Pacific pregnant women are engaged with antenatal services.  
• Strengthening of referrals from the high risk diabetes maternity clinic at Auckland Hospital to the Alliance Health Plus Fanau Ola service.  
• Work with Healthy Families West Auckland to develop and implement nutrition and physical activity policies and practices in the Pacific Early Childhood Education Centres in West Auckland.  
• Work with the providers of Active families programme to engage Pacific children and families in the programme.  
• Work with the Auckland Regional Dental Service (ARDS) to implement the Auckland Region Preschool Oral Health Action Plan.  
• Work with Pacific providers & Pacific communities to increase awareness of the importance of dental health of children & increase enrolment & access to ARDS.  
• Triple P Positive Parenting Programmes. In 2016 and 2017, 2 programmes were delivered at Auckland & 5 at Waitematā DHBs. A total of 170 parents enrolled and 155 (91%) attended. Parents received developmental, management and prevention advice on specific parenting issues. The programme focused on positive parenting strategies, active skills training, problem solving and developing a personalised parenting plan.  
• Living Without Violence programmes. In 2016 and 2017, 2 programmes were delivered at Auckland & 5 at Waitematā DHBs. A total of 456 people attended the 4-week programme, delivered to Tongan, Samoan, Tuvaluan, Rotuman & Pan-Pacific communities. | • Positive parenting and living without violence programmes are no longer being delivered. As part of the refresh of PHAP, the Pacific team will consider community and DHB priorities and, if appropriate, develop funding proposals for further parenting and Living Without Violence programmes. |
<table>
<thead>
<tr>
<th>Priority</th>
<th>Activities that are on-track and ongoing</th>
<th>Activities that have been completed</th>
<th>Activities that are off-track</th>
</tr>
</thead>
</table>
| 2. Pacific people are smoke-free | • Work with new churches in the Healthy Village Action Zones (HVAZ) & Enua Ola programmes to ensure that they are smoke-free.  
• Review of referral protocols between church members & The Fono & ProCare stop smoke services. | • Education sessions delivered to new churches, and development of smoke-free policies and smoke-free signage  
• Trained 73 smoke-free community champions from HVAZ & Enua ola groups to promote smoke-free messages, implement smoke-free policies and refer smokers to Ready Steady Quit services. | • Work with providers and Pacific community groups to co-design ethnic-specific approaches to stop smoking services for: Tongan men, Cook Island women and Samoan men & women. The Pacific Health Gain team have undertaken preliminary work with Tongan & Samoan community groups and a project proposal is being drafted as part of the Pacific Health Pipeline (see Section 6). |
| 3. Pacific people eat healthy & stay active | • Enua Ola & HVAZ lifestyle programmes.  
• Aiga Challenge Weight Loss Competition.  
• Co-design project with young people who have participated in the Aiga Challenge to assist them to maintain their weight loss.  
• Collaboration with other organisations (Pacific Heartbeat, Vaka Tautua, Active Auckland) to promote healthy lifestyles for Pacific people, including those with disabilities and mental health conditions.  
• Work with Pacific providers to develop & support in-house wellness programmes. | • Implemented Aiga challenge competition  
• Pacific providers implemented in-house wellness programmes | | |
| 4. Pacific people get help early | • Breast screening community education service to support women to access breast screening services.  
• Breast and cervical screening education services by Parish Community Nurses.  
• Cardiovascular risk assessment & active follow-up of individuals by Parish Nurses.  
• Work with the Northern Region Bowel Screening Programme to improve participation rates. | • Diabetes & other chronic disease self-management education (DSME/SME) programmes (started in Auckland DHB in 2011 and in Waitematā DHB in 2016).  
Based on Stanford model & translated into Samoan and Tongan by expert Pacific health committees. In 2016-17, 10 programmes were delivered at ADHB & 10 at WDHB (~15 people/course).  
• Community-based stroke awareness & prevention programme co-funded by DHBs & Stroke Foundation from 2015-18. | • The Pacific team will further consider self-management programmes in primary and community care. |
<table>
<thead>
<tr>
<th>Priority</th>
<th>Activities that are on-track and ongoing</th>
<th>Activities that have been completed</th>
<th>Activities that are off-track</th>
</tr>
</thead>
</table>
| 5. Pacific people use hospital services when needed | • Pacific Cancer Nurse at WDHB to ensure Pacific patients with cancer receive timely access to services & patients/families are fully informed & supported in decision-making about treatment options.  
• Engagement of Pacific patients in the review & design of hospital services.  
• Pacific cultural competency training for DHB staff.  
• Pacific Health Science Academies (Section 7.2). | | |
| 6. Our families live in warm healthy houses that are not overcrowded | • Support of the Kainga Ora: Healthy Homes Initiative Service. | | |
| 7. Pacific people will experience optimal mind health & wellbeing | • Support to ensure that Pacific people are able to access the Awhi Ora service for people with mild to moderate distress. | | |
| 8. Pacific elders are valued & experience optimal health and wellbeing | • A day programme for Pacific elderly people was delivered at Auckland DHB by The Fono from 2015-2018. | • As part of the refresh of PHAP, the Pacific team plans to develop proposals for strategies aligned to the Ministry of Health’s Healthy Ageing Strategy.\(^1\) | |

4. Pacific-specific Health Delivery

The Pacific Health Gain team within Planning, Funding and Outcomes (PFO) currently funds two major initiatives within the community and primary care at Auckland and Waitematā DHBs: (i) the church and community group-based programmes Health Village Action Zones (HVAZ) and Enua Ola and (ii) the Integrated Services/Fanau Ola programme in primary care to address the health and social needs of Pacific families with complex needs. In addition, there is a Pacific cancer nurse coordinator and cancer support worker at Waitematā DHB to support Pacific cancer patients to better understand their diagnosis and treatment and access services in a timely fashion.

4.1. Healthy Village Action Zones and Enua Ola

The HVAZ and Enua Ola Pacific health programmes are a central vehicle through which health promotion activities are delivered to Pacific communities in Central, East, West and North Auckland. The programmes are a partnership between Pacific communities, DHBs and health providers. They are well established (having both been launched 10 years ago) and have the vision ‘Pacific individuals, families and communities achieving quality health outcomes inclusive of holistic wellbeing’. At the heart of these programmes is an integrated community-led development model that is owned by Pacific communities and takes a holistic approach to health.

There are currently 77 Pacific churches and community groups engaged in the HVAZ/Enua Ola programmes: 42 at Auckland DHB and 35 at Waitematā DHB (25 in West Auckland and 10 on the North Shore). Religious affiliation among Pacific people is very high (84% at the 2013 Census, compared to 60% of non-Pacific people), and most of the groups engaged in the programme are Pacific churches. Each group is given nominal funding to support health-based activities for their congregation or group, as well as the wider community. This is achieved via the establishment of a health committee, which develops and implements health plans to improve the health status of their parish or community group population. Members of the health committee are supported in their work by HVAZ/Enua Ola coordinators, parish community workers and parish community nurses. Health activities include setting up regular fitness and nutrition groups, the development of healthy eating and smokefree church policies, parish nurse-led clinics, tailored health education sessions and an annual Aiga Weight Loss Challenge. Until 2017, parish community nurses were also involved in the delivery of the diabetes component of the DSME/SME programmes.

The HVAZ/Enua Ola programmes also form a key network of Pacific community groups that is often activated when meaningful engagement or urgent communication is needed with the Pacific community. For example, these groups were an important part of a communication chain in response to a case of typhoid in Auckland in 2017.

Parish community nurses provide a unique model of care that is currently not available elsewhere. The parish nursing role includes facets of care which encompass parts of primary care and public health nursing, but differs importantly in the fact that it is community-based and not limited by an enrolled population. It is therefore a role that is able to reach individuals and populations who may find it difficult to access health care, particularly primary care and preventive services, through other, more traditional, routes. Parish nurses are fluent in at least one Pacific language and with strong links to their communities. They are therefore often perceived to be trusted sources of health information and care for people who may otherwise not seek advice or help. It is a model of care that facilitates preventive care and early detection and treatment. There are four parish nursing roles in Auckland DHB (one based at Procare PHO, one at Alliance Health Plus and two with the Tongan Health Society) and three in Waitematā DHB (all based at The Fono). Two of the Waitematā parish nurses were closely involved in the recent MMR vaccination catch-up programme in high schools throughout West Auckland in response to an outbreak of mumps in the latter part of 2018.
One of the key challenges with these community-based programmes and nursing roles is the ability to track individuals over time and demonstrate improvements in individual health outcomes. Parish nurses, for example, often intervene opportunistically at one point in time (for example, providing individual education on diabetes medications for a newly diagnosed diabetic at a parish nursing clinic), but may not collect pre- or post-testing of key measurements (for example, adherence to medications, HbA1c) is appropriate or feasible. The Pacific Health Gain team are working closely with the Clinical Nurse Director, Pacific Health, to develop a new reporting template for these services that will more accurately capture the work being done and the outcomes being achieved. In addition, the Nursing Development Team, Primary Care at Waitematā DHB have been supporting the Pacific team to develop a professional development programme for HVAZ/Enua Ola staff.

4.2. Integrated Contracts and Fanau Ola

Integrated Services/Fanau Ola is a primary care-based initiative involving multidisciplinary teams of nurses, social workers and community health workers working with Pacific families to comprehensively address their health and social needs. This programme was specifically designed to meet the high and complex health and social needs of our most vulnerable Pacific families and households. The programme recognises that Pacific culture embraces collectivism rather than individualism and that the health of an individual cannot be considered outside the context of their wider family.²

Individual clients with high health and social needs are identified through self-referral or in primary or secondary care settings. The immediate needs of that client are addressed first, and then the multidisciplinary team conducts a comprehensive assessment of the client and family’s health and social service needs and capability. Together with the family, a plan is developed to address their needs, which may include any of the following: access to health education, health services, lifestyle change support, clinical management and navigation to housing, education and social services. Each family receives a package of care tailored to meet their specific needs and to empower them to both navigate services and make decisions about their own health when they graduate from the service.

This model of care is being delivered to families in Auckland DHB by Pacific providers South Seas, Bader Drive and Tongan Health Society (overseen by Alliance Health Plus PHO) and in Waitematā DHB by The Fono. At Auckland DHB the service has been in place, but evolving over time, since 2013. Between July 2015 and July 2018, 1050 families received integrated care services at Auckland DHB. At Waitematā DHB, the model of care was agreed to in July 2018 and is currently being implemented.

4.3. Whanau Ora Review

In 2018, the Minister for Whānau Ora, Hon. Peeni Henare, initiated a review of the whānau ora commissioning approach and its ability to effect sustainable change for Māori and Pacific whānau. The comprehensive review findings is currently being considered. Opportunities to strengthen DHB strategies, enhance and reorient models of care across DHB funded services to family centred and directed models will be explored.

4.4. Pacific Cancer Nurse Coordination at Waitematā DHB

Waitematā DHB employs a 1.0 FTE Pacific cancer coordinator nurse to support Pacific people diagnosed with cancer along their treatment pathway at North Shore and Waitakere hospitals. The role includes navigation, education and support. In addition, the Pacific PFO team has a contract with the health provider HealthWest to employ a cancer support worker at 0.75 FTE to support

Waitematā DHB cancer patients to access secondary care services as part of their ongoing cancer treatment.

5. Other PFO initiatives related to Pacific health

The following section highlights some key areas across the breadth of PFO with benefits for improved health outcomes or a specific focus on Pacific. Many of these initiatives take a targeted approach to addressing or preventing health issues specific to Pacific people.

5.1. Mental Health Initiatives

5.1.1 Pacific Maternal Mental Health Utilisation and Access Review

Following a review of Maternal Mental Health (MMH) service use, which showed under-utilisation for Pacific mothers, the Auckland DHB MMH team analysed referral and engagement data by ethnicity. This analysis identified that post referral, Pacific mothers attended three to four fewer sessions than non-Pacific mothers and had higher did-not-attend (DNA) rates (9.6%) than Māori (8.1%) and Europeans (2.5%).

In response to these findings, Auckland DHB have developed a research proposal to review Pacific women’s access to, and engagement in, MMH services in order to improve equity of access and engagement, as well as quality of service. The project will identify barriers to referrals and, once a referral is accepted, barriers to engagement in the service, with potential strategies to address these barriers. The research will consist of data analysis, file review and qualitative research.

The proposal has been endorsed by the Northern Region Perinatal and Infant Mental Health Clinical Governance group, and referred to the Northern Region Mental Health and Addictions Network. The Network have approved the proposal in principle but have requested that it be revised to include a regional research approach. When this is complete, a paper will be presented to the Regional Funding Forum to endorse an approach to the Ministry of Health to approve the application of unspent establishment costs from the implementation of the acute continuum service to fund the research.

5.1.2 Fit for the Future and Awhi Ora

In 2017/18, the Ministry of Health put out a request for proposals for initiatives to support people with mild to moderate mental health needs. Auckland DHB Fit for the Future project funding was applied to existing interventions from the Tamaki Mental Health and Wellbeing initiative (Awhi Ora Supporting Wellbeing), including upscaling primary mental health and addiction nurse credentialing, implementing new health coaching roles within primary care teams, and evaluating implementation and service delivery.

The recently completed evaluation described the Awhi Ora approach of access to community support for people experiencing life challenges innovative.3 Previously such support was only available to people through secondary mental health services. Awhi Ora support workers were placed at primary care practices with high numbers of Māori, Pacific and youth. A range NGOs participated to provide wellbeing or social support for people – usually for brief periods of time (typically weekly for up to three months) – who would previously have been considered ineligible to access such services (the so-called ‘missing middle’). The evaluation found that social and housing supports were particularly important for people, and the health coach roles considered an important culturally responsive approach for Māori and Pacific people.

5.2. Child Health Initiatives

5.2.1. Kainga Ora Healthy Housing
The DHB Healthy Housing programme Kainga Ora is working with the Pacific Health Gain team to identify all families that might be eligible for Kainga Ora referral. An audit has been carried out to ensure that any family that has a rheumatic fever client who is being seen by a Fanau Ola service are being reviewed to identify any that meet the criteria for a Kainga Ora referral. Process maps from the Kainga Ora programme are also being shared with the Pacific Health Gain team to identify and share any learnings from these business processes that can be implemented within the integrated Fanau Ola contracts for quality improvement purposes.

5.2.2. Oral Health Fluoride Varnish Programme for Pacific preschool children
As part of the Preschool Oral Health Action Plan, an outreach programme to apply fluoride varnish and engage families in ARDS services has been implemented in Te Kohanga Reo, Pacific language Nests and early childhood centres with high numbers of Māori and Pacific children throughout the Auckland region. The programme is also an opportunity to enrol children not previously known to the service, complete ‘lift the lip’ examinations and facilitate ARDS appointments for those not previously seen or overdue for assessments. All children receive a toothbrush and oral health promotion pack and opportunities are taken to engage with whānau, address issues or concerns and promote oral health.

In 2018, children from two Samoan language nests, two Tongan language nests, four Te Kohanga Reo and one early childhood centre (ECE) with a high proportion of Māori and Pacific children were visited, and will receive regular fluoride varnish application every six months. An additional five Tongan language nests, three Samoan language nests, one Te Kohanga Reo and one ECE with a high proportion of Māori and Pacific children have been engaged this year. Plans to continue roll out to high needs ECEs throughout the region are ongoing.

5.2.3. Sudden Infant Death (SUDI) Prevention Programme
The DHB SUDI prevention programme manager presented to the Parish Community Nurses network education session on SUDI prevention. This was well received by the nurses and further opportunities for improving awareness of SUDI prevention amongst health workers and the Pacific community are being discussed.

5.2.4. On-time Immunisation Advertising
Auckland DHB led a two week radio campaign at the end of January on Flava, Niu FM and Mai FM, in an effort to raise on-time immunisation awareness in Māori and Pacific communities. The radio advert focused on whānau support for immunisation, including asking for a ride to the clinic or help watch other children, as well as comforting baby by feeding before, during or after. The radio advertisements were supported by an ad-lib message and social media post by a Mai FM presenter who has recently had her fourth child, reflecting on her personal experience of immunising during pregnancy and her child. The social media post was well received, with many positive comments.

The campaign was well timed for the increase in pertussis cases experienced in the region at the end of 2018.
5.3. Primary Care Initiatives

5.3.1. Primary Care Green Prescription
There has been a targeted approach to Pacific engagement in the Green Prescription programme, which is a health promotion initiative to encourage and facilitate physical activity and weight reduction. In particular, Harbour Sport has a Pacific team that provides healthy lifestyle programmes tailored to the Pacific community, such as ‘Niu Movement’ (a physical activity and nutrition weekly programme for Pacific families) and ‘Niu Ways’ (a programme to introduce Pacific people to regular physical activity). Harbour Sport is also engaging with Pacific people through Enua Ola by supporting the Aiga Weight Loss challenge.

Proximity to Pacific populations has been carefully cultivated to increase access, with Sport Auckland providing Green Prescription physical activity sessions and nutrition education from recreation centres in six locations in the Auckland DHB area, including Glen Innes, Otahuhu, Avondale and Onehunga.

In Quarter 3 of 2018, 257 Pacific people were enrolled in a Green Prescription programme at Auckland DHB and 264 at Waitematā DHB.

5.3.2. Diabetes Service Level Alliance
There are approximately 10,000 Pacific people living with diabetes across Auckland and Waitematā DHBs. The Auckland and Waitematā Diabetes Service Level Alliance has a substantial work programme of work underway with a particular focus on improving diabetes care and outcomes for Māori and Pacific people.

The flagship project for the diabetes work programme is using co-design to transform the way diabetes care will be provided. This project will take the lived experiences of people with diabetes and the clinicians who work with them to identify how a new system of diabetes care can be developed. Primary care practices with large numbers of Māori and Pacific peoples have been selected to participate in this project, as a key goal is reducing inequity in diabetes outcomes.

Another major project is the redesign of diabetes retinal screening services. In late 2018, in-depth interviews were carried out with 22 people not engaged with screening services. Nine of these interviewees were Pacific peoples. The learning from these conversations has led to diabetes retinal screening clinics being re-established at The Fono in Henderson. It has also significantly shaped the proposal for a new service model which is now more focused on ease of access, with more screening sites closer to where people live and work.

5.3.3. Pacific Abdominal Aortic Aneurysm (AAA) screening project
The pilot and extension of the targeted AAA screening initiative for eligible Māori has been completed across Auckland and Waitematā DHBs. An evaluation has been conducted and patients and whānau interviewed. Based on the success of this initiative a further study, to investigate AAA screening for Pacific, is currently being scoped. This pilot initiative would examine the Pacific prevalence of AAA and the level of participation in screening. It would also develop further initiatives based on the evaluation learnings, including a potential ‘health check’ with Pacific providers/primary care clinics.
6. **Pacific Health Pipeline**

The Pacific Health Pipeline is an Auckland region initiative started in 2018 to accelerate projects that have high level support and mandate due to their potential for improving equity in Pacific health outcomes. Opportunities identified to date include: (i) an insights analysis to better understand Pacific subpopulations through a stock-take of existing work and key informant discussions/interviews, (ii) support for ongoing work to improve oral health outcomes for Māori and Pacific children (particularly those referred for dental treatment under general anaesthesia) and (iii) development of ethnic-specific group-based smoking cessation initiatives. Other pipeline initiatives are being scoped.

7. **Pacific Health Workforce Initiatives**

7.1. **Pacific Alliance Leadership Team (PALT)**

PALT is a group set up to oversee and coordinate Pacific workforce initiatives across the Auckland region. Its objectives are four-fold:

1. Increase the supply, recruitment, retention and development of the Pacific workforce in the metro-Auckland health system.
2. Increase the number of Pacific people in senior clinical and managerial leadership roles.
3. Set annual targets for priority workforces and an action plan to meet these.
4. Commission and seek resources for objectives (1) to (3).

PALT is chaired by Margie Apa, Chief Executive, Counties Manukau DHB, and includes members from the Northern Regional Alliance and the three Auckland region DHBs.

Table 2 shows the percentage of Pacific people employed in different health workforce groups at each of the four Northern region DHBs. PALT has set individual targets for each of the DHBs (to be met by 2025), based on the proportion of the population that identifies as Pacific. The exception to this is the dental therapist category, which has a target of 12% at each of the three Auckland region DHBs, because all dental therapists working at ARDS are employed by Waitematā DHB.

<table>
<thead>
<tr>
<th>Workforce Group</th>
<th>Northland</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMO</td>
<td>1.8%</td>
<td>4.0%</td>
<td>2.8%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Nurse</td>
<td>1.0%</td>
<td>2.8%</td>
<td>6.2%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Midwife</td>
<td>0.0%</td>
<td>1.9%</td>
<td>0.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>0.0%</td>
<td>8.3%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Dietitian</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0.0%</td>
<td>1.4%</td>
<td>4.0%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>0.0%</td>
<td>4.7%</td>
<td>0.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>All Workforce</td>
<td>1.1%</td>
<td>5.2%</td>
<td>8.5%</td>
<td>12.9%</td>
</tr>
<tr>
<td>2025 % Pacific Target</td>
<td>2.4%</td>
<td>7.0%</td>
<td>9.2%</td>
<td>21.0%</td>
</tr>
</tbody>
</table>

*RMO – Resident Medical Officer (includes house officers and registrars, training to be medical specialists)*

Across the Northern region, the workforce groups with the highest proportion of Pacific people are nurses and dental therapists. There are currently no Pacific dietitians employed at Waitematā or Counties Manukau DHBs and no Pacific midwives or physiotherapists at Auckland DHB.

The percentage of medical, nursing and allied health staff that are Pacific at both DHBs remains far lower than the percentage of the overall population that identify as Pacific (Table 3).
Table 3. Number and % of Pacific people employed at Auckland and Waitematā DHBs

<table>
<thead>
<tr>
<th>Workforce Group</th>
<th>Auckland DHB</th>
<th></th>
<th>Waitematā DHB</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. Pacific</td>
<td>% Pacific</td>
<td>No. Pacific</td>
<td>% Pacific</td>
</tr>
<tr>
<td>Medical specialists</td>
<td>12</td>
<td>1.0%</td>
<td>RMO &amp; Med spec</td>
<td></td>
</tr>
<tr>
<td>RMOs</td>
<td>19</td>
<td>2.6%</td>
<td>22</td>
<td>2.6%</td>
</tr>
<tr>
<td>Nursing</td>
<td>414</td>
<td>8.8%</td>
<td>147</td>
<td>5.3%</td>
</tr>
<tr>
<td>Allied</td>
<td>107</td>
<td>4.8%</td>
<td>96</td>
<td>6.2%</td>
</tr>
<tr>
<td>Management/Administration</td>
<td>148</td>
<td>9.3%</td>
<td>49</td>
<td>5.3%</td>
</tr>
<tr>
<td>Support</td>
<td>172</td>
<td>33.8%</td>
<td>43</td>
<td>13.3%</td>
</tr>
<tr>
<td>Total</td>
<td>872</td>
<td>8.0%</td>
<td>357</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

Proportion of DHB population that are Pacific

1. Auckland DHB statistics based on head count, as at 31 December 2018
2. Waitematā DHB statistics based on total FTE, as at 28 February 2019
3. Support staff include cleaners and orderlies

Individual DHBs also have specific workforce initiatives in place to increase Māori and Pacific representation in the workforce. For example, Auckland DHB has a policy of shortlisting all Māori and Pacific candidates who fulfil criteria and enlisting the appropriate peoples on the recruiting panel who reflect the worldviews of the interviewees.

7.2. Pacific Health Science Academies (PHSA)
The PHSA is a key workforce initiative across the Auckland region to grow the Pacific health workforce from secondary school. It is a drive to build a workforce that better reflects the community we serve by partnering with schools, their communities and tertiary providers.

The PHSA is the result of a collaboration between Counties Manukau DHB, Waitematā DHB Workforce Development and Waitematā/Auckland DHB Pacific Health, which together, successfully bid for a Ministry of Health contract in 2014. The PHSA started with three high school ‘Health Science Academies’, which had dedicated student cohorts that focused on science, literacy and numeracy skills through extra tutorials, teacher and parental support. Students participating in the PHSA were also exposed to health careers through a tertiary mentoring programme.

A formative evaluation after three years of implementation of the programme reported a significant increase in the uptake of senior sciences (chemistry, physics and biology) among Pacific students. There were also significant increases in the quality of NCEA credits achieved: 100% of the PHSA cohorts achieved Level 1 NCEA Certificate in science (compared to 70% of Pacific students nationally) and 96% achieved Level 2 NCEA Certificate (compared to 78% of Pacific students nationally).

Currently, there are eight high schools and 402 students across Years 11 to 13 involved in the PHSA. Schools within the Auckland DHB region include Auckland Girls Grammar School, Onehunga High School and Tamaki College. At Waitematā DHB, there is Waitakere College, and at Counties Manukau DHB, Alfriston, De La Salle, James Cook and Tangaroa Colleges are all involved.
4.3 Pacific Health Snapshot in the Auckland Region

Recommendation:

That the Community and Public Health Advisory Committees receive the Pacific Health Snapshot report, which is an interim high level analysis pending the release of the updated census populations.

Prepared by: Corina Grey (Public Health Physician), Leani Sandford (Acting Pacific Health Gain Manager), Michael Walsh (Epidemiologist)
Endorsed by: Debbie Holdsworth (Director Funding), Karen Bartholomew (Director Health Outcomes)

Glossary

Amenable Mortality - Deaths under the age of 75 years that could potentially be avoided with effective and timely health care
ASH - Ambulatory sensitive hospitalisations (hospitalisations for conditions that are potentially preventable or that could have been treated earlier in primary care)
BMI - Body mass index
DHB - District Health Board
Enua Ola - A Pacific church- and community-based health promotion programme based at Waitematā DHB
GP - General Practitioner
HbA1c - Glycated haemoglobin, a measure of how well diabetes is controlled
HVAZ - Healthy Village Action Zones (a Pacific church-based health promotion programme based at Auckland DHB)
Life Expectancy - The average lifespan of a baby born in a particular year
Multimorbidity - The co-existence of two or more chronic conditions in a single patient
NZ - New Zealand
SLMs - System Level Measures

Executive Summary

This report contains a high level summary of key health status, risk factors and outcome indicators for Pacific in the metro Auckland context. This provides an interim high level picture, pending the release of the most recent census results in late 2019. This report updates previous health needs analysis work, and provides a Pacific view on routinely reported indicators. The reports help inform Pacific focused equity work underway in metro Auckland, and will be updated over time with other analyses including more detailed cancer analyses, hospitalisations and service utilisation. Other complementary information is also being collated to inform planning and equity work programmes.

Summary: Pacific Health at a Glance

Key highlights

- Life expectancy continues to increase for the Pacific population across both DHBs.
- Mortality rates from cardiovascular disease have declined 25% in Auckland DHB and nearly halved in Waitematā DHB since 2001-03.
- Mortality rates from cancer have declined over 25% in Waitematā DHB since 2001-03.
- Mortality rates from conditions considered amenable to health care intervention have declined between 30 to 45% since 2001-03.
- The Pacific population has some of the highest child immunisation rates of any ethnicity.
- HPV vaccination coverage is high in Auckland DHB (87%) and very little equity gap across both DHBs.
- Breast screening rates are higher in Pacific than non-Māori/non-Pacific ethnicities across both DHBs.

**Key Challenges**

- There is a 7-8 year gap in life expectancy between Pacific and non-Māori non-Pacific ethnicities.
- Over recent times the gap has gradually increased despite gains in Pacific life expectancy.
- Mortality rates from cancer, cardiovascular disease and conditions considered amenable to healthcare remain 2 to 3 times higher than the non-Māori/non-Pacific ethnicities.
- Hospitalisation rates for conditions considered potentially related to poor housing are over three times higher compared to non-Māori/non-Pacific ethnicities.
- The prevalence of obesity is nearly double in Pacific adults and three times higher in Pacific children compared to the European population.
- One of five Pacific adults in Auckland DHB and one in four in Waitematā DHB are daily smokers of cigarettes, this compared to around one in ten of the total population.
- Rate of hospitalisation for conditions considered ambulatory sensitive are the highest of any ethnic group and three times higher compared to non-Māori/non-Pacific ethnicities.
- The prevalence of diabetes is around 3 times that of non-Māori/non-Pacific ethnicities.

---

**Life Expectancy Gap**

**CVD Mortality**
Cancer Mortality

Amenable Mortality

Key Health statistics*

<table>
<thead>
<tr>
<th>Pacific Population</th>
<th>ADHB</th>
<th>WDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Population 2018/19</td>
<td>55,840</td>
<td>44,150</td>
</tr>
<tr>
<td>Projected Population in 10 years</td>
<td>61,900</td>
<td>53,550</td>
</tr>
<tr>
<td>% growth over next 10 years</td>
<td>10.9%</td>
<td>21.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Outcomes</th>
<th>Pacific</th>
<th>nMnP</th>
<th>Pacific</th>
<th>nMnP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Expectancy (2015-17) years</td>
<td>76.1</td>
<td>84.1</td>
<td>77.9</td>
<td>84.7</td>
</tr>
<tr>
<td>Gap in Life expectancy (2015-17) years</td>
<td>8.0</td>
<td>6.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amenable Mortality (2013-15)</td>
<td>166.8</td>
<td>59.9</td>
<td>134.4</td>
<td>57.3</td>
</tr>
<tr>
<td>Cancer Mortality (2013-15)</td>
<td>167.7</td>
<td>99.3</td>
<td>162.1</td>
<td>100</td>
</tr>
<tr>
<td>CVD Mortality (2013-15)</td>
<td>189.5</td>
<td>90.1</td>
<td>147.0</td>
<td>77.7</td>
</tr>
<tr>
<td>% of deaths from potentially avoidable causes (2013-15)</td>
<td>41.4%</td>
<td>21.9%</td>
<td>44.5%</td>
<td>22.8%</td>
</tr>
<tr>
<td>% of deaths attributable to smoking (2013-15)</td>
<td>12.7%</td>
<td>10.4%</td>
<td>13.6%</td>
<td>12.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Service utilisation</th>
<th>ADHB</th>
<th>WDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Sensitive Hospitalisations – 0 to 4y (2018)</td>
<td>12,469.9</td>
<td>5,415.1</td>
</tr>
<tr>
<td>Ambulatory Sensitive Hospitalisations – 45 to 64y (2018)</td>
<td>8,703.9</td>
<td>2,662.2</td>
</tr>
<tr>
<td>Potentially housing related hospitalisations – 0 to 14y</td>
<td>2,808.3</td>
<td>766.1</td>
</tr>
<tr>
<td>ED Attendance Rate (2018)</td>
<td>11,670</td>
<td>6,360</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Factors, Immunisation and screening</th>
<th>ADHB</th>
<th>WDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Prevalence - 15+ and PHO enrolled (VDR)</td>
<td>14.3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Obesity Prevalence - Adults (2014-17)**</td>
<td>69.3%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Obesity Prevalence - Children (2014-17)**</td>
<td>30.6%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Smoking Prevalence - Daily (2014-17)**</td>
<td>20.8%</td>
<td>9.1%</td>
</tr>
<tr>
<td>% of pregnant women receiving a pertussis vaccination (2018)</td>
<td>29.7%</td>
<td>60.7%</td>
</tr>
<tr>
<td>% 8 month olds fully immunised (Q2 18/19)</td>
<td>94.4%</td>
<td>96.3%</td>
</tr>
<tr>
<td>% of 2 year olds fully immunised (Q2 18/19)</td>
<td>96.0%</td>
<td>94.3%</td>
</tr>
<tr>
<td>HPV vaccination (2017-18)</td>
<td>87%</td>
<td>91%</td>
</tr>
<tr>
<td>Breast Screening (Q2 18/19)</td>
<td>70%</td>
<td>64%</td>
</tr>
<tr>
<td>Cervical Screening (Q2 18/19)</td>
<td>63%</td>
<td>65%</td>
</tr>
</tbody>
</table>

*rates presented per 100,000 population unless otherwise stated; prioritised Pacific ethnicity; nMnP = non-Māori non-Pacific comparator

**Comparator here is total population; note that obesity is reported here rather than obesity and overweight (see section 2.6)

Auckland DHB and Waitematā DHB Community and Public Health Advisory Committee Meeting 15/05/19
1. Our Pacific Population

There are more than 300,000 people in New Zealand (7.5% of the total population) that identify with at least one Pacific ethnic group. By the year 2038, the Pacific population in NZ is projected to grow to over half a million people (10% of the population).\(^1\) Auckland is home to two-thirds of NZ’s Pacific population, where Pacific is the third most populous ethnic group and comprises 15% of the region’s population (approximately 230,000 people after the 2013 Census).\(^2\)

The three Auckland DHBs have the largest Pacific populations of all DHBs in NZ. More than half (54%) of the Pacific population in Auckland resides in the Counties Manukau DHB region, where approximately 22% of the population identifies as Pacific. At Auckland DHB, Pacific people make up 12% of the population and at Waitematā, they make up approximately 8% of the DHB’s population (Table 1).

Table 1. Comparison of the Population Composition of the Metro Auckland DHBs

<table>
<thead>
<tr>
<th>DHB</th>
<th>Waitematā</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population (2018/19)</td>
<td>628,970</td>
<td>545,640</td>
<td>563,210</td>
</tr>
<tr>
<td>% of population who are Pacific</td>
<td>8%</td>
<td>12%</td>
<td>22%</td>
</tr>
<tr>
<td>% of DHB Pacific population that is*:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Samoan</td>
<td>52%</td>
<td>44%</td>
<td>51%</td>
</tr>
<tr>
<td>Tongan</td>
<td>17%</td>
<td>31%</td>
<td>23%</td>
</tr>
<tr>
<td>Cook Island Māori</td>
<td>15%</td>
<td>17%</td>
<td>21%</td>
</tr>
<tr>
<td>Niuean</td>
<td>10%</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Other Pacific</td>
<td>17%</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

*Note that percentages are based on total response ethnicity (people who identify with more than one ethnic group are included in both groups) so percentages add up to >100%.

Sources: Ministry of Health [https://www.health.govt.nz/new-zealand-health-system/my-dhb](https://www.health.govt.nz/new-zealand-health-system/my-dhb), Northern Region Long Term Investment Plan (Northern Regional Alliance, 2018), Census 2013, ARPHS Pacific Demographic Profile Report

The term ‘Pacific people’ is a collective term describing a young, dynamic and diverse population made up of more than 16 distinct ethnic groups, languages and cultures.\(^3\) The five largest groups are Samoan (49%), Cook Island Māori (21%), Tongan (20%), Niuean (8%) and Fijian (5%). Most Pacific people (approximately 60%, similar to the non-Pacific Auckland population) were born in NZ. Among Pacific people born overseas, the majority have spent many years living here. Approximately 70% of Samoans and Tongans, 80% of Cook Islanders and 90% of Niueans born overseas have spent 10 or more years in New Zealand.

Our Pacific population is becoming increasingly diverse. One in four Pacific people (and 40% of Pacific children aged 0-4 years) identify with more than one ethnic group (compared to 7% of non-Pacific people). More than one-third are younger than 15 years old (compared to 18% of the non-Pacific population) and only 5% are older than 65 years (compared to 14% of the non-Pacific population).\(^2\)

More than a quarter of Pacific families (compared to 4% of non-Pacific families) have more than six members.

The social and economic determinants of health play an important role in the creation and perpetuation of health inequities for Pacific people. Income, education, employment and housing conditions can play a role in shaping the health of our families. The effects of these determinants can be direct (for example, through cold and damp living conditions increasing susceptibility to respiratory and other infectious
conditions) or indirect (for example, by limiting a family’s resources and opportunities to engage in activities that enhance health). In Auckland, 60% of Pacific people (compared to 14% of non-Pacific people) live in the 20% of areas classified as most deprived by the NZ Deprivation index. Unemployment rates are high in our population (6.2% compared to 3.9% in non-Pacific [February 2019]), the median annual personal income is the lowest of all ethnic groups ($19,700, compared to $30,900 for Europeans (2013 Census)), and home ownership is low and declining (19%, compared to 50% of the NZ population (2013 Census)).

Pacific people are religious people. In the 2013 Census, 72.8% Pacific people affiliated with one or more Christian religions compared with 43.8% of the total NZ population. Similarly, Pacific students in the Youth 2012 Survey were four times more likely than NZ European students to report that their spiritual beliefs were important to them.

These characteristics mean that the health, social and spiritual needs, and therefore the health system’s response, to our Pacific population are likely to require different approaches and resources in order to achieve equitable health outcomes.

2. Pacific Health Outcomes

In New Zealand, inequities in health outcomes between Pacific and non-Māori non-Pacific groups are well recognised. Many of these inequities are long-standing and reflect the unequal distribution in the social determinants of health for Pacific compared to non-Māori non-Pacific people. These disparities are seen at all ages and in important summary measures of health, such as life expectancy, amenable mortality and ambulatory sensitive hospitalisations, in specific conditions (for example, diabetes and cancer) and in risk factors for disease (for example, smoking and increased body mass index (BMI)).

The following section outlines some key health outcomes and risk factors for Pacific people in the Auckland region. Many of these health outcomes are considered preventable, which means that with careful consideration to health service access and our responsiveness to differing social needs, gains in Pacific health outcomes, and a closing of the equity gap, are possible.

2.1 Life Expectancy

Life expectancy at birth is a frequently used indicator of the health of populations. It represents the average lifespan of a baby born in a particular year. The higher the life expectancy, the better shape a population is in. Life expectancy is said to reflect how the health system, living conditions and wider societal efforts contribute to the length of a person’s life.

Figure 1 shows the improvement in life expectancy for Pacific and overall (total) population from 2005/07 to 2015/17, and Figure 2 shows the trend in life expectancy gain over time in metro Auckland for Pacific compared to non-Māori non-Pacific. At Waitematā DHB the Pacific gain (2.3 years) is greater than the overall gain (1.9 years), although in Auckland DHB the Pacific gain (1.4 years) is lower than overall gain at 1.8 years resulting in a slight increase in the life expectancy gap at Auckland DHB and a reduction in the gap from 7.4 to 6.8 years at Waitematā DHB. The change over time in the life expectancy gap can be seen in Figure 3 – the most noticeable feature is that despite variation the life expectancy gap is relatively flat, as opposed to the reduction in the life expectancy gap seen for Māori over the same time period in Auckland DHB and Waitematā DHB.
Figure 4 shows life expectancy, as estimated from 2015-2017 mortality data, for Pacific, Māori and non-Māori non-Pacific people. At Auckland DHB and Waitematā DHB, Pacific people have the lowest life expectancy of all groups, at 76.1 and 77.9 years, respectively, compared to 84.1 and 84.7 for non-Māori non-Pacific people. The same picture is not seen at Counties Manukau, with Māori having the lowest life expectancy.

Figure 1. Change in life expectancy for Pacific and overall (total) population for a ten year period from 2005/07 to 2015/17 – New Zealand and the Northern Region DHBs

* Top bar for each ethnicity is 2005/07 and bottom bar is 2015/17
** Gap figures use non-Māori/non-Pacific as comparator group (not shown) and compares gap in 2005/07 with 2015/17

<table>
<thead>
<tr>
<th>Region</th>
<th>Pacific 2005/07</th>
<th>Pacific 2015/17</th>
<th>Overall 2005/07</th>
<th>Overall 2015/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>74.5</td>
<td>79.1</td>
<td>81.1</td>
<td>82.9</td>
</tr>
<tr>
<td>Waitematā</td>
<td>75.5</td>
<td>77.9</td>
<td>82.2</td>
<td>84.1</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>75.2</td>
<td>75.4</td>
<td>79.8</td>
<td>81.3</td>
</tr>
<tr>
<td>Northern Region</td>
<td>75.2</td>
<td>76.6</td>
<td>80.3</td>
<td>81.5</td>
</tr>
</tbody>
</table>
Figure 2. Gain in life expectancy (years) for Pacific compared to non-Māori non-Pacific; 2005/07 to 2015/17 metro Auckland DHBs.

Figure 3. Life expectancy gap for Pacific compared to non-Māori non-Pacific; 2005/07 to 2015/17 metro Auckland DHBs.

*NMNP = Non-Māori Non-Pacific
Figures 4, 5 and 6 show the specific conditions contributing to this gap in life expectancy for Pacific people include chronic disorders, such as heart disease, stroke and diabetes, as well as lung, bowel, breast and other cancers. The picture for Pacific men is similar to that for Māori men (although diabetes is second for Pacific men and third for Māori men), whereas the pattern for Pacific women is quite different, with coronary disease being the top condition similar to Māori whereas diabetes and cerebrovascular disease feature more highly than Māori women. Many of the risk factors for these diseases are considered preventable or modifiable (able to be changed through lifestyle interventions and with appropriate support from the health system).
Figure 5 and 6. Male and Female Pacific life expectancy gap decomposition (attributable conditions)
2.2 Cardiovascular disease mortality
Cardiovascular disease is a key component of the life expectancy gap for both Pacific and for Māori. Cardiovascular disease mortality has been reducing over time for Pacific, as shown in Figure 6 below, and there is an impression of some narrowing of the gap.

Figure 6. Cardiovascular disease mortality 2001/03 to 2013/15, by ethnicity, metro Auckland DHBs

2.3 Cancer mortality
Cancer mortality remains the other key component of the life expectancy gap for both Pacific and Māori. Death rates from cancer in the Northern Region are significantly higher in Māori and Pacific, compared to non-Māori non-Pacific people. As noted in Figures 5 and 6 endometrial cancer is one of the top causes for Pacific women which does not feature for Māori women, and breast cancer remains a key component of cancer mortality. Stomach cancers feature for both Pacific and Māori men and women, which does not feature highly for non-Māori non-Pacific. Figure 7 shows that cancer mortality is also reducing over time for Pacific, however in metro Auckland it has been relatively flat since 2009-11 compared to non-Māori non-Pacific where the incremental improvement continues over this time period.
A national analysis of cancer deaths between 2006 and 2011 found that Pacific men and women were 1.32 and 1.46 times more likely to die from cancer than European/Other groups. The greatest contributors to absolute inequalities in cancer death rates were lung cancer (Pacific men), breast cancer (Pacific women) and stomach cancers (Pacific men and women). Endometrial cancer in women and liver cancer in both men and women were also important contributors to inequities in cancer incidence over that time. Drivers of these inequities include differences in rates of smoking, overweight/obesity, certain infections (e.g. hepatitis C) and access to cancer screening.

The results of that national analysis was consistent with various studies over the years that have reported lower rates of survival among Māori and Pacific breast and bowel cancer patients. These survival differences have been linked to later stage at presentation and post-diagnosis differences in care, which can be explained, at least in part, to differences in both access to and quality of care for Māori and Pacific patients.

The Northern Region Long term Investment Plan cancer workstream is beginning work on an equity model for cancer focused on key cancer priority areas for Māori and Pacific.

2.4 Amenable mortality
Amenable mortality is the rate of deaths in people younger than 75 years that could potentially have been avoided through effective and timely health care. Amenable mortality rates are being closely monitored in all DHBs as part of the prevention and early detection component of the System Level Measures (SLMs) framework. The Ministry of Health developed this framework to support DHBs to work
in collaboration with their local health system partners (primary, community and hospital) to improve health outcomes for their population.

Figure 8 shows amenable mortality rates for Pacific and non-Māori non-Pacific people from 2001 to 2015. Despite a reduction in amenable mortality rates at all three Auckland region DHBs (24% at Counties Manukau, 31% at Auckland and 45% at Waitematā over the 14-year period), amenable mortality rates remain more than double that of non-Māori non-Pacific people.

**Figure 8. Amenable mortality (2001-03 to 2013-15), by ethnicity and DHB**

![Amenable Mortality Rates Graph]

2.5 Ambulatory Sensitive Hospitalisations, 0-4 and 45-64 year olds

Ambulatory sensitive hospitalisation (ASH) rates are hospitalisations for conditions that are potentially preventable or that could have been treated earlier in primary care. While primary care provision is traditionally a focus of ASH rates, many other aspects of the health care system – hospital supply and configuration, emergency care department management and community care provision – can also have an effect on ASH. ASH rates for 0-4 year olds are a part of the SLMs framework, focused on ‘keeping children out of hospital’.

Figure 9 shows ASH rates for 0-4 and 45-64 year olds from 2010-2017 in the three Auckland region DHBs. In both age groups and at all DHBs, Pacific ASH rates are higher than non-Māori non-Pacific rates. Childhood ASH rates in particular are highest in Pacific compared to all other ethnic groups. The largest contributors to childhood ASH rates are respiratory disorders (including bronchiolitis and pneumonia), gastroenteritis, dental and skin conditions. For adults, important contributors to ASH rates include...
angina/chest pain, asthma, cellulitis/skin infections, heart failure, epilepsy, gastroenteritis and pneumonia.11

Figure 9. ASH rates at Auckland region DHBs, 2010-2017, by ethnicity

2.6 Diabetes Prevalence
Diabetes is an important contributor to health inequities for Pacific people, and is a key focus for the metro Auckland DHB and Primary Health Organisation (PHO) Alliance Leadership Teams. Figure 10 shows the proportion of people with diabetes at Auckland DHB, estimated from the Virtual Diabetes Register (VDR).16 Similar patterns by ethnicity are seen at other DHBs and for the total NZ population. By the age of 40-44 years, more than 10% of Pacific people (compared to 1% of Europeans) have diabetes. By the age of 65 years, this figure rises to almost 60% of Pacific people (compared to 12% of Europeans).
It is estimated that there are between 49,433 and 52,759 people with diabetes living in Auckland and Waitematā DHBs. The breakdown of number of diabetes by ethnicity and DHB is presented in Table 1, below.

Table 1. Estimated number of people with 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>Waitematā</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>

Source: VDR, Metro Auckland Clinical Governance Forum diabetes and CVD indicators

For those with diabetes, glycated haemoglobin (HbA1c) is used to measure blood sugar control over the past three months. Table 2 shows the proportion of people with diabetes with an HbA1c <64mmol/L (defined as ‘good diabetic control’). Approximately half of Māori and Pacific diabetics, compared to two-thirds of non-Māori non-Pacific diabetics, have well-controlled diabetes, representing a substantial equity gap and an important area of focus for the health system.

---

1 As reported to CPHAC in February 2019 in the report Community Based Diabetes Care Programme Update.
Table 2. Proportion of people with diabetes with good diabetic control\(^1\) by DHB, May 2018

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Pacific</th>
<th>Māori</th>
<th>Non-Māori non-Pacific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>51%</td>
<td>53%</td>
<td>63%</td>
</tr>
<tr>
<td>Waitematā DHB</td>
<td>53%</td>
<td>49%</td>
<td>67%</td>
</tr>
</tbody>
</table>

\(^{*}\)Metro Auckland Clinical Governance Forum diabetes and CVD indicators; good diabetic control defined as HbA1c<64mmol/mol in the 62\% of people with diabetes aged 15-74 years who had an HbA1c measurement in the last 15 months.

2.7 Overweight/Obesity

Excess body weight is a risk factor for a myriad of conditions, ranging from diabetes and heart disease to osteoarthritis and endometrial, breast and liver cancer. The percentage of Pacific people considered to be carrying excess body weight is significantly higher than other ethnic groups. In the Auckland region, approximately 90\% of Pacific adults,\(^2\) compared to 70-80\% of Māori and 60-70\% of the total population, are considered to be in the ‘overweight/obese’ category (Figure 11). Similar differences in rates of overweight/obesity are seen in children (Figure 12). More than half, and up to two-thirds of Pacific children aged 2-14 years in the Auckland region are considered overweight or obese, compared to 40-50\% of Māori children and 25-40\% of the total child population.

Figure 11. Percentage of adults in the ‘overweight/obesity’\(^*\) range, by DHB, 2014-2017

\(^{*}\)Note: Adults aged ≥15 years with BMI >25kg/m\(^2\) Source: NZ Health Survey

\(^2\) Note that the obesity prevalence reported in the Summary Pacific Health at a Glance at the beginning of this report was for obesity; whereas the data presented in section 2.7 includes both obesity and overweight BMI categories.
Figure 12. Percentage of children in the ‘overweight/obesity’* range, by DHB, 2014-2017

*Note: Children aged 2-14 years with BMI equivalent to an adult BMI >25kg/m² Source: NZ Health Survey

2.8 Smoking

Cigarette smoking is a leading cause of preventable deaths and an important risk factor for chronic airways disease, lung cancer, heart disease and stroke. Rates of smoking are much higher in Māori and Pacific people compared to other ethnic groups (Figure 13). Smoking rates among Pacific people are highest at Waitematā DHB (30%, approximately the same as Māori), followed by Auckland and Counties Manukau DHBs (approximately 23% each).

Figure 13. Percentage of people who are current smokers, by DHB, 2014-17

Source: NZ Health Survey
2.9 Multimorbidity
Multimorbidity (the co-existence of two or more chronic conditions in a single patient) is increasingly being recognised as an issue in New Zealand, particularly for primary care. It is associated with poor physical functioning and mental health outcomes, poor quality of life and high healthcare costs. Multimorbidity analyses have highlighted the quality of life burden of mental health, musculoskeletal and chronic pain issues. Because of the way health services are delivered (mainly with a focus on the management of single diseases), people with multimorbidity face many health service challenges, including short consultation times, multiple appointments with different health providers, poorly coordinated care and conflicting information from different providers, and difficulties accessing healthcare due to financial and other constraints. Multimorbidity is often associated with polypharmacy – when one person uses multiple medications at one time. Polypharmacy, when appropriate, can be beneficial, improving health outcomes when the risks and benefits of multiple medications are adequately managed. However, polypharmacy may also be harmful, increasing the risk of adverse medication reactions, non-adherence and poor health outcomes.

There have been no Auckland-specific studies of multimorbidity in Pacific people. However, a recent analysis based on national health data reported much higher rates of multimorbidity among Māori and Pacific, compared to European and Asian, groups. After standardising for age and sex, the prevalence of multimorbidity was 13.4% for Māori and 13.8% for Pacific, compared to 7.6% for Europeans and 6.9% for Asians. Those with multimorbidity in this study were at substantially higher risk of an adverse outcome (death, ASH admission) in the year following hospitalisation. Similarly, a cross-sectional study of patients in a Dunedin general practice reported high levels of multimorbidity among their Māori (52.5%) and Pacific (64.3%) population. Polypharmacy was also high (13.6% of Māori patients and 32.9% of Pacific patients).

These studies indicate that the health system needs to be reoriented to cater to the needs of a large proportion of patients in primary care with multiple chronic conditions that require active management and affect quality of life. This will require a continued shift from a focus on the management of individual diseases to care of the whole patient (including a consideration of how their social circumstances impact on their ability to manage their conditions and access care).

3. Pacific Perspectives of Health and Access to Healthcare
There is a large body of evidence showing that Pacific people experience barriers to health care and report greater levels of unmet need for health care. A comprehensive review of the perspectives of Pacific people and health providers on primary care was published in 2012. Pacific people’s views of health are frequently underpinned by spirituality or family relationships, but this review found that these views were accompanied by a strong narrative of poverty and limited resources. Poor health and ‘unhealthy lifestyles’ were not due to a lack of knowledge, but limited economic resources and thus, the ability to ‘make better choices’. Many participants reported a connection between high levels of stress in their lives and poor health.

---

3 For example, gout and arthritis.
Barriers to seeking help include a lack of transport, the cost of healthcare, and a degree of frustration and disappointment at the gap between expectations of providers and actual experience of health services. Many participants in this 2012 study described difficulties making appointments to see their General Practitioner (GP), especially the same GP and older patients in particular reported a lack of confidence in communicating with doctors. These communication problems were due in part to language barriers and a lack of interpreters, but also due to issues with health professional cultural competency.

Availability of public and/or private transport was identified as a key factor enabling Pacific people to access primary care, as well as improved appointment system approaches, including walk-in clinics, extended hours and processes that reduce waiting times. Development of translation policies and practices, further developing the Pacific workforce and cultural competency training for mainstream services were also identified as important factors to increase access to healthcare for Pacific people. Integrating both health and social services is also thought to be an important way of addressing the higher health and social needs of our Pacific communities.

More recent data indicates that these barriers to care continue to be an issue for Pacific people. The NZ Health Survey includes questions on unmet need for primary health care and unfilled prescriptions due to cost. Surveys have consistently shown higher levels of unmet need, particularly due to cost, in Māori and Pacific, compared to non-Māori non-Pacific, people. Between 2014 and 2017, approximately 25% of Pacific people at Auckland DHB and 35% at Waitematā DHB reported not being able to access primary care in the last 12 months (Figure 14).

**Figure 14. Percentage of people unable to access primary care services for any reason in the previous 12 months, by DHB, 2014-17**

![Bar chart showing percentage of people unable to access primary care services by DHB and ethnic group.](image)

*Source: NZ Health Survey*

The main reason for this unmet need for Pacific people was cost (Figure 15). Approximately 20% of Pacific people in the Auckland region, compared to 12% of the total population, report that cost was a barrier to accessing primary care in the previous year.
Similarly, a higher proportion of Pacific people (approximately 20%, compared <10% of the total population) report not picking up a prescription medication due to cost (Figure 16).

Unmet need for secondary care is not routinely measured, although several clinical groups have recently called for this to be changed. Therefore, Māori and Pacific patients have higher rates of non-attendance at specialist outpatient appointments, indicating that there are also higher levels of unmet need for secondary care in these groups.
4. **Pacific Health Providers in the Auckland Region**

Pacific health providers in New Zealand first began to emerge in the 1980s in response to an identified need for services that were responsive to, and recognised the worldviews of, Pacific communities. A list of Pacific providers in the Auckland region is given in Table 3.

<table>
<thead>
<tr>
<th>Name</th>
<th>Location and DHBs served</th>
<th>Description of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaka Tautua</td>
<td>National Pacific organisation, Head Office in Manukau</td>
<td>Health and Social Support Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provides community support for older people and people living with a disability and/or mental illness.</td>
</tr>
<tr>
<td>Pacific Homecare</td>
<td>Papatoetoe (Auckland region DHBs)</td>
<td>Health and Social Support Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provides home-based care for disabled and elderly who wish to stay living at home, but need assistance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• In-home/homecare services include: disability care, elderly care, in-home respite care, long-term chronic health care, rehabilitative care, respite home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Elderly wellness programmes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• One Care Family Medical Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Whanau Ora</td>
</tr>
<tr>
<td>The Fono</td>
<td>Henderson (Waitematā DHB)</td>
<td>Health and Social Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical and dental clinics (Henderson, Blockhouse Bay, Auckland City, Manurewa, Northcote, Kaikohe)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Whanau Ora, Integrated (Fanau Ola) Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enua Ola/Parish nursing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Healthy Babies Healthy Futures Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Older Peoples Support Programmes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ready Steady Quit Stop Smoking Service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Oceania Career Academy</td>
</tr>
<tr>
<td>Health Star Pacific</td>
<td>Panmure (Auckland, Counties Manukau DHBs)</td>
<td>Primary healthcare and Well Child Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical clinic, Antenatal Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Well child and Mana Kidz services, Diabetes services</td>
</tr>
<tr>
<td>Tongan Health Society</td>
<td>Onehunga (Auckland DHB)</td>
<td>Health and Social Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Langimalie Integrated Family Health Centre (Onehunga, Panmure and Kelston)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Well Child services, Integrated (Fanau Ola) Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Youth health services, Parish nursing, Whanau Ora</td>
</tr>
<tr>
<td>Mt Wellington Integrated Healthcare Centre</td>
<td>Mt Wellington (Auckland, Counties Manukau DHBs)</td>
<td>Primary healthcare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Primary care, Whanau Ora</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Specialist services (orthopaedics, dental, diabetes nurse specialists, clinical psychology, clinical psychiatry, hand therapy and smoking cessation)</td>
</tr>
<tr>
<td>TOA Pacific Inc.</td>
<td>Otahuhu (Auckland, Counties Manukau DHBs)</td>
<td>Health of Older People</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MAAMA programme (health and disability info/education service for Pacific older people)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Empower-to-Pamper (Etp) programme (prevention of elder abuse and neglect for Pacific people)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asiasiga (trained volunteers and staff visit homebound older people in the community)</td>
</tr>
<tr>
<td>Name</td>
<td>Location and DHBs served</td>
<td>Description of Services</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Southseas Healthcare Trust    | Papatoetoe (Counties Manukau DHB) | - Time Out (half a day respite care for older people with Alzheimer’s, stroke or live alone)  
- TOAPAC – Treasured Older Adults, the Pacific Aiga Carers (national network for all Pacific carers of older people). |
| Bader Drive Doctors           | Mangere, Manurewa (Counties Manukau DHB) | - Medical clinic, Integrated (Fanau Ola) Services                                        |
| Penina Health Trust           | Manurewa (Counties Manukau DHB) | - Medical clinic (including antenatal services)                                        |
| Cavendish Doctors             | Manukau (Counties Manukau DHB) | - Medical clinic (including antenatal services)                                        |
| Southpoint Family Doctors     | Manukau (Counties Manukau DHB) | - Medical clinic (including antenatal services)                                        |
| Alliance Community Initiatives Trust | Manukau (Counties Manukau DHB) | - One Love Mangere (community-led initiative to build social capital)                
- Healthy Families Manukau (large-scale initiative to bring community leadership together for better health)  
- Pasefika Proud (Pacific family violence training programme)  
- Do Good Feel Good (Pacific youth health project to engage young people aged 17-24 in preventive health and improve access to health services)  
- Tangata o le Moana – Auckland Region Pacific Provider Network |
References

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 & 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

ABC - Ask, Brief Advice and Cessation
ACE - Angiotensin-converting-enzyme
ADHB - Auckland District Health Board
AOD - Alcohol and Other Drugs
ARRC - Age Related Residential Care
ARC - Aged Residential Care
ARD - Auckland Regional Dental Service
ARPHS - Auckland Regional Public Health Service
BP - Blood Pressure
CADS - Community Alcohol and Drug Service
CASA - Clinical Advisory Service Aotearoa
CEO - Chief Executive Officer
CMDHB - Counties Manukau District Health Board
CPHAC - Community and Public Health Advisory Committee
CVD - Cardiovascular Disease
DHB - District Health Board
DSLA - Auckland Waitematā Diabetes Service Level Alliance
GM - General Manager
GP - General Practitioner
HbA1c - Glycated Haemoglobin
HCSS - Home and Community Support Services
HPV - Human Papilloma Virus
HML - Homecare Medical Limited
HNA - Health Needs Assessment
HNZ - Housing New Zealand
IPS - Individual Placement and Support
IPS - Intentional Peer Support
LARC - Long Acting Reversible Contraceptives
MACGF - Metro Auckland Clinical Governance Forum
MECA - Multi-Employer Collective Agreement
MH&A - Mental Health and Addiction
MMR - Mumps, Measles and Rubella
MoE - Ministry of Education
MoH - Ministry of Health
MSD - Ministry of Social Development
MVCOT - Ministry of Vulnerable Children Oranga Tamariki
1. Executive Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitematā DHBs’ (DHB) planning and funding activities and areas of priority, since its last meeting on 20 February 2019. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting’s agenda.

Highlights

- As outlined in the quarter two CPHAC paper Community Based Diabetes Care Programme Update the repurposed DCIP PHO Agreements now encourage flexibility and innovation with the expectation that achieving equity of outcomes will guide DCIP activity. There are very promising examples of gains against the MACGF diabetes and CVD clinical indicator targets for total practice populations and for Māori and Pacific subsets of the practice populations. So far, strategies that involve nurse led care, extended consults, and/or health coaching show a great deal of promise.

- Across both Auckland and Waitematā we have consistently achieved the CVD secondary prevention target in people with diabetes since January 2018.

- A focused programme to catch up mumps immunisations in Pacific youth in response to an earlier outbreak has proven beneficial in the recent increase in measles cases. This has ensured there are fewer adolescents vulnerable to measles, as mumps programmes delivered 3,608 and 1,501 MMR vaccinations respectively, resulting in an increase of adolescents who had at least 1 dose of MMR.

- The Maternal Oral Health prototype which aims to provide free oral health care for pregnant women in Tāmaki has entered the implementation phase.
• The Whānau Ora review has reported positive findings. Of particular note was the high trust and long term nature of funding and support which focused on purchasing services and care that built resilience and capability of Whānau.

2. Planning

2.1 Annual Plans
The 2019/20 Annual Planning guidance was received in late December from the Ministry of Health and has been updated several times since. First drafts of the Annual Plans are underway and have been presented at Auckland Board and Waitematā Board early in 2019. The 2019/20 financial plan was not included in the Draft Annual Plans as this is still being developed due to late advice on funding from the Ministry of Health. The complete draft 2019/20 Annual Plan and financial templates will be submitted plan to the Auckland Board and Waitematā Board in early July.

2.2 Auckland and Waitematā DHB Quarterly Performance Scorecard
The Auckland and Waitematā 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 3 of the 2018/19 year. As noted previously, this scorecard is intentionally reported by ethnicity and in areas of known priority and focus.
### Auckland DHB and Waitematā DHB Community and Public Health Advisory Committee Meeting 15/05/19

#### Health Targets - Auckland DHB

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV immunisation coverage - girls</td>
<td>94%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Orally Health - % enrolled utilisation at 2 years</td>
<td>84%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Orally Health - % Infants enrolled at 2 years</td>
<td>82%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Diabetes management</td>
<td>97%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Raising Healthy Kids</td>
<td>100%</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>

#### Health Targets - Waitematā DHB

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV immunisation coverage - girls</td>
<td>87%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Orally Health - % enrolled utilisation at 2 years</td>
<td>85%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Orally Health - % Infants enrolled at 2 years</td>
<td>85%</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>

### Child, Youth and Women - Auckland DHB

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>68%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>89%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>83%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>138%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Vaccination coverage - girls</td>
<td>78%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>62%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>64%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>82%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>83%</td>
<td>75%</td>
<td></td>
</tr>
</tbody>
</table>

### Child, Youth and Women - Waitematā DHB

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>83%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>96%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>83%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>138%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Vaccination coverage - girls</td>
<td>78%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>62%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>64%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>82%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>83%</td>
<td>75%</td>
<td></td>
</tr>
</tbody>
</table>

### Primary Care - Auckland DHB

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO enrolment</td>
<td>82%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>72%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>85%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>68%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>87%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

### Primary Care - Waitematā DHB

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO enrolment</td>
<td>83%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>72%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>85%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>68%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>87%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

### Health of Older People - Auckland DHB

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBSS clients with Clinical interRAI</td>
<td>57%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>62%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>63%</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>65%</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>61%</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>61%</td>
<td>82%</td>
<td></td>
</tr>
</tbody>
</table>

### Health of Older People - Waitematā DHB

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBSS clients with Clinical interRAI</td>
<td>50%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>60%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>60%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>60%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>60%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>60%</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

### How to Read

- **Achieved**: Target met
- **Achieved but off target**: Target met but goal not achieved
- **Partially achieved/On track**: Progress to target
- **Not achieved/Detrended**: Progress away from target
- **Not achieved/Off target**: Progress away from goal
- **Not achieved**: Progress away from target

### Key Notes

- **Actual and targets are reported for the latest 12-month period (June to May).**
- **Actual and target targets are reported for the latest 12-month period (June to May).**
- **Trend lines represent the data available for the latest 12-month period.**
- **Trend lines represent the data available for the latest 12-month period.**
- **Population data is reported on an annual basis.**
- **Population data is reported on an annual basis.**
- **Data range may result in small trend lines.**
- **Data range may result in small trend lines.**
- **Scorecard header.**
- **Scorecard header.**
3. **Primary Care**

3.1 **National Health Targets**

‘Better Help for Smokers to Quit’ DHB Target: 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. The ‘Better Help for Smokers to Quit’ result is reported as a National Health target (NHT). Results for Q3 2018-19 have not been provided by the Ministry by the deadline for this report, therefore no update can be provided.

3.2 **Diabetes Management**

Metro Auckland DHBs and PHOs are committed to improving population health outcomes for people with diabetes. To help achieve this goal, five regionally agreed Diabetes and Cardiovascular disease (CVD) clinical indicators have been prioritised for monitoring performance. All metro Auckland PHOs (seven) have been reporting anonymised practice level data relating to these five clinical indicators since June 2017. Performance against these indicators is being reported to the Metro Auckland Clinical Governance Forum (MACGF) and the Auckland Waitematā Diabetes Service Level Alliance (DSLA).

The below Tables 1 and 2 outline performance against the five MACGF diabetes and CVD clinical indicators as at 31 December 2018 and compare this to the performance as at 30 September 2018 to highlight performance change over quarter two 2018/19.

**Table 1: Auckland DHB performance against the MACGF Diabetes and CVD Clinical Indicators as at 31 December 2018¹ compared to performance as at 30 September 2018.**

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Goal</th>
<th>Auckland DHB</th>
<th>Total number required to reach the indicator target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c Glycaemic control:</strong> Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months</td>
<td>80%</td>
<td>51% (no change)</td>
<td>48% (↓ 1%)</td>
</tr>
<tr>
<td><strong>Blood pressure control²:</strong> Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is &lt;140mmHg</td>
<td>80%</td>
<td>59% (↓ 1%)</td>
<td>60% (↓ 1%)</td>
</tr>
<tr>
<td><strong>Management of Microalbuminuria:</strong> Percentage of enrolled patients with</td>
<td>90%</td>
<td>73% (no change)</td>
<td>79% (no change)</td>
</tr>
</tbody>
</table>

¹ Data Source: Numerator and denominator is extracted from the PHO enrolled data. The denominator is different than that for previous CPHAC reports and Ministry of Health reports.

² In quarter one there were significant data capture issues affecting the blood pressure control and CVD primary prevention indicators. This issue was resolved in quarter two.
### Table 2: Waitematā DHB performance against the MACGF Diabetes and CVD Clinical Indicators as at 31 December 2018 compared to performance as at 30 September 2018.

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Goal</th>
<th>Waitematā DHB</th>
<th>Total number required to reach the indicator target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c Glycaemic control:</strong> Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months</td>
<td>80%</td>
<td>49% (↓ 1%)</td>
<td>51% (↑ 1%)</td>
</tr>
<tr>
<td><strong>Blood pressure control:</strong> Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is &lt;140mmHg</td>
<td>80%</td>
<td>63% (↑ 1%)</td>
<td>65% (↑ 1%)</td>
</tr>
<tr>
<td><strong>Management of Microalbuminuria:</strong> Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker</td>
<td>90%</td>
<td>78% (↑ 2%)</td>
<td>78% (no change)</td>
</tr>
</tbody>
</table>

---

3 Data Source: Numerator and denominator is extracted from the PHO enrolled data. The denominator is different than that for previous CPHAC reports and Ministry of Health reports.
3.2.1 Performance against the five regionally agreed clinical indicators at a DHB level

As can be seen in Table 1 and Table 2, above, gaining traction against clinical indicator targets has been challenging. It is encouraging to note that as the MACGF data set becomes more complete (for the number of people with diabetes, elevated blood pressure, microalbuminuria, CVD and CVD risk >20%) some of the challenges to achieving the targets become more apparent.

The recent repurposing of one of the PHO funding streams (Diabetes Care Improvement Package (DCIP) funding) is one of five priority DSLA projects designed to attain equity of health outcomes and improved health outcomes for people living with diabetes. As outlined in the quarter two CPHAC paper Community Based Diabetes Care Programme Update the repurposed DCIP PHO Agreements now encourage flexibility and innovation with the expectation that achieving equity of outcomes will guide DCIP activity. There are very promising examples of gains against the MACGF diabetes and CVD clinical indicator targets for total practice populations and for Māori and Pacific subsets of the practice populations. So far, strategies that involve nurse led care, extended consults, and/or health coaching show a great deal of promise. As work progresses and confidence in successful strategies grows, the next phase will be to promulgate the successful strategies of high achieving practices more widely. This work sits alongside and is complementary to the search for new, more successful ways of delivering care via the DSLA flagship co-design project.

Across both Auckland and Waitematā we have consistently achieved the CVD secondary prevention target in people with diabetes since January 2018.

In December 2018 a number of the historical data issues were resolved and the data between January 2018 and December 2018 was re-uploaded. There has been minimal change in performance against all five indicators between January 2018 and December 2018. However, in Auckland DHB there are two exceptions to this general picture. Firstly the management of microalbuminuria in Māori decreased by 4% between January 2018 and December 2018. This is predominantly due to more Māori with diabetes with microalbuminuria being identified. However, as more Māori with diabetes are identified with microalbuminuria the number who are on an ACE inhibitor or

---

4 In quarter one there were significant data capture issues affecting the blood pressure control and CVD primary prevention indicators. This issue was resolved in quarter two.
Angiotensin Receptor Blocker continues to increase, which is positive. Secondly there is an increase in Pacific people with a CVD risk >20% on dual therapy. This has increased from 49% in January 2018 to 55% in December 2018, which is also positive.

### 3.2.2 Data quality issues affecting this quarter’s data

The data quality achieved by primary care has improved considerably from the last quarterly upload. However, there are data extraction issues that have resulted in data not being available for 21 out of 234 (9%) practices across Auckland and Waitematā DHBs. The PHOs are working to resolve these issues but we have not been provided with a date for when these issues will be resolved. However, at the December 2018 upload data was available for 207 out of the 234 (88%) general practices in the Auckland and Waitematā districts and this number continues to improve with each upload.

It is recognised that the data contained within this report has some ongoing data quality issues and is incomplete. Caution needs to be taken when interpreting data within this report. In particular it should be noted that practices with outlying performance (either poor or good) may have data quality issues or contain very small enrolments of people with diabetes or CVD, rather than true outlying performance.
Summary of each indicator by DHB and ethnicity

Auckland DHB - by Ethnicity

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HbA1c Glycaemic Control</td>
<td>Sauvaget-Tahiti, Other, Pacific, Auckland</td>
</tr>
<tr>
<td>2. Blood Pressure Control</td>
<td>Sauvaget-Tahiti, Other, Pacific, Auckland</td>
</tr>
<tr>
<td>3. Management of Microalbuminuria</td>
<td>Sauvaget-Tahiti, Other, Pacific, Auckland</td>
</tr>
<tr>
<td>4. CVD Secondary Prevention (Diabetes)</td>
<td>Sauvaget-Tahiti, Other, Pacific, Auckland</td>
</tr>
<tr>
<td>5. CVD Secondary Prevention (Total CVD)</td>
<td>Sauvaget-Tahiti, Other, Pacific, Auckland</td>
</tr>
<tr>
<td>6. CVD Primary Prevention (Diabetes)</td>
<td>Sauvaget-Tahiti, Other, Pacific, Auckland</td>
</tr>
<tr>
<td>7. CVD Primary Prevention (Total CVD)</td>
<td>Sauvaget-Tahiti, Other, Pacific, Auckland</td>
</tr>
</tbody>
</table>
Waitematā DHB - by Ethnicity

1. HbA1c Glycaemic Control

2. Blood Pressure Control

3. Management of Microalbuminuria

4. CVD Secondary Prevention (Diabetes)

5. CVD Primary Prevention (Diabetes)

6. CVD Primary Prevention (Total CVD)

7. CVD Secondary Prevention (Total CVD)

Ethnicity:
- Māori
- Other
- Pacific
- Whānau
3.3 Cardiovascular Disease (CVD) Risk Assessment

3.3.1 CVD risk assessment in total population
Auckland DHB has achieved and sustained the 90% CVD risk assessment target at a total population level since September 2014 (Figure 3).

Waitematā DHB had also achieved and sustained the 90% CVD risk assessment target at a total population level since September 2014 (Figure 3). However, since July 2018 Waitematā DHB CVD risk assessment rate has declined and as of 30 March 2019 the CVD risk assessment rate was 88.1% (↓0.6%), as compared to quarter two 2018/19. The main cause for this decline is due to a significant number of people receiving a CVD risk assessment between July and September 2014 in order to achieve the 90% target in 2014 and these people are now coming due their repeat CVD risk assessment. The PHOs have given assurances that achieving the 90% CVD risk assessment target is a priority and they are actively working to achieve this target.

3.3.2 CVD risk assessment in Māori men aged 35-44 years
To support achieving the CVD risk assessment target in Māori, the Ministry of Health has focused on achieving this 90% CVD risk assessment target in Māori men aged 35-44 years. The screening rate for Māori men aged 35 to 44 years was 76.0% (↑0.6%) and 69.7% (↑0.7%) for Auckland and Waitematā DHBs respectively at the end of quarter three, 2018/19. The increases noted are relatively to quarter two, 2018/19. The PHOs have submitted action plans on what activities they plan to undertake in 2018/19 to achieve the CVD risk assessment target in Māori men aged 35-44 years and we will continue to monitor progress against both these plans and this target.

Figure 3: ‘More Heart & Diabetes Checks’ performance for Auckland DHB and Waitematā (Q2, 2018-19)

Note: More Heart and Diabetes Checks quarter two, 2018/19 – Preliminary Data, Ministry of Health.
4. Child, Youth and Women’s Health

4.1 Immunisation

4.1.1 Immunisation Health Target

Immunisation coverage in quarter 3 is often lower than other quarters, most likely due to the holiday period, with practices closed and families on holidays. Neither DHB achieved 95% of babies fully immunised by 8 months of age. However, both remain well above the national average of 90% with Auckland reaching 94% and Waitematā reaching 92%.

Auckland DHB with 94% of babies being fully immunised by 8 months of age, reflects similar coverage to that achieved in the same quarter 2017/18. The falling Māori coverage stabilised this quarter although remains low at 84%, whilst Pacific coverage fell to 93%.

Waitematā DHB with 92% coverage at 8 months remains stable over the previous two quarters and is an improvement on the 91% for the same quarter in 2017/18. Māori coverage is 87% and Pacific is 93%.

Tamariki Māori decline rates continue to be problematic. National Immunisation Register (NIR) analysis shows increasing decline rates for tamariki Māori at 6.5% in Auckland DHB (10 tamariki) and 6.0% in Waitematā DHB (17 tamariki) in Q3 2018/19. An in-depth analysis of immunisation timeliness for tamariki Māori turning 8 months, 24 months and 5 years of age in Quarter 2 2018/19 is being finalised. This is the basis of work with the Māori Health Gain team on activities to improve immunisation, including working with Māori leadership to promote new approaches to immunisation. New promotional material is also being finalised following consumer testing with Māori groups, with a suite of photographs shot last week.

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 6 years of age. Auckland DHB’s coverage at 24 months and 5 year has remained stable at 94% and 87% respectively. Waitematā DHB had a 1% increase in 24 month coverage to 92%, however coverage at 5 years decreased by 2% to 86%.

The collaboration with Plunket continues to provide an additional outreach immunisation contact for Māori and Pacific children who have not yet responded to the HealthWEST Outreach Immunisation Service (OIS). This combined Well Child tamariki ora (WCTO) health support worker and nurse vaccinator service has had an increased focus on children turning 24 months and 5 years of age.

Auckland and Waitematā DHBs continue a programme of work with PHOs to improve early enrolment for infants. Following a workshop with PHOs and HealthWEST NIR/ Outreach immunisation services (OIS), PHOs have identified practices in priority area to trial a supported pathway to enrolment with a PHO. We are now working with HealthWEST OIS on implementing this trial.

4.1.2 Measles
As noted in the paper Auckland Regional Public Health service update, there were 17 confirmed cases of measles in the Metro Auckland area – seven in Waitematā DHB, eight in Auckland DHB and one in Counties Manukau. ARPHS are currently operating within a “stamp it out” phase. ARPHS are co-ordinating a regional health sector response for measles control should the case numbers continue to escalate.

The current Ministry of Health recommendation for areas outside Canterbury is to maximise MMR immunisation uptake for infants at 15 months and four years of age as per the National Schedule. The second priority is to offer MMR immunisation to youth and adults <50 years who have never had any doses of MMR immunisation.

In response to the Mumps outbreak last year, both Auckland and Waitematā DHBs undertook school-based MMR vaccine catch up programmes for Pacific students over 2017 and 2018 in low decile secondary schools with funded school health services. These programmes delivered 3,608 and 1,501 MMR vaccinations respectively, resulting in an increase of adolescents who had at least one dose of MMR.

4.1.3 Antenatal Immunisation
Pertussis continues to be reported. Although the January peak has reduced now, in the last four weeks, there have been three cases under one year old age in the metro Auckland region.

The Auckland DHB opportunistic vaccinator service which launched in October 2018 has expanded to include antenatal clinics at Auckland City Hospital in addition to those at Greenlane Clinical Centre. The opportunistic vaccinators are offering both pertussis and flu vaccines to women attending these clinics as well as providing education for mums-to-be on the importance of timely immunisation of their babies.

The well-established Waitematā DHB Opportunistic Vaccinator at Waitakere Hospital continues to offer immunisation to women attending the antenatal clinics, immunising 54 women in the last quarter in addition to providing immunisation to families in Rangatira ward.

Work continues on the SMILE campaign (Smoke and alcohol free, Mental wellbeing matters, Immunise, Lie on your side and Eat healthily). The Auckland DHB communications team have completed a photo shoot for the imagery, with the messages now having final feedback from
maternity leads. These images will be incorporated into the SMILE resource suite to promote immunisation as part of a health pregnancy (in addition to being smoke and alcohol free, promoting maternal mental wellbeing, lie on the side and eat well and exercise).

A first workshop to co-design a prototype wrap around care model for maternity services has been held. The workshop was facilitated by the Auckland DHB performance improvement team. This prototype is intended to first roll out in Tāmaki. Stakeholders from this area are actively engaged in the co-design.

A new round of distribution of the successful antenatal vaccine reminder cards for both Boostrix and Influenza will commence this month, with a focus on providing this resource to lead maternity carers (LMC). The health professional survey undertaken at the end of last year provided feedback that this resource is well received and utilised.

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 on the proposal to implement a shared coordination service hosted by Auckland and Waitematā DHBs to support the NCHIP platform. The changes required include repatriating the National Immunisation Register (NIR) to DHB management. The DHBs are seeking feed-back particularly regarding unintended consequences of change. Feedback closed in February. There will be some delay in presenting the summary report while all responses are fully considered.

The NCHIP Privacy Impact Assessment (PIA) has been reviewed and updated for the Northern Region implementation. This month the Regional Privacy Advisory Group formally approved the Northern Region NCHIP PIA.

4.3 Child and Youth Well Being Strategy and National Well Child Tamariki Ora Review
The Department of Prime Minister and Cabinet has released the summary report of the public consultation on the future Child and Youth Wellbeing Strategy. The consultation workshop series and submissions culminated in 10,000 contributions being made. Key themes to emerge are:

- Change is needed, and it’s needed now.
- The Strategy needs to be bigger than the government of the day.
- Local communities are integral to the success of the Strategy.
- The Strategy needs to have a focus on family and whānau wellbeing.
- Te Tiriti o Waitangi should be a clear and empowering dimension of the Strategy.
- The Strategy needs to focus on reducing inequity.
- A good life is more than the bare basics.
- Children and young people have a right to be included in the decision making process.
- Invest in ensuring all kids get a great education.
- Focus on early intervention and specifically the first 1000 days.
- Government, agencies, and community services need to work together better.

Outcomes from the consultation will inform development of the first Wellbeing Strategy which is due to be published later this year.

In related work, the Ministry of Health also has a National Review underway for WellChild Tamariki Ora. Following a series of regional symposiums, the Ministry of Health (MoH) have announced the following Key Milestones for the review:
• March 2019: Planning Phase
• June 2019: Early Analysis Phase. During this phase evidence and data will be gathered to inform the shape of the Review
• June – October 2019: Options Phase. Possible improvements to Well Child Tamariki Ora will be tested during the Options Phase
• October 2019 – 1 July 2020: Implementation Phase. The first changes to Well Child Tamariki Ora are expected to be in place from 1 July 2020

The timelines have been shared with WCTO stakeholders in the Auckland and Waitematā region and we are actively encouraging groups to be engaged with the Review.

4.4 Oral Health
The Maternal Oral Health prototype which aims to provide free oral health care for pregnant women in Tāmaki has entered the implementation phase. Recruitment is now underway for the project lead as well as clinical & support staff. A steering group is being developed to oversee the implementation with members from the provider Auckland Regional Dental Service (ARDS), and the AUCKLAND DHB Community Maternity Service.

Due to high demand from families for the child oral health Saturday service in the Point England, an additional chair was opened, bringing the total to 3 chairs.

Work under the Metro Auckland Pre-school Oral Health Strategy continues with activities to improve equity currently focused on refining enrolment processes and reducing DNAs, predominately by improved booking services. ARDS is continuing to develop relationships with Early Child Education centres and kohunga reo with a view to expanding service linkages.

4.5 Youth Health
The Enhanced School Based Health Services work plan for the 2019 calendar year includes:
• implementing services in decile 4 schools including an opportunistic vaccination catch-up service
• implementing and reporting on the Shared Outcomes Framework for both DHBs
• new requirements for schools to have healthy food and beverage policies
• sexual health (including LARC) training for school based nurses
• increased chlamydia testing
• increased youth appropriate alcohol and other drugs (AOD) screening.

The mindfulness and resilience group programme for pre-teens (intermediate school age) has been rolled out Term 1 2019 and an evaluation will be undertaken by ProCare this calendar year.

4.6 Transgender Healthcare – Tender for new Peer Support Service
The Planning, Funding and Outcomes (PFO) team transgender health project focused on improving access to gender affirming healthcare for transgender peoples for the northern region DHBs came to a close in January 2019. Project work has moved into business as usual, overseen by the Northern Region Transgender Clinical Governance Group (NRTCGG).

The Northern Region DHBs have sought a provider for a new Transgender Peer Support Service through an open tender process. Counties Manukau Health will hold the contract on behalf of the Northern Region District Health Boards. Service delivery is scheduled to start 1 July 2019.

The Peer Support Service will use a multi-faceted approach to service delivery, including: Peer Support Workers (PSW) trained and working in a locally informed Intentional Peer Support (IPS) \[1\]
model; Peer Volunteers who receive training to run peer led groups and other low level interventions; and moderated online channels to increase access to peers and information outside of formal appointments. In addition to increasing service capacity, volunteering opportunities are well correlated with improved health outcomes.\textsuperscript{5,6} Service users will be transgender people aged 12+, and family / Whānau of transgender people of all ages. All new referrals to the service will receive an initial contact with a Peer Support Worker, where the best supports for the person and their family are identified. The Peer Support Service will tailor its activities towards specific groups including: parents of transgender children (<12 years), adolescents (13 – 17 years), young people (18 – 24 years), and those who are older (50+ years). Through the use of Peer volunteers, the service will be better able to meet the needs of Māori, Pacific, Asian and other ethnic groups than through the sole use of paid staff.

4.7 Healthy Housing
The Kāinga Ora (Healthy Housing) service has a priority focus on pregnant women and those with young babies. As at March 31 2019, Auckland and Waitematā DHBs have received 1541 referrals to Kainga Ora. 6534 family members have had access to healthier home interventions. Of the referrals received 504 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 (MSD).

E-referrals for primary care are live. The evaluation of Kāinga Ora funded by Starship and Well Foundations was conducted. The results demonstrate a high level of acceptability and accessibility as reported by clients. The majority of clients in private rentals found their homes warmer and drier after healthy housing interventions were completed. Clients had increased confidence to engage with social services, with one client discussing her increased knowledge enabling her to support two other homeless families through MSD and Housing New Zealand (HNZ) processes, into new public houses.

Habitat for Humanity’s To Kainga Whare service, which provides housing interventions for Auckland DHB, Waitematā DHB and Counties Manukau Health (CMH) Healthy Housing Initiatives (Kainga Ora and Awhi) has received funding of $819,800.00 for the period April 2019 – March 2020 from Foundation North, Huge Green Foundation, Starship Foundation and Green Star. This enables continuation of important interventions for Kainga Ora families, including those in private rentals, for items such as minor repairs, curtains and landlord liaison.

4.8 Cervical and Breast Screening
Our cervical screening coordination service is working alongside Piritahi health service provider on Waiheke to provide cervical screening to women who are overdue in that location. The service provides support with invitation and recall, quality improvement within health care practices with respect to their cervical screening data and support with screening. Prioritized engagement with other practices is ongoing.

4.9 Long Acting Reversible Contraceptives
Funding has been received from the MOH to invest in improved access to long term contraceptive devices such as the contraceptive implant, Jadelle and Intra uterine devices. These devices provide contraception for a period of 5 years, enabling women a high degree of control over their reproductive lives. The work will involve improving training and credentialing available for nurses,


midwives and doctors in this area. Initiatives to improve accessibility to women for comprehensive contraceptive services in the community as well as post-partum in maternity services will be developed.

5. Health of Older People

5.1 Age Residential Care (ARC)
In order to partially offset the impact of the DHB Nurses MECA settlement on ARC it has been confirmed that ARC providers will receive two lump sum payments, which will be the equivalent to a full year 0.43% increase to all service levels in the Aged Residential Care (ARRC) Agreement. A payment was made in March 2019 and the second payment will be in August/September 2019 for the previous financial year. From the 1 July 2019, the 0.43% increase will be incorporated into any contract price increase that is agreed with the sector.

ARC providers in Auckland and Waitematā DHBs continue to raise concerns about the significant challenges they are facing in recruiting and retaining registered nurses. Planning and Funding are closely monitoring this area and DHB gerontology nurse specialists supporting ARC are aware of the situation.

Changes to the ARRC Agreement identified through the A21 Review (annual contract review process) for 2019/20 are relatively minor. It is noted that the ARC Funding Model Review is due to be released in May 2019 and this will set the direction for future considerations in terms of both the funding of ARC services and the contract arrangement.

5.2 Home and Community Support Services
Devolution of Pay Equity funding to DHBs for 1 July 2019 is currently a major piece of work. A technical working group has been set up to identify models to incorporate this funding into contract price for Home and Community Support Services (HCSS). Planning and Funding has representation on the working group. There are a number of principles that underpin this work including the need to limit financial risk to the Crown, funders and providers when incorporating the funding into contracts and to ensure Pay Equity legislative requirements are met.

The HCSS Medication Guidelines initiated by Waitematā DHB and its HCSS providers have now been finalised and will be published on the MoH website on 30 April 2019.

The Auckland DHB HCSS cost model review has been completed. The revised model reflects changes that have occurred with the model of care and within the sector such as the administration requirements for support worker guaranteed hours and In between Travel. The rates for the case mix categories have been adjusted accordingly to reflect changes in relativities however the total HCSS funding pool remains unchanged.

In March 2019 a workshop on ethics and safety was held for the Auckland DHB HCSS providers and the Needs Assessment Service Coordination (NASC) team. This was a collaborative workshop with a panel of experts from Auckland DHB available to talk through some of the complex and ethical scenarios that come up for clients, support workers, NASC and home care providers in the community. A wide range of scenarios were discussed and feedback was positive; approximately 50 people attended.

A falls prevention project manager has been employed on a fixed term contract to undertake activities to promote the falls prevention services and drive demand particularly in the general...
practice setting. Planning and Funding has set up e-referrals to the service and a falls risk assessment on the Patient Dashboard in general practice. However, despite these actions referrals from general practice are still lower than expected and it is clear that older people who would benefit from these services are not being referred. It is hoped with additional support from a project manager referrals particularly to the in-home strength and balance programme will increase.

6. Mental Health and Addictions

6.1 Government Inquiry into Mental Health and Addiction Services
The Government Inquiry into Mental Health and Addictions was announced by Government in early 2018 and commenced in February 2018, with the final report (He Ara Oranga) presented to Government and released to the public in November 2018. It was expected that the Minister of Health would release a response to the report in the latter part of March 2019; however the response has been delayed due to the health response required in the aftermath of the Christchurch tragedy. The response is now expected to be released mid 2019.

Early indications from the MoH are that initial priority areas will be:
- Reform of the Mental Health Act
- establishment of a Mental Health and Wellbeing Commission
- building workforce capability, including peer work force, and
- refreshed Suicide Prevention Strategy (by June 2019).

6.2 Psychosocial Response to Christchurch post 15 March 2019
Emergency Planners across metro Auckland DHBs co-ordinated the Auckland psycho-social response to the traumatic event in Christchurch of 15 March 2019. The National Telehealth Service based at Homecare Medical Ltd (HML) has been the central responder to distressed callers, and media and public figures promoted this as the national response service (call 1737). Naturally the service has been an unprecedented rise in calls. The Emergency Planners have co-ordinated with DHB mental health services and PHO psychological services, to establish rosters of additional staff resource, to fill shifts at the National Tele-health Service. The staff covering these shifts are predominantly psychologists or other clinicians with expertise in trauma counselling.

The calls to 1737 are primarily from people who experienced the Christchurch earthquake and are now re-traumatised, and also those traumatised by the media coverage, in particular social media coverage of the event of 15 March. The need for support is expected to be on-going in coming weeks and months. As of early April Homecare Medical projected a 30% to 80% increase in service demand over that month.

Other local responses have included:
- An Auckland DHB NGO (Kahui Te Kaha) immediately mobilised their Muslim Mental Health Support team and other Muslim workers in their service to go to Christchurch the weekend immediately following the event. This was at the request of Muslim leaders in Christchurch.
- Other NGOs have offered to provide support in Auckland, if required, for the Muslim community, by offering community training, for example (Mental Health First Aid)

As of late March the MoH Mental Health and Addictions Directorate took responsibility for co-ordinating the national psycho-social response and planning. A central email address has been established so that community needs and volunteers of help can be centrally co-ordinated.
6.3 Suicide Prevention and Postvention
The Waitematā DHB and Auckland DHB Suicide Prevention and Postvention Plan 2015/17 is undergoing a review process. The current phase of review is awaiting publication of guidelines, which will then be aligned with an updated plan. This process should shortly be completed, and an implementation phase will begin in July 2019. The plan will undergo a further review in 2024. In the interim we continue to report on suicide prevention.

A more detailed statement intended for CPHAC on suicide prevention and postvention has been delayed. This delay is owing to the desire to include mortality data which has not yet been finalised by the MoH. The next meeting of CPHAC will include a comprehensive paper on this topic.

6.4 Mental Health and Addictions Support Worker Pay Equity
As of 1 December 2018, all Auckland DHB Mental Health and Addiction 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 the DHB, for the same purchase units.

The subsequent stages of work currently underway and led by the MoH Pay Equity Team supported by Technical Working Groups are:

- The development of a reconciliation method to backdate contract payments to 1 July 2018 to ensure correct contract price uplift and pay equity rates have been applied. All DHBs have reviewed and amended the spread-sheets created by the Pay Equity team for this purpose, and a wash-up process will follow
- pay Equity into contracts for 19/20 - the Technical Working Group has recommended a calculated percentage increase across all eligible providers based on national increase in qualification levels derived from workforce data submitted by providers to the Pay Equity team. This approach has been endorsed by the Pay Equity Governance Group, and the Collaborative Partnership Group, and is awaiting endorsement by the National GM Funders
- devolution Steering Group (to devolve pay equity to DHBs)
- collaborative Partnership group comprises DHB CEOs, NGO CEOs and Funder GMs, tasked to address longer term issues including national consistency of price and service specifications, and commissioning for outcomes.

6.5 Individual Placement Support Project Waitematā DHB
Individual placement support (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 three years to be provided by the Adult Mental Health Services at Waitematā DHB. This programme of work has already been in place in Auckland DHB for some time.

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 Waitematā DHB. 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 Waitematā, increasing client access to this employment support from 50 to 500 people over the coming 2 years.

The initial prototype has been extended to ensure service delivery does not stop during the procurement process for the wider trial. The procurement process continues to take place and it is
anticipated that a final outcome will be announced in April. The trial will commence no later than 1 July 2019 and continue until 30 June 2021.

6.6 Integrated Detox Services with Community Alcohol and Drug Service and Auckland City Mission

Mission HomeGround is the Auckland City Mission’s (Mission) rebuild initiative in Hobson Street. The detailed design for Waitematā DHB’s medical managed withdrawal floor will be finalised by the end of May 2019.

Key Mission personnel were scheduled to meet with key Waitematā DHB personnel in February 2019 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, but this work has been delayed due to the current focus on the build activity. The Mission has agreed to hire additional change management resource to support its management team to develop and execute the necessary planning required in this area.

The Northern Regional Alliance (NRA) is progressing its review of the Auckland region’s current end to end managed withdrawal service – from acute through to home-based care. The literature review has been completed and now a gap analysis to identify areas of improvement to meet best practice is being completed. A Steering Group has been established to oversee this work and the NRA’s findings will be reported back to this Group to determine next steps in the first instance.

A further briefing with impacted Community Alcohol and Drug Service (CADS) staff and their union delegates is scheduled prior to the Easter break.

7. Māori Health Gain

7.1 Summary findings from the Whānau Ora Review

In 2018, the Minister for Whānau Ora, Hon. Peeni Henare, initiated a review of the whānau ora commissioning approach and its ability to effect sustainable change for Māori and Pacific whānau. There are three commissioning agents – Te Pou Matakana (for North Island Māori), Pacific Futures (for Pacific people) and Te Pūtahitanga o Te Waipounamu (for South Island Māori).

The review, published in late 2018, of each commissioning agency found that they operated different investment models and approaches. For example, one approach was to fund networks of providers working with whānau through a collective impact methodology. This brought together a myriad of providers, agencies and community groups to focus in on a single, yet complex, community identified issue like youth unemployment or access to health services. Another approach was one of direct and on-going engagement with whānau. In this model, whānau would identify an issue they were experiencing, and work directly with the funder to purchase support to understand how they can address the issue(s) of importance to them. The review found that each approach had its benefits, with the first creating major system change initiatives while the other could show real tangible health and wellbeing outcomes at the whānau level.

Overall, the review was extremely positive about the commissioning approach employed under whānau ora. Of particular note was the high trust and long term nature of funding and support which focused on purchasing services that built resilience and capability of whānau. The review recommends that other funders look at opportunities for whānau-centred and strength based investment. By empowering whānau to identify their own issues and develop their own solutions,
the review concluded that this would build resilience within whānau that would affect other areas of life.

The funding was also flexible and agile enough to allow for whānau to present a range of issues to be addressed through targeted investment. Whānau outcome frameworks were used to prioritise and direct whānau ora funding by commissioning agencies. A recommendation of the review was for other funders to align their funding to these frameworks to create opportunities for co-investment. This would also embed whānau centred approaches to care within the wider provider/NGO sector. In essence, improving the way in which services across the board are provided to whānau.

Auckland and Waitematā DHBs have an opportunity to leverage the findings from the review to strengthen DHB strategies, models of care, contracts and contracting processes. In particular:

- Governance/strategy – developments with the Iwi-DHB Partnership Board to support a critical and supportive Māori voice in strategy setting, prioritising resource allocation and co-design of new services
- Accountability and high trust environments - develop specific measures using the pre-existing Auckland and Waitematā DHB Outcome Framework Ngā Painga Hauora to measure and review the performance of services funded and provided by DHBs
- Models of care - reorient and enhance models of care across DHB funded and provided services to whānau-centred and directed models. This is particularly important for services with high Māori engagement such as primary care and hospital services
- Contracting - improve alignment of all current contracts to existing/new outcomes and equity measures/targets, including outcomes reporting and data collection, and valuing whānau centred and strength based approaches. An equity audit is currently underway to identify areas for improvement in contracting.

7.2 Whānau House Health Needs Assessment – Implementation

7.2.1 Enhanced Well Child Service
The first business case and response to the needs identified in the Health Needs Assessment (HNA) is well underway. This was an enhanced well child service which supported a social worker role to complement existing infant care already provided at Whānau House. Already, this service has worked with over 30 vulnerable Māori families through service coordination, immunising babies, and facilitated enrolment with general practice.

7.2.2 Taitamariki Alcohol and Drug Prevention
The second service, a youth alcohol and drug prevention service is currently being developed for a go live date in June. The details of the service are being co-designed with youth, Māori providers, specialist services and NGOs in West Auckland.

7.2.3 Family Violence
The third business case will look at developing a family violence service for Whānau House. As reported previously, we reviewed data from Whānau House that identified a number of whānau being screened for family violence and referred to external social sector agencies where the majority of family violence intervention programmes are funded. The options for this process include working with existing providers to co-locate an intervention programme in Whānau House, integrate services for more seamless transition between screening, referral and treatment for whānau, or enhancement of existing family violence services. For the latter, this could mean further engagement with the wider whānau affected by violence as a means for repairing the entire whānau, and/or using cultural reconnection approaches to build resilience within whānau. This process will be informed by a review of a previous kaupapa Māori service funded by the Ministry of Health in Auckland DHB called Hohourongo. This review recommended a more comprehensive
programme that worked with the entire whānau, while focusing treatment on individuals who committed violence.

7.3 Iwi-DHB Partnership Board
The Northland, Waitmatā and Auckland DHBs, our nine iwi partners⁷, and urban Māori represented by Te Whānau o Waipareira are proposing a genuine Te Tiriti o Waitangi-based partnership that recognises the Mana Motuhake (authority and self-empowerment through control over one’s own destiny) of iwi and accelerates Māori health gain across our districts.

This partnership is underpinned by the Articles of Te Tiriti – Kawanatanga (governance), Tino Rangatiratanga (self-determination), Oritetanga (equity) and Te Ritenga (rights to beliefs and values), while the New Zealand Public Health and Disability Act 2000⁸ provides the operating framework in which this partnership is realised and supported.

In partnership with iwi, we wish to pursue the attainment of both DHB and iwi aspirations to maximise Māori health outcomes for whānau, hapu and iwi. The challenges facing Māori health equity within the health sector are deeply enmeshed in complex systems, beliefs and behaviours. Genuine partnership and co-operation with Māori at all levels of the system are required to identify and dismantle unfair systems and practices that have maintained or hidden Māori health inequities and, in their place, co-design new services of value to Māori.

7.3.1 Background
In late December 2018, governance and executive representatives from Waikato, Counties Manukau, Auckland, Waitmatā and Northland DHBs met with iwi from across the districts to discuss a new direction for Māori health across the five DHBs. At this meeting, we agreed to form two partnership boards between the five DHBs. These partnership boards would be a joint governance partnership between iwi and their aligned DHBs with the authority to act within their agreed terms of reference. The Northern Iwi-DHB Partnership Board would represent Northland, Waitmatā and Auckland DHBs with their Iwi partners. The southern governance partnership would combine Counties Manukau and Waikato DHBs with their iwi partners.

We also agreed that each Partnership Board will be an autonomous grouping of iwi and DHB members that operates within the scope of the NZPHD Act 2000, yet sits outside of the standard DHB governance structures (where previous Māori health gain advisory committees once sat) in order for the board to truly practice Mana Motuhake and make decisions that set and drive its strategic agenda for Māori health.

To support the achievement of the final point, representatives from the northern grouping met in April 2019 to refine a Terms of Reference, confirm a purpose and discuss next steps for the establishment of the Northern Iwi-DHB Partnership Board.

It was agreed that:
- The Partnership Board will feature DHB and iwi governance representatives as members. This partnership would provide a platform for Māori and health sector leaders to galvanise their collective expertise, knowledge and resources across services and districts to deliver outcomes for Māori.

---

⁷ Ngāti Kuri, Te Aupōuri, Te Rarawa, Ngai Takoto, Ngāti Kahu, Whaingaroa, Ngāpuhi, Ngāti Wai and Ngāti Whātua
⁸ New Zealand Public Health and Disability Act 2000, Section 23(1)(d) and (e) the DHBs will establish and maintain “processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement” and continue “to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori”.

Auckland DHB and Waitmatā DHB Community and Public Health Advisory Committee Meeting 15/05/19
Its purpose will be the maximisation of Māori health outcomes (including outcomes chosen by iwi) as well as the elimination of health inequities between Māori and non-Māori. This will be achieved by co-designing a new system and services that value Māori whānau, improves their experience of health services, addresses immediate health issues, while also addressing underlying determinants of ill-health to create intergenerational wellbeing for Māori.

The Partnership Board functions will include:

- Setting a strategic agenda for Māori health gain by identifying iwi health and wellbeing aspirations, and aligning these with health sector priorities to develop a set of outcomes and indicators to achieve Pae Ora across our districts. This will strengthen the coherence of actions across the region which increases resource flows to redress current patterns of Māori health inequity.
- Oversee the DHBs’ performance and investment in Māori health. The Partnership Board will provide a critical view of DHB activity in Māori health, while conversely co-designing sustainable and valuable solutions for Māori.
- Initiate and lead reviews of services and programmes where significant disparities between Māori and non-Māori exist to identify opportunities and make recommendations for improvement.
- Allocation of a designated Māori health budget agreed by the Boards of each DHB.

### 7.3.2 Next steps

Although this is a Tiriti o Waitangi based partnership with iwi, the NZPHD Act 2000 provides the operating procedures for the Partnership Board. In order to achieve the above objectives, agreement from our respective Boards is required in order to delegate agreed powers to the Partnership Board.

### 7.4 Māori pipeline projects

The Māori health pipeline is currently progressing proposal development in a range of areas. Waitematā DHB has added a focus on equity in funding/contracting. Auckland DHB has an accelerated focus on screening and PHO enrolment.

A summary of recent Māori Health Pipeline activity is below:

- **Lung cancer screening** - grant funding has been secured from the A+ Trust to undertake an initial phase of a qualitative research project which includes three focus groups and a survey of 300 Māori who would potentially be eligible for a future programme. A protocol has been drafted and will be submitted to ethics in mid-May 2019. The broader project governance has been established with leadership from Associate Professor Dr Sue Crengle (University of Otago), and in collaboration with a range of Māori clinicians, academics and other partners

- **alternative community pulmonary rehabilitation model** – an establishment meeting has been set for late May 2019 with leadership from Dr Sandra Hotu, respiratory physician and kappa kara experts

- **alternative community cardiac rehabilitation model** – the pilot has been completed and evaluated. A business case is being developed

- **northern region breast screening datamatch (‘500 Māori women campaign’)** – due to the late roll out of the NES data has been delayed and is expected in late April-early May 2019. All other preparations have been completed

---

9 New Zealand Public Health and Disability Act 2000, Section 22(1)(e). DHBs have an objective "to reduce health disparities by improving health outcomes for Māori and other population groups".


Auckland DHB and Waitematā DHB Community and Public Health Advisory Committee Meeting 15/05/19
• Māori provider and PHO datamatch – a Māori Data Sovereignty assessment has been completed and was taken to the Auckland DHB and Waitematā DHB Māori Provider Forum for discussion. This is the first such assessment and generated a range of considerations. The decision for iwi governance of the project was agreed and this is being progressed with the nominated representatives and supporting agreements are being drafted.

• Facilitated PHO enrolment – a joint project between PFO, the Māori Health provider arm team, primary care and PHOs is under development. Exploratory data analysis are being undertaken for consideration – including datamatching to ascertain PHO enrolment in the maternity services, ED admissions, hospitalisations and for specified services and conditions. The purposes of this work is to develop a facilitated PHO enrolment process for Māori whānau that touch hospital services and are not currently enrolled with a PHO.

• HPV Self-Testing demonstration projects starting with the high grade cervical screening project - audit work has been undertaken and project planning undertaken to develop an intensive supported offer of service for women who have a history of a high grade screening result but have not attended follow up. A Māori GP who has been active in the Smea your Mea campaign has agreed to provide leadership to this project.

Additional areas of work will be included over time.

8. Pacific Health Gain

A standalone update paper has been provided in this agenda.

9. Asian, Migrant and Refugee Health Gain

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

The team continue to work on the actions from the Asian, migrant and refugee health plan 2017-2019.

The first of three Refugee Health Forum’s for 2019 will be held on Tuesday 30 April at the Fickling Centre, Three Kings. The topic is Social wellbeing – understanding welfare entitlements for former refugees & asylum seekers and how we can improve their access to it.