Community and Public Health Advisory Committees Meeting

Wednesday 7 August 2019

10.00am

Venue

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

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.
AUCKLAND AND WAIWAKA DISTRICT HEALTH BOARDS  
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING  
7 August 2019

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

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

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>10.00am</td>
<td>2. CONFIRMATION OF MINUTES</td>
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<tr>
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<td>2.1 Confirmation of Minutes of the meeting held on 15/05/2019</td>
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<td>Actions Arising from previous meetings</td>
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<tr>
<td>10.10am</td>
<td>4. INFORMATION PAPER</td>
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<tr>
<td></td>
<td>4.1 Abdominal Aortic Aneurysm Screening in Māori</td>
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<td>10.25am</td>
<td>4.2 Cardiac Rehabilitation Prototype</td>
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<td>10.40am</td>
<td>5. STANDARD REPORTS</td>
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<tr>
<td></td>
<td>5.1 Planning, Funding and Outcomes Update</td>
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<td></td>
<td>- Executive Summary</td>
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<td>- Planning</td>
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<td>- Primary Care</td>
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<td>- Child, Youth and Women</td>
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<td>- Health of Older People</td>
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<td>- Māori Health Gain</td>
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<td>- Pacific Health Gain</td>
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<td>- Asian, Migrant and Refugee Health Gain</td>
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6. GENERAL BUSINESS

Auckland and Waitematā DHBs Community and Public Health Advisory Committee Meeting 07/08/19
### Auckland and Waitematā 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>
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<tbody>
<tr>
<td>Sharon Shea</td>
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<td>Max Abbott</td>
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<td>Edward Benson-Cooper</td>
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<td>Zoe Brownlie</td>
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<td>Sandra Coney</td>
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<td>Warren Flaunty</td>
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<td>Lee Mathias</td>
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<td>Judith McGregor (ex-officio)</td>
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<td>Pat Snedden (ex-officio)</td>
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<td>Robyn Northey</td>
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<td>Allison Roe</td>
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- ✔ attended
- ✗ absent
- * attended part of the meeting only
- ^ leave of absence
- # absent on Board business
## 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>
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</thead>
</table>
| **Max Abbott**            | Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology  
Patron - Raeburn House  
Advisor - Health Workforce New Zealand  
Board Member, AUT Millennium Ownership Trust  
Chair - Social Services Online Trust  
Board member - Rotary National Science and Technology Forum Trust | 19/03/14     |
| **Judith Bassett**        | 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**          | Director – Unless Consulting  
Workplace Programme Lead - YWCA  
Board member - RockEnrol  
Partner – CAYAD Auckland Council | 15/05/19     |
| **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 Flaunt**         | 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 Waitāmatā 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  
Director/shareholder - Pictor Limited  
Director - Pictor Diagnostics India Private Limited | 20/02/19     |
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<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
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</thead>
</table>
| 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 |
| Robyn Northey | Shareholder of Fisher & Paykel Healthcare  
Shareholder of Oceania  
Member - New Zealand Labour Party  
Husband - member Waitemata Local Board  
Husband - shareholder of Fisher & Paykel Healthcare  
Husband - shareholder of Fletcher Building  
Husband - Chair, Problem Gambling Foundation  
Husband - Chair, Community Housing Foundation |
| 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 |
| Allison Roe | Chairperson - Matakana Coast Trail Trust  
Member - Rodney Local Board, Auckland Council  
Member - Wilson Home Committee of Management (past role) |
| 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 |
| 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 - Manaiaikalani Education Trust  
Chair - National Science Challenge Programme – A Better Start  
Chair - The Big Idea – Not-for-profit-trust |

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 07/08/19
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<tr>
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<td></td>
<td>Director - Te Urungi o Ngati Kuri Ltd</td>
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<td>Director - Wharekapua Ltd</td>
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<td>Director - Te Paki Ltd</td>
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<td>Director - Ngati Kuri Tourism Ltd</td>
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<td>Director - Waimarama Orchards Ltd</td>
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<td>Chair - Auckland District Health Board</td>
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<td>Director - Ports of Auckland Ltd</td>
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<td>Board member - Counties Manukau DHB</td>
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<td>Chair - Counties Manukau Audit, Risk and Finance Committee</td>
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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.
Draft Minutes of the Meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 15 May 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) (until 11.02am, item 4.3)
Max Abbott (WDHB Board member) (present from 10.05 a.m.)
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)

ALSO PRESENT:

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)
Ruth
Peta Molloy (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:

Aroha Hudson, HealthWEST
Gaylene Sherman, HealthWEST
Teresa Taylor, T & T Consulting Limited

KARAKIA:
The Committee Chair opened the meeting with a karakia.

WELCOME:
The Committee Chair welcomed those in attendance.

APOLOGIES:

Apologies were received from Matire Harwood, Judith Bassett, Judy McGregor, Pat Snedden,
Dale Bramley and Ailsa Claire and for early departure from Sharon Shea.
ACKNOWLEDGEMENTS:

Debbie Holdsworth and the Committee warmly congratulated Sharon Shea on receiving her MNZM (Member of the New Zealand Order of Merit) for services to Māori health and development.

The Committee Chair acknowledged the staff and Michael Walsh and Corina Grey for their excellent work in the equity space and the paper recently published.

DISCLOSURE OF INTERESTS:

Zoe Brownlie advised that she would send the Board Secretary a copy of your updated register of interests following the meeting.

Sharon Shea advised that she was undertaking work with ACC related to Māori service development and outcomes. She was also working with Counties Manukau DHB in the area of contracting and outcomes.

Sharon Shea noted her declared interest as a board member of Alliance Health Plus as it relates to information only items 4.2 and 4.3, Pacific Health updates.

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 20 February 2019 (agenda pages 9 -17)

Resolution (Moved Lee Mathias/Seconded Zoe Brownlie)

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

Carried

Matters Arising (agenda page 18-19)

The schedule was noted.

4 INFORMATION ITEMS

4.1 Auckland Regional Public Health Service Update (agenda pages 20-37)

Julia Peters (Medical Officer of Health, Auckland Regional Public Health Service Clinical Director) was present for this item. She introduced the report, noting the key items reported under ‘Purpose’ of the report (page 20 of the agenda).
Matters covered in discussion and response to questions included:

- Noting the updated provided on vaping regulation and what Government has agreed (page 32 of the agenda); ARPHS will be making a submission on this matter. There is an understanding that vaping is not risk free, but much safer than smoking tobacco or cigarettes. Vaping has not been around for a sufficient period of time to understand associated risks. While the proportion of young people taking up cigarette smoking is reducing, there is a concern that young people will start vaping, becoming a gateway to cigarette smoking.
- That the position on the legalisation of and medicinal cannabis use from a health perspective is not currently on the ARPHS work plan; it was noted that the Waitemata DHB is looking at this matter under its mental health and addiction portfolio.
- That the number of Measles cases is increasing, modelling suggests that a peak will not be reached for a while yet. Those that have contracted Measles are largely unvaccinated; there is has been a couple of ‘break through’ cases of vaccinated people. At this time the majority of cases are in the Pacific community.
- The syphilis outbreak is being monitored. More than half of the reported cases nationally are north of Taupo (noting that this applies to a lot of infectious diseases in New Zealand).
- ARPHS is in support of active transport and the speed management bylaws. They have a good relationship with Auckland Transport and work closely to promote active transport and public transport, including equity in the way planning and funding is allocated. With regards to safety fund and its use towards active transport, it was noted that the road safety statistics are world leading and of concern. Safety funds for Auckland Transport need to be directed at road safety. However, promotion of other forms of transport is supported.
- In response to a query about what the two DHB Boards can do to support Auckland Transport in the area of public health, it was noted that road safety needs to be approached as a comprehensive problem, with speed limits and red light cameras being part of the overall strategy. Auckland Transport will be releasing a comprehensive plan in June providing the opportunity for further input.
- ARPHS looks at issues related to environmental hazards as resources permits. It was noted that in the prior summer the trapping of more exotic mosquitos was observed, the potential impact of that and ensuring diseases such as dengue fever to not gain traction in New Zealand.
- Noting the update provided on Refugee health (page 33 of the agenda) and that many refugees settle outside of Auckland.

4.2 Pacific Update (agenda pages 38-50)

Bruce Levi (Pacific General Manager), Carina Grey (Public Health Physician) and Leani Sandford (Acting Pacific Health Gain Manager) were present for this item.

Leani Sandford summarised this item, noting that achieving health equity requires a multi-pronged approach.
Matters covered in discussion and response to questions included:

- In response to a comment regarding whether or not progress was being made, it was noted that the two DHBs are reviewing the Pacific health action plans to look at outcomes being delivered and going forward. Work is underway with communities and the family approach is the way to gain traction. A review of the Plan is timely giving the opportunity to provide direction.
- That with regard to where Pacific families receive health services, it was noted that there is a lot of diversity in the Pacific Community with many cultures and there is not a ‘one size fits all’. Pacific church based programmes are one avenue to reach Pacific people, but approaches are also needed in the wider community and primary care pathways.
- The planning evaluation for Pacific Health is underway with a business case to be presented soon.
- That involvement form Parish community nurses stopped due to resource availability.
- That while the positive parenting and living without violence programmes are no longer being delivered, the issue is still prevalent and the programmes will be looked at in terms of the refreshed plan and resourcing what is effective.
- In response to a query, it was noted that the catalyst for violence in families can be social stresses, social economics and the like. The Family violence programme will not solve things, but addresses social needs.
- Family safety and children have been identified as the number one priority in the Pacific community.

The Committee Chair noted the teams work and that it was seeking to influence a lot of people and providers. She noted the need to generate opportunities to work together creating effective health outcomes. She also noted that 60% of youth now have mixed heritage and that needs to be considered with forming cultural wellbeing. She reiterated the Committees support with the work being undertaken.

11.02am – Sharon Shea retired from the meeting, the Committee gave their best wishes for her investiture. Warren Flaunty (Deputy Committee Chair) took the Chair.

Resolution (Moved Robyn Northey/Seconded Zoe Brownlie)

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.

Carried

4.3 Pacific Health Snapshot in the Auckland Region (agenda pages 51-72)

This paper was discussed in conjunction with item 4.2 ‘Pacific Health Update’.

5. STANDING ITEMS

5.1 Planning, Funding and Outcomes Update (agenda pages 73-96)

Tim Wood (Deputy Director Funding), Ruth Bijl (Funding and Development Manager Child, Youth and Women’s Health), Kate Sladden (Funding and Development Manager Health of Older People) and Shayne Wijohn (Manager Māori Health Gain) were present for this item.

Tim Wood introduced this item and summarised the highlights reported (page 74 of the agenda).

Matters covered in discussion and response to questions included:

- That with regards to diabetes management, data can be provided for populations other than Māori and Pacific as reported (page 77 of the agenda, table 1). The data provided for Māori and Pacific people highlights the need for improvement in diabetes management.
- Noting International Nurses day and the Auckland DHB Nursing and Midwifery Awards and acknowledging those who won various awards.
- Work is underway to continue the focus on smoking cessation and improving performance. The programme aims to get people to quit smoking and then provide adequate support to stop.

Child, Youth and Women’s Health

Ruth Bijl summarised this section of the report. Matters covered in discussion and response to questions related to this section included:

- That with regard to transgender youth, it was noted that there is a pathway established for youth who identify as transgender providing the opportunity for conversations. The pathway provides sensitivity and care. A project on improving transgender care has included the development of guidelines for the region. A copy of these will be provided to the Committee.
- Aroha Hudson (HealthWEST) advised that there is support in primary care for a number of transgender youth; the Youth Health Hub has been in place since 2006.
Health of Older People
Kate Sladden summarised this section of the report.

Comment was made on services provided by NASC, Kate advised that it is not a service provided by Planning and Funding and that the service would be happy to receive feedback directly.

Mental Health and Addictions
Tim Wood summarised this section of the report. He noted the recent tragic event in Christchurch and the support being provided in Auckland’s Muslim community.

Māori Health Gain
Shayne Wijohn summarised this section of the report.

In response to question, it was noted that with regard to the Whanau Ora approaches, the ideal model works directly with whanau and funds through whanau.

Pacific Health Gain
This section of the report was noted.

Asian, Migrant and Refugee Health Gain
This section of the report was noted.

General Business

There were not items of general business.

The Deputy Committee Chair thanked those who attended the meeting.

The meeting concluded at 11:40 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 15 MAY 2019

______________________________ CHAIR
# Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 01 August 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>
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<tr>
<td>20/2/19</td>
<td>4.3</td>
<td>Maori Health Update</td>
<td>Shayne Wijohn Ruth Bijl</td>
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<td>Update on broader family violence programme including approach with Maori providers.</td>
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<td>15/05/19</td>
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<td>Child, Youth and Women’s Health</td>
<td>Ruth Bijl</td>
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<td></td>
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<td>A copy of the guidelines for improving transgender care be provided to the Committee</td>
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4.1 Abdominal Aortic Aneurysm Screening in Māori

Recommendation:

That the report be received.

Prepared by: Corina Grey (Public Health Physician) and Anna Maxwell (Research Coordinator)
Endorsed by: Karen Bartholomew (Director Health Outcomes) and Debbie Holdsworth (Director Funding)

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AAA</td>
<td>Abdominal Aortic Aneurysm</td>
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<tr>
<td>AF</td>
<td>Atrial Fibrillation</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>IT</td>
<td>Information Technology</td>
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<td>PDH</td>
<td>Precision Driven Health</td>
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1. Executive Summary

AAA screening was identified as a highly cost-effective intervention that could make a small but significant impact on increasing Māori life expectancy and reducing the survival gap between Māori non-Māori. This paper reports the findings of a series of pilot projects undertaken at Waitematā District Health Board (DHB) and Auckland DHB between 2016 and 2018 to screen for abdominal aortic aneurysm (AAA) and atrial fibrillation (AF). The projects were evaluated to determine (1) Whether organised screening for AAA is justified, safe, acceptable and accessible, and (2) How AAA screening should be implemented to maximise participation and participant experience. Summary evaluation findings are included in this paper, and have recently been reported in the Health Quality and Safety Commission report *A window on the quality of Aotearoa New Zealand’s health care 2019 – a view on Māori health equity.*

The projects were developed with strong Māori leadership from Māori public health physicians, the Project steering group and advisors, the Māori Health Gain Team, and the Māori screening team members. The project was also driven by strong epidemiological and intervention support from the Health Gain Team. The intention of the project was to design-in equity as both a primary purpose of the work and to maximise the potential benefit for Māori from a tailored screening approach.

2. Abdominal Aortic Aneurysm

An abdominal aortic aneurysm (AAA) is a widening in the lower aorta, the major artery that supplies blood to the body. The major complication of AAA is rupture, which is usually fatal. Māori are disproportionately impacted by AAA. They are significantly more likely to die from a ruptured AAA and are less likely to have elective surgery to have it repaired. Māori also develop AAA on average 8 years earlier than non-Māori.

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Large randomised trials in Europe and Australia have shown that it is possible to reduce mortality from AAA through once-in-a-lifetime ultrasound screening of the abdominal aorta to detect, monitor and repair aneurysms before they rupture. Abdominal ultrasound is quick and accurate, and screening has been found to be cost-effective in at-risk populations.

AAA screening has therefore been identified as a highly cost-effective intervention that could make a small but significant impact to increase Māori life expectancy and reduce the survival gap between Māori and non-Māori.

![Abdominal Aortic Aneurysm](image)

**Figure 1: Abdominal Aortic Aneurysm**

### 3. AAA Screening Research Programme

The Waitematā DHB and Auckland DHB AAA research programme was the first screening programme to specifically target Māori in New Zealand. The programme consisted of a series of pilot projects to screen for AAA, and later also atrial fibrillation (AF), conducted between June 2016 and March 2018.

Waitematā DHB invested in a Māori-specific pilot to test a range of parameters of importance to the development of a screening programme and to national policy, including feasibility of community screening, participation, prevalence of AAA in the target population and completion of follow up. The initial pilot consisted of screening 50 Māori Waitematā DHB staff and 470 eligible Māori from three primary care practices. The success of the initial pilot study informed further investment across both Waitematā and Auckland DHBs to extend the programme to all eligible Māori (men aged 60-74 years and women aged 65-74 years). Screening for AF – a risk factor for stroke – was added in the roll-out, testing the integration of a second life-threatening condition into the screening session. Blood pressure was taken on all participants, and smokers were given brief cessation advice and offered referral to quit smoking services.

A third component of the screening project, a Precision-Driven Health (PDH) Pilot, was undertaken in June and October 2017, to test the validity and precision of a New Zealand-specific risk algorithm for AAA in 637 non-Māori patients enrolled in Coast to Coast Healthcare. Further work on the application of this for Māori is currently being undertaken.

Māori were involved at all levels of the project design, development and implementation of the AAA screening pilots. The project grew out of the partnership between the DHBs and Memorandum of Understanding (MoU) partners Te Rūnanga o Ngāti Whātau and Te Whānau o
Waipareira. Māori patient and whānau experience was centralised for the projects and Māori leadership and high-quality Māori:non-Māori partnerships were reflected at each stage of project development and implementation. The project was approved, supported and guided by the DHBs’ GM Tikanga, the Māori Research Advisor, Māori public health physicians and three Māori providers. A Māori screener (ultrasound technician) and administrator worked directly with invitees, and Māori health literacy experts and researchers were engaged to develop culturally appropriate materials.

The project began with an awareness-raising hui. Tailored invitation letters and brochures, incorporating a personal story and use of Te Reo, were mailed to eligible Māori, with follow-up phone calls. Screening was community-based, at venues close to public transport, including primary care practices, marae and more remote locations. Evening clinics were also offered.

A Māori ultrasound technician received specialised training for the DHB programme and conducted AAA screening under the supervision and quality assurance of the radiology team. AF screening was conducted using a simple AliveCor device which produces a heart rhythm trace on a wirelessly linked mobile device. Positive AF traces were interpreted by the cardiology team and reported to general practitioners (GPs). AAA referral protocols were based on Vascular Society of New Zealand guidelines.

The research programme successfully screened more than 2,500 eligible Māori across Auckland and Waitematā DHBs (see Figure 2). The project enabled high participation rates and valuable information was gathered on the prevalence of AAA for Māori men and women (the first AAA programme to include women internationally) and cost effectiveness being provided to inform national policy discussions.

**Figure 2: Schematic of the DHB AAA Research Programme**

Participation rates were 79% in the initial pilot and 65% in the wider roll-out. These participation rates are very high and compare very favourably to other screening programmes (e.g. the bowel screening programme which has only recently achieved a 60% participation rate in Māori). Over the
two pilot projects, seven large AAAs (≥50mm) requiring urgent assessment, were detected. Appointments at vascular services were prompt, and successful repair was achieved for the majority of large AAAs identified. Unfortunately, one participant found to have a large AAA at screening died of a ruptured AAA prior to surgery, highlighting the deadly nature of the disease. Results of AAA screening are summarised in Figure 3.

In addition:
- 64 small AAAs (30-49mm) and 41 mild aortic enlargements (26-29mm) were referred to vascular services for assessment and surveillance
- 36 new cases of AF were detected (prevalence 2.0%)
- 37 participants were urgently referred back to their GP for very high blood pressure (≥190 systolic and/or ≥130 diastolic)
- 34 referrals to smoking cessation services were made.

3. AAA Screening Evaluation

The programme has been evaluated and a series of patient and whānau interviews have been conducted by an independent Māori researcher, including an assessment of potential anxiety generated by the process of AAA screening (an issue raised in the international literature). The report on the programme and evaluation findings are currently being finalised and will be brought forward for governance, to consider whether the programme should be considered for ongoing investment in the absence of a national programme. Factors identified as critical to the programme’s success are summarised in Table 1.

<table>
<thead>
<tr>
<th>Table 1. Critical Success Factors for the AAA Screening Pilots</th>
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<tbody>
<tr>
<td>• Optimisation of the screening programme for Māori from the outset of project development</td>
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<td>• Māori leadership at all stages of project development and implementation</td>
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<td>• Tailored strategies to optimise Māori participation in screening</td>
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<td>• Ensuring that the pilots included all the critical elements of a high quality screening programme</td>
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• A close working relationship with primary care
• Robust processes to exclude people who would not benefit from screening
• Integration of co-benefits into the programme (including AF, blood pressure measurement and smoking cessation)
• Awareness and minimisation of stresses and anxieties for participants arising from screening and diagnosis
• Workforce development - ultrasound sonographer role

From the outset, the pilots aimed to optimise the programme for Māori, making it different to other screening programmes, which tend to retrofit equity improvements. Careful attention was given to the design of a person-centred and culturally appropriate programme, and this led to a high level of satisfaction with the screening process from participants interviewed, many of whom wanted it made more widely available to family members:

“... if you can keep it going for those out there who may be like me.”

“...I rung my other brother, I told him that he had to go and have this check-up....so he did, and he paid $500 for it.”

A number of tailored strategies were used to optimise Māori participation in screening, including carefully designed invitation resources targeted to the population, and incorporating personal stories. A health literacy approach was important to ensure that written and verbal information (in Te Reo and English) was presented in a clearly understandable format to support understanding, minimise anxiety and facilitate sharing of information with whānau. This was also facilitated through community awareness-raising hui and verbal conversations through a consumer representative well-known in the community. Screening clinics located in accessible community locations (including primary care and marae) were important, as was active follow up of invitations with phone calls.

A close relationship with primary care was a focus of the project, particularly during the initial pilot, to ensure that the purposes and process of screening were clear, as well as identify the actions needed for those with non-normal results. Greater involvement of GPs, as in the initial and PDH Pilots, led to higher participation rates and more accurate identification of people who were unlikely to benefit from screening. Participants reported positive engagement with GP endorsement of the programme, including invitation letters that came directly from the GP.

Particular attention was given to ensuring that the pilots included all the critical elements of a high quality screening programme, including strong clinical governance and oversight, robust quality assurance and strong information technology (IT) systems and follow up.

Strong clinical governance and oversight facilitated good working relationships between the screening programme (including DHB programme providers, primary care, radiology) and the vascular service. Quality assurance processes ensured that accurate imaging was achieved by the trained ultrasound technician. Almost all non-normal screening AAA scans and over 20% of normal AAA screening scans were reviewed by a senior radiology registrar. Almost all (99.5%) scans quality assurance, providing strong support for a model of screening undertaken by an ultrasound technician with specialised training and support. Quality assurance for AF screening was undertaken by an experienced cardiac physiologist.

Robust failsafe processes by screening, vascular and public health staff ensured that there was not only complete, but timely, follow-up of all patients with non-normal screening results. This was made possible by the comprehensive IT system developed specifically for the programme.
There was also seamless integration of co-benefits into the programme. AF screening was readily incorporated into the screening process, and a number of co-benefits (identification of high blood pressure, referral to quit smoking services, positive life-style changes) were achieved. Other opportunities for future programmes, depending on the needs identified in primary care, are also possible, such as checking how up-to-date people are with other screening programmes, diabetes checks, and further integration of smoking cessation approaches.

Interviews with screening participants also highlighted that an awareness of, and a need to minimise, stresses arising from screening and diagnosis are important, particularly around attending appointments and anxiety for a proportion of those identified with small AAA. Practical suggestions from participants to reduce stress and anxiety in these areas included: encouragement of whānau engagement with the programme, and facilitating whānau support throughout the pathway; a nurse or Māori cultural support worker at or post vascular appointments to answer questions and clarify and discuss any key messages; personalised written information for people attending vascular appointments; and assistance getting to appointments such as provision of transport and free parking to reduce stress of attending hospital appointments.

The proactive measurement of anxiety, or any other harms, before and after screening would be a useful addition to future programmes.

5. Conclusion and Next Steps

The DHB AAA research programme confirmed the high burden of AAA for Māori, and the highly cost effective nature of abdominal ultrasound screening. While the evaluation report is still being finalised, the strong positive feedback and high participation rates indicate that with careful attention to design of a person-centred and culturally appropriate programme, a one-off screen for AAA is highly acceptable. AF screening was readily incorporated into the programme, and a number of co-benefits (identification of high blood pressure, referral to quit smoking services, positive life-style changes) were achieved.

The next step is to further investigate a precision-driven approach as planned. While the algorithm appears to have been excellent at discriminating between high and low risk non-Māori patients, potentially reducing the need for screening for a large part of the population, this approach needs to be tested for Māori. Planning for this work is underway.
4.2 Cardiac Rehabilitation Prototype

Recommendation:

That the report be received.

Prepared by: Shayne Wijohn (Acting Manager Māori Health Gain) and Roimata Tipene (Māori Health Gain Portfolio Manager)
Endorsed by: Karen Bartholomew (Director Health Outcomes) and Debbie Holdsworth (Director Funding)

Glossary

<table>
<thead>
<tr>
<th>ACS</th>
<th>Acute coronary syndrome</th>
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<tr>
<td>CEP</td>
<td>Clinical Exercise Physiologist</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<tr>
<td>CR</td>
<td>Cardiac rehabilitation</td>
</tr>
<tr>
<td>DNA</td>
<td>Did not attend</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>TWoW</td>
<td>Te Whānau O Waipareira Trust</td>
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1. Executive Summary

Addressing inequity in cardiovascular outcomes, alongside cancer, is a key priority for reducing the life expectancy gap for Māori. Cardiac rehabilitation (CR) is an important cardiovascular intervention that has strong evidence to support improving outcomes. CR is a clinically supervised programme that supports recovery and ongoing wellbeing after a cardiac event or heart disease diagnosis. It reduces the risk of future heart events and hospitalisation, and improves quality of life. Although strong nurse-led education and support was provided in an inpatient setting, a service gap was identified at Waitematā DHB through a 2016 assessment against a newly agreed regional CR standard for outpatient CR. In response, a project was developed initially under the Māori Health Plan and then under the Māori Health Pipeline to pilot test an alternative delivery model. The CR Prototype was initiated in 2017 as a community based and whānau-centred CR pilot with partnership between Māori Health Gain, cardiologists, nurse leaders, cardiac exercise physiologists and Te Whānau o Waipareira. The Prototype was completed in late 2018 and this paper summarises the results of the prototype and the findings of the evaluation conducted by WaiResearch.

2. Strategic Alignment

The cardiac rehabilitation prototype reflects and supports many of the Board’s priorities, strategic themes, and values.

| Community, whanau and patient centred model of care | The CR prototype offered patient centred and integrated community care to patients beyond their hospital stay by providing community-based needs assessments, personalised guided exercise programmes, and home visits by community nurses to oversee progress amongst patients and their whānau. The programme also focused on the patient and GP relationship as a |

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key factor for sustainable long term cardiac management and secondary prevention.

All nursing assessments, and some exercise assessments, were carried out at Whānau House in Henderson. This location was easily accessible, offered free parking and also supported the integration of a wider array of health and social services offered from this location. The planning of the prototype embraced the principles of whānau ora and whānau centred design.

<table>
<thead>
<tr>
<th>Emphasis and investment on both treatment and keeping people healthy</th>
<th>The CR Prototype focused on secondary prevention. The programme offered a range of interventions to support individuals and whānau to make positive lifestyle changes that would prevent further cardiac complications. This included specific interventions for exercise, medication compliance and nutrition, alongside assessments for smoking cessation and mental health. The programme also focused on broader health education, improving relationships between patients and their primary healthcare providers, and whānau ora nursing to address wider social issues that patients and their whānau may be experiencing.</th>
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| Service integration and/or consolidation | The CR Prototype employed and multi-disciplinary/multi-provider approach to provide a comprehensive cardiac rehabilitation programme. An electronic shared care platform was used by all clinicians on the programme, as well as regular face to face and virtual meetings to ensure a high degree of communication between team members. |

3. **Introduction/Background**

Addressing inequity in cardiovascular outcomes, alongside cancer, is a key priority for reducing the life expectancy gap for Māori. Overall the data demonstrates that, Māori are, compared to non-Māori:

- More than twice as likely to die from cardiovascular disease / ischemic heart disease
- 1.5 times as likely to be hospitalised for cardiovascular disease
- Less likely to participate in, or complete, a cardiac rehab programmes.

It is also noted that Māori women are almost twice as likely to be hospitalised for ischaemic heart disease as non-Māori.¹

Cardiovascular risk assessment and management, and tobacco control remain key components of Māori Health Plan and the System Level Measures Plan. Further along the pathway, cardiac rehabilitation (CR) is an evidence based intervention that improves cardiac outcomes. International best practice is that cardiac rehabilitation (CR) is offered to patients following an acute coronary syndrome event (heart attack or unstable angina), heart failure, heart disease diagnosis or intervention (eg stent). CR is a complex intervention which includes components of health education, advice on cardiovascular risk reduction, physical activity and stress management. There is evidence

that cardiac rehabilitation reduces mortality, morbidity, and unplanned hospital admissions in addition to improvements in exercise capacity, quality of life and psychological well-being.\(^2\)

In 2016 there was agreement by the Northern Region Cardiac Network to a regional standard for cardiac rehabilitation.\(^3\) This was developed alongside the consideration of Māori Provider delivery of CR services and how these could be optimised in the context of integrated contracts. It was noted, during the regional assessment process, that there was a service gap at Waitematā DHB, with a lower update of CR (25%) delivered through a hospital based service than the completion rates of other DHBs (approx. 60%).\(^4\) Māori, and also Pacific, were noted to be under-represented in completion of CR programmes across the region. A number of improvement projects had been undertaken in various DHBs over time.

In 2017 a trial of an alternative cardiac rehabilitation model, called the CR Prototype, was approved at Waitematā DHB. This alternative collaborative model included a physical activity programme as well as a proposal to move services to the community and integrate services with a Māori Provider. The pilot was led by the Māori Health Gain Team and the Cardiology unit in partnership (cardiology and nursing leadership) with Te Whānau o Waipareira Trust and Auckland University of Technology (AUT) who provided clinical exercise expertise. The Prototype was completed in late 2018 and evaluated by WaiResearch.

### 4. Components of the CR Prototype

The Māori Health Gain Planning and Funding team supported the testing of a service Prototype which would potentially be more appropriate for Māori, Pacific and quintile 5 patients entering Phase 2 CR, and ultimately the wider population of Waitematā DHB. The prototype was proposed to include leading clinical interventions integrated into the community based collaborative service. This approach entailed collaborations with other providers with expertise in exercise rehabilitation and also Māori community networks. It was envisaged the latter would ensure cultural aspects of engagement and care were included, and more referrals made for vulnerable whānau to social support services and primary care, thus ensuring a wrap-around service. Furthermore, the aim was to bring patient data together in a shared care platform which all teams and clinicians could use. This Prototype aimed to test its processes with a defined cohort of high needs patients – Māori, Pacific and Quintile 5. Particularly, it will focus on Māori. The evaluation of the prototype was designed to identify areas where equity has been, or may potentially be, achieved or areas where inequity was created. The planned components of the CR prototype were:

**Community based nurse led clinics**

- 45 minute Waitematā DHB Clinical Nurse Specialist led clinics conducted at Whānau House.
- Clinics managed with patient focused bookings (flexible to suit patients), and overseen by a cardiologist or an onsite cardiac nurse practitioner.

**Whānau-centred guided exercise programme**

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\(^3\) These are now the New Zealand Guidelines: New Zealand Cardiac Support and Secondary Prevention (Cardiac Rehabilitation) Core Components guidelines; CSANZ Secondary Prevention Working Group, 2018. https://cardiacsociety.org.nz.nzcpr-working-group/#5

\(^4\) Taking into account nurse led follow up clinics, the physical activity component and the CR education programme
A 1.5 hour clinical exercise physiology (CEP) led exercise assessment at Whānau House. CEPs have the knowledge and clinical training to provide guidance and prescribe exercise programmes that are safe and effective for people with a wide range of medical conditions.

- A 12 week physical activity programme prescribed by the CEP and developed to suit the needs and lifestyle of the patient. Whānau were encouraged to attend and also participate. The exercise programme involved a mix of individual and group activity.
- Facility options included Whānau House, AUT Millennium and West Wave.

Whānau ora community nursing
- A Te Whānau o Waipareira community registered nurse conducted up to 6 home visits over 3 months with patients who elected to access this service. A key goal of this service was to ensure medication adherence.
- The Waitematā DHB nurse practitioner will support the community nurse in their role.
- The community nurse will ensure, where possible, that there is a strong relationship forged between the patient and their GP and support access to GP services as needed.

Service integration
- Service providers work together regarding patient appointments and care plans.
- Service providers utilise shared data management and information using data from the hospital Concerto database, community Care Connect database and Whānau Tahi database utilised by the community nurse.

5. Results

The pilot was completed in late 2018 with delivery to 20 participants, with 17 completing the programme: five Māori, six Pacific, nine other Q5 and any other relevant detail. The results of measuring clinical outcomes were completed and are presented as follows:

- **Attendance rate** 95% attendance at exercise sessions
- **Blood pressure** some participants showed reduction in high blood pressure, some showed increase in blood pressure from low to normal BP.
- **Percentile Cardiorespiratory Fitness for population (%)** shows significant positive change.

  Average pre percentile fitness for participants was 17%; with the highest being 45%.
  Average post percentile fitness for participants was 43.5%; with the highest 85%.

The biggest change seen in the pre and post percentile fitness for population was observed as 52% for one of the participants.

Average change seen in pre and post percentile fitness for participants = 27%.

**Relative Risk Reduction, it was observed that there is 27% reduction in risk to All-Cause**

The highest reduction in risk is seen as 44% for one of the participants.

**The average reduction in risk for CVD is observed as** 34% for the participants. Of these, the highest reduction in risk for CVD was seen as 55%.

- **Gas Exchange Threshold:** On average, participants show positive change
  The average change is seen as 4.53 ml/kg/min, with the highest change shown as 11.4 ml/kg/min
- **Change in weight for participants:** Average change in weight is observed as 2.19 kg with the highest weight loss seen as 5.5 kg. The change in weight also includes some participants who show increase in weight as well.
• **Average change in waist circumference**: The average change in waist circumference for the 8 participants who completed the programme is observed as 3.1cms (reduced). The highest reduction was shown as 15.5cms
• Those who have completed or are nearly towards the completion of the programme: 17 out of 20 (85%) have joined a gym or engaging in some kind of exercise programme at home.

WaileaResearch undertook an evaluation of the pilot that showed overall positive results of the programme. Both participants and staff were supportive of the pilot and several enablers of the prototype were identified. Findings included:
• Whānau planning greatly helped whānau to move from a crisis focus to positive development where some patients felt it was useful having whānau present during visits with nurses and discussing cardiac rehabilitation.
• Staff worked as collectives (nursing and CEP) to enable whānau to come together, identify their aspirations and begin to build capability, develop goals and plans for rehabilitation.
• Development of relationships with patients and whānau enabled change in diet and exercise, and in medication adherence.
• The collective entity enabled improved service integration and system changes where data management and information sharing was paramount across agencies like the Waitakere Hospital and CEP services.
• A clear vision, combined with effective governance and management and tangible strategies for change, enabled the translation of theory into practice such as a robust nursing protocol and CEP exercise protocol.
• Cultural competency, including an emphasis on whanaungatanga, ensured that changes were focused on whānau wellbeing and grounded in whānau realities.
• Resources for collectives to better meet whānau needs filled gaps in priority areas
• A flexible approach enabled engagement and service delivery that catered to whānau realities and identified pragmatic solutions including the provision for home visits and rescheduling of exercise sessions.

The evaluation, and subsequent discussion with key stakeholders, has identified a range of themes identified as working towards best practice for Māori and were evident in the CR pilot evaluation report including;

• **Whakawhanaungatanga**: Participants appreciated the time to build relationships with staff and recognised staff efforts around building relationships with comments about connectedness, holistic approaches, positive relationships with staff, participation, whānau support, and the desire to continue their rehabilitation journey. Having the clinics based at Whānau House also gave patients the time to meet members of the team such as the clinical nurse specialist, cardiac nurse and community nurse.
• **Collaboration**: A critical factor in the pilot was the collaboration between the nurse lead roles and CEPs, and this was acknowledged as a strength in the Prototype.
• **Whānau rangatira**: flexibility and support for behavioural changes/outcomes tailored to patient and whānau aspirations. Also whānau being part of the patient care and rehabilitation was seen as extremely positive as well as being part of the decision making processes.
• **Co-location and accessibility of services**: Having the opportunity to have the nursing clinics and exercise assessments at Whānau House were seen as a positive experience by the patients. Some spoke of the ideal location in relation to their home location. One of the participants did not know the location but “loved Whānau House”. Whanau House was seen as a one-stop-shop and being in a community setting meant more time could be spent with each patient. Participants could receive thorough checks, parking was free, problems were identified and addressed earlier,
the clinics are in an appealing setting and the participants often see people they know. In addition, the pharmacy is adjacent.

- **Information sharing**: A key improvement from the prototype was around the need for more work to be done around a more efficient and effective shared data platform as well as provision for improved communications between services.

- **Supportive environments**: Community based clinic options, home visits, holistic/integrated services, team approaches and future planning all provided for supportive environments in the prototype

**Community based nurse led clinics**

Establishing the clinics in the community at Whānau House that were nurse-led was a strength of the pilot. These clinics had patient focused bookings and also allowed for whānau to attend alongside. Considerations going forward around clinics ideally being forty-five to sixty minutes to enable whakawhanaungatanga and opportunities to improve clinic scheduling. Additional clinics could be set up that would provide more efficiency for scale as well as a regular drop in session/SOS clinic may also be future improvements (nursing staff noted that of the 20 readmissions for participants during the programme, 11 of these could have been potentially prevented with easily accessible expert advice.

**Whānau-centred guided exercise programme**

Another key success of the pilot was the exercise component. There were positive exercise results and patients overall enjoyed the sessions with many commenting about the positive relationship with the CEP in the evaluation. Patient and whānau led appointments featured and were important to the successful attendance rates, as was choice of venue

**Home visits**

All Māori and some Pacific patients agreed to home visits, however many on the pilot did not. Overall the evaluation shows insufficient evidence about the level of acceptability of homes visits. In terms of medication adherence, in general the compliance was very good where 18 of 20 patients adhered to medication and the remaining two were intermittent with their medication. Clinical benefit from home visiting was most evident in the participant with heart failure. The evaluation report noted that home visits were acceptable for those that received them and participants remembered the CR clinical nurse specialist and the community nurse attending. Those that did comment thought the visits were pleasant and the nurses came to check progress. Others who received phone calls from the community nurse to check their progress viewed the calls as useful, especially for those who were back at work, but again, there was insufficient evidence because of the small numbers.

**Primary care engagement and access**

The evaluation noted that all patients were enrolled with a GP, some had seen their doctor or spoken with them by phone. Others had yet to see their doctor but felt the support from the service and the information given at the nurse led clinic was enough to give them a level of comfort about their conditions. None felt they needed to change GP and talked of going to see them when prescriptions needed repeating. Some talked of improved relationships.

**Community location**

One of the factors that was not able to be progressed for the Prototype were the sessions shifted to Whānau House; the delivery remained at Waitakere Hospital. The main barriers to shifting the clinic location was safety, after hours security and administration support for the sessions. From the pilot, 6 of the 20 patients attended the education sessions at Waitakere Hospital. For future development the move to a community location is again recommended, with the evaluation noting that the acceptability of Whānau House was very positive.
Community nursing
Those that elected to receive whānau ora services were provided with this support as part of their interaction and care from the community nurse at Te Whānau o Waiparera. At the time of the evaluation some patients were still enrolled and receiving social services support. Nursing Protocols were completed for the service and training and mentoring offered to community nurses. Further opportunities were identified for workforce development and community nurse specialisation in CR.

6. Conclusion
The CR Prototype was initiated to provide improved community service delivery of CR at Waitematā DHB, to enable the exercise component of CR delivery (meeting the regional CR standard), and to test a range of components in an alternative model designed around the needs of whānau. The Prototype demonstrated high completion rates, important physiological improvements, strong positive feedback from staff and participants and a number of key learnings. The Māori Health Pipeline also includes an alternative pulmonary rehabilitation project, and there are many transferrable critical success factors and learnings between these pilots. The next steps for the CR Prototype is the development of a further case for consideration which includes refinement of the model (including shifting the location, further Māori provider integration, inclusion of technology) and the scale up of participant numbers.
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 (Acting Manager Māori Health Gain), Leani Sandford (Acting Manager Pacific Health Gain), and Samantha Bennett (Manager Asian, Migrant and Former Refugee Health Gain)

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

Glossary

ACE - Angiotensin-converting-enzyme
ADHB - Auckland District Health Board
ARC - Aged Residential Care
ARPHS - Auckland Regional Public Health Service
BP - Blood Pressure
CELT - Commissioning Executive Leadership Team
CEO - Chief Executive Officer
CHIL - Child Health Information Link
CPHAC - Community and Public Health Advisory Committee
CVD - Cardiovascular Disease
DHB - District Health Board
DMFT - Decayed, Missing and Filled teeth
DQLA - Auckland Waitematā Diabetes Service Level Alliance
GM - General Manager
GP - General Practitioner
HbA1c - Glycated Haemoglobin
HCSS - Home and Community Support Services
HIP - Health Improvement Practitioners
HPV - Human Papilloma Virus
IPS - Individual Placement and Support
LMC - Lead Maternity Carer
MACGF - Metro Auckland Clinical Governance Forum
MBIE - Ministry of Business, Innovation and Employment
MMR - Mumps, Measles and Rubella
MoH - Ministry of Health
MSD - Ministry of Social Development
NCHIP - National Child Health Information Platform
NCSP - National Cervical Screening Program
NGO - Non Governmental Organisation
NHT - National Health Target
NIR - National Immunisation Register
NZ - New Zealand
OIS - Immunisation Outreach Service
PFO - Planning, Funding and Outcomes Team
PHARMAC - The Pharmaceutical Management Agency

Auckland and Waitematā DHBs Community and Public Health Advisory Committee Meeting 07/08/19
PHO - Primary Health Organisation
Q - Quarter
ROI - Registration of Interest
SMILE - Smoke and Alcohol Free, Mental Health Matters, Immunise, Lie on Your Side, Exercise, Eat Healthy
TUG - Time up and go test
WDHB - Waitematā District Health Board

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 15 May 2019. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting’s agenda.

Highlights

- Kāinga Ora, in partnership with the other Healthy Homes Initiative Services around the country, are finalists for the State Services Commission’s ‘Spirit of Service awards’, in the category of Better Outcomes.
- Falls prevention programmes are receiving positive feedback from participants. The in-home strength and balance programme is being delivered to people at highest risk of falls and two thirds to three quarters of participants are completing the programme with large improvements in TUG (time up and go test) and number of falls.
- On 30 May 2019, the Wellbeing budget announced 1.9 billion over four years for mental health and addictions (1.5 billion for Vote Health). Further advice was received from the Ministry of Health Deputy Director-General Mental Health and Addictions on 9 July 2019, signalling that expanding access to primary mental health and addiction support will be a key priority, with an expectation that services be developed collaboratively between District Health Boards (DHBs), Primary Healthcare Organisations (PHOs), Non-Governmental Organisations (NGOs), Māori, Pacific peoples, those with lived experience and whānau. The Ministry of Health (MoH) will issue an Expression of Interest for the collaborative development of these integrated models (based around general practice).
- Individual Placement and 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 provided investment (via the Ministry of Social Development) for an initial prototype of the model within Waitematā, which has now led to a wider trial of the model for 500 people. A provider has been selected and a project coordinator appointed to this wider trial as it is delivered over the next 23 months. An evaluation of model impact will take place during the trial, including assessment of cultural appropriateness for Māori.
- The human papilloma virus (HPV) self-testing for cervical screening community trial has completed recruitment, with more than 5,500 Māori, Pacific and Asian women invited to the study. The early results are encouraging and have contributed to national discussions. Final results will be available in mid-2020.
- The Māori Health Pipeline projects continue to progress with the lung cancer screening project (Study 1) and kapa haka projects now underway, the cardiac rehab pilot completed and the ‘Find 500 Māori women’ breast screening campaign datamatch complete and moving on to contacting women to invite for screening.
• A Pacific health pipeline has been established. A number of key projects and areas of focus have been identified by the steering group that will improve equity across the metro Auckland District Health Boards. Future work will include the development of project briefs and business cases of benefit to pacific people.

2. Planning

2.1 Annual Plans
Draft two of the 2019/20 Waitematā District Health Board (DHB) Annual Plan was submitted to the Ministry of Health on 28 June 2019. This version included financial information which was not included in draft one. The financial information for draft two of the 2019/20 Auckland DHB Annual Plan is still being finalised. The full Plan will be circulated to Board (with financials) in July for approval.

Further Planning advice was received from the Ministry on 28 June 2019. There will also be an update of the Minister’s Letter of Expectations. The updated planning advice included substantial updates for two priority areas: Planned Care and Inquiry into Mental Health and Addictions as well as other updates for some child and youth sections, breast and cervical screening and primary care. A final draft is due with the Ministry on 26 July 2019. To date, the Ministry have provided feedback on the non-financial aspects of the submitted Annual Plans and the Plan is currently being updated in response to this and the latest planning guidance.

2.2 Annual Reports
Both Auckland and Waitematā DHB 2018/19 Annual Reports are under development. We continue to work with the auditors to review performance for the past financial year and plan to present first drafts to respective audit and finance committee meetings in September, with final versions due for completion by the end of October 2019.

2.3 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 and Waitakere DHB Quarterly Performance Scorecard

**CPAC Outcome Scorecard**

**June 2019**

#### Health Targets - Auckland DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better help for smokers to quit</strong> - primary care</td>
<td>Total: 60%</td>
<td>60%</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Mihi: 87%</td>
<td>80%</td>
<td>Y</td>
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<tr>
<td></td>
<td>Pacific: 80%</td>
<td>80%</td>
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<td></td>
<td>Other: 80%</td>
<td>80%</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Increased immunization (10-month old)</td>
<td>Total: 92%</td>
<td>90%</td>
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<tr>
<td></td>
<td>Mihi: 92%</td>
<td>90%</td>
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<td>Pacific: 92%</td>
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<td>Asian: 96%</td>
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<td>Other: 96%</td>
<td>95%</td>
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<tr>
<td></td>
<td>Parking Healthy kids</td>
<td>Total: 100%</td>
<td>95%</td>
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<tr>
<td></td>
<td>Mihi: 100%</td>
<td>95%</td>
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<td>Other: 100%</td>
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#### Health Targets - Waitakere DHB

<table>
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<td>Other: 100%</td>
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#### Child, Youth and Women - Auckland DHB

<table>
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<th>Target</th>
<th>Trend</th>
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<td><strong>Oral health - % infants enrolled at 2 years</strong></td>
<td>Total: 68%</td>
<td>90%</td>
<td>Y</td>
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<tr>
<td></td>
<td>Mihi: 88%</td>
<td>90%</td>
<td>Y</td>
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<td>Pacific: 70%</td>
<td>90%</td>
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<td>Other: 75%</td>
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<td></td>
<td>Oral health - % enrolled utilisation at 2 years</td>
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<td></td>
<td>Mihi: 64%</td>
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<td>Pacific: 62%</td>
<td>70%</td>
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<td></td>
<td>Asian: 85%</td>
<td>75%</td>
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<td></td>
<td>Other: 80%</td>
<td>75%</td>
<td>Y</td>
</tr>
<tr>
<td><strong>HPV immunisation coverage - girls</strong></td>
<td>Total: 80%</td>
<td>80%</td>
<td>Y</td>
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<tr>
<td></td>
<td>Mihi: 80%</td>
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<td>Pacific: 80%</td>
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<td>Other: 80%</td>
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#### Child, Youth and Women - Waitakere DHB

<table>
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<tr>
<td></td>
<td>Other: 80%</td>
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#### Primary Care - Auckland DHB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
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<tr>
<td><strong>PHO enrolments</strong></td>
<td>Total: 80%</td>
<td>90%</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Mihi: 74%</td>
<td>90%</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Pacific: 70%</td>
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<tr>
<td></td>
<td>Asian: 70%</td>
<td>90%</td>
<td>Y</td>
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<tr>
<td></td>
<td>Other: 77%</td>
<td>90%</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Diabetes management</strong></td>
<td>Total: 61%</td>
<td>62%</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Mihi: 52%</td>
<td>62%</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Pacific: 48%</td>
<td>62%</td>
<td>Y</td>
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<td></td>
<td>Asian: 48%</td>
<td>62%</td>
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<tr>
<td></td>
<td>Other: 52%</td>
<td>62%</td>
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</tbody>
</table>

#### Primary Care - Waitakere DHB

<table>
<thead>
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<th>Target</th>
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</tr>
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<tr>
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<td></td>
<td>Other: 52%</td>
<td>62%</td>
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</table>

#### Health of Older People - Auckland DHB

<table>
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<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c clients with Clinical Interests</strong></td>
<td>Total: 80%</td>
<td>90%</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Mihi: 80%</td>
<td>90%</td>
<td>Y</td>
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<td></td>
<td>Pacific: 80%</td>
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<td>Other: 80%</td>
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#### Health of Older People - Waitakere DHB

<table>
<thead>
<tr>
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<tr>
<td></td>
<td>Other: 80%</td>
<td>90%</td>
<td>Y</td>
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</tbody>
</table>

### How to read

1. All indicators are shown as a percentage of the actual outcome (see scorecard methods).

### Key notes

1. **Waitakere** DHB population data is shown for the calendar year 2016.

### A question?

**Waitakere DHB Reporting Analyst, Planning & Health Intelligence Team: sarah.curtis@ waitakerehd.org.nz**

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**Auckland and Waitematā DHBs Community and Public Health Advisory Committee Meeting 07/08/19**

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3. Primary Care

3.1 Priority Health Outcomes: Better Help for Smokers to Quit

DHB Target: 90% of Primary Healthcare Organisation (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). Quarter 3 2018/19 results are reported here as Quarter 4 2018/19 results had not been provided by the Ministry of Health by the deadline for this report. Results from the PHOs showed Auckland DHB performance at 87.3% and Waitematā DHB at 86.6%. The national average for Quarter 3 2018/19 is 86.3%, with both DHBs achieving above this average. PHOs did not achieve the primary care ‘Better Help for Smokers to Quit’ health target in Quarter 3. Although the target has not been reached, ProCare (for both Auckland and Waitematā DHBs) and Auckland PHO are close to reaching the target, with ProCare coming very close to target in Waitematā DHB. Table 1 below has the results by PHO for Quarter 3.

<table>
<thead>
<tr>
<th>DHB</th>
<th>PHO</th>
<th>Performance %</th>
</tr>
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<tbody>
<tr>
<td>Auckland DHB</td>
<td>Auckland PHO</td>
<td>88.7%</td>
</tr>
<tr>
<td></td>
<td>Alliance Health Plus</td>
<td>77.6%</td>
</tr>
<tr>
<td></td>
<td>National Hauora Coalition</td>
<td>84.1%</td>
</tr>
<tr>
<td></td>
<td>ProCare</td>
<td>88.7%</td>
</tr>
<tr>
<td>Waitematā DHB</td>
<td>Comprehensive Care</td>
<td>83.1%</td>
</tr>
<tr>
<td></td>
<td>ProCare</td>
<td>89.4%</td>
</tr>
</tbody>
</table>

Auckland and Waitematā PHOs have set up systems to enable, and provided support to encourage general practices to provide brief advice directly to patients. For several years, PHOs have provided assistance to practices that are not meeting the target by contacting patients on behalf of the practices. Some of the PHOs (eg Alliance Health Plus) are relying on practices to provide the advice themselves, as brief advice should ideally be provided by the practice during a patient visit. Having brief advice provided directly by the general practice makes it more sustainable in the long term, however it leads to a lower health target result. The Primary Care team have noted the decline in the brief advice results over the year and are addressing this with each PHO. The PHOs are being asked to advise on factors contributing to the decline and the actions that they will take to address this.

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

- Auckland DHB – 87.3%, ↓0.7% from the previous quarter
- Waitematā DHB – 86.6%, ↓0.9% from the previous quarter
3.2 Diabetes Management

3.2.1 Ministry of Health visit

The Ministry of Health diabetes team, Sian Burgess (Programme Manager) and Dr Paul Drury (Clinical Advisor), visited Auckland and Waitematā DHBs on 1 May 2019. The programme for the day included presentations from a wide range of primary and secondary providers, and a site visit to the National Hauora Coalition. The Ministry team wrote to Eirean Gamble (Planning, Funding and Outcomes Programme Manager for Long Term Conditions) on 17 June 2019 to express their appreciation both for a well hosted event and, importantly, for the evidence of very positive progress in diabetes management across Auckland and Waitematā DHBs. Excerpts from this letter are provided below:

“We enjoyed the presentations and the detailed, high quality reports you provided, including the Q2 2018-19 report and the Diabetes Service Level Alliance reports. We noted a fresh and invigorated approach to the issues in improving care and outcomes for all people with diabetes in Auckland and Waitematā DHBs, and the involvement of many other disciplines/representatives. We were pleased to note an overall ‘sea change’ in the approach to diabetes services.

The proactive PHO leadership in changing culture within practices and use of data to drive quality improvement and optimise management of diabetes within your population provides a foundation for change and innovation we have not seen elsewhere.”

3.2.2 Clinical Indicators

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 (7) 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).
Tables 2 and 3 below outline performance against the five MACGF diabetes and CVD clinical indicators as at 31 March 2019 and compare this to the performance as at 31 December 2018 to highlight changes in the intervening quarter.

### 3.2.3 Auckland DHB Performance

The Auckland DHB quarter three 2018/19 results are mixed. For Māori, no change in performance was seen in the diabetes clinical indicators, and a slight decline (1%) was seen in the CVD clinical indicators. Results for Pacific peoples are more variable, with small improvements (1%) seen in blood pressure and microalbuminuria management in those with diabetes. However, a larger decline (3%) was seen in each of the CVD clinical indicators for Pacific people. This decline in the CVD clinical indicators for Pacific is primarily due to one PHO, who have a large Pacific enrolled population, having ongoing data capture issues. These issues are expected to be resolved when they have fully transitioned to a new data warehouse by December 2019.

#### Table 2: Auckland DHB performance against the MACGF Diabetes and CVD Clinical Indicators as at 31 March 2019 \(^1\) compared to performance as at 31 December 2018.

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Auckland DHB</th>
<th>Goal</th>
<th>Māori</th>
<th>Pacific</th>
<th>Total</th>
<th>Total number required to reach the indicator target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Indicators – Long Term Conditions Management – Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HbA1c Glycaemic control:</strong> Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months</td>
<td></td>
<td>80%</td>
<td>51% (no change)</td>
<td>48% (no change)</td>
<td>61% (↑ 1%)</td>
<td>4,399</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></td>
<td>80%</td>
<td>57% (no change)</td>
<td>55% (↑ 1%)</td>
<td>61% (↑ 1%)</td>
<td>4,305</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></td>
<td>90%</td>
<td>73% (no change)</td>
<td>75% (↑ 1%)</td>
<td>73% (↓ 3%)</td>
<td>1,089</td>
</tr>
<tr>
<td><strong>Clinical Indicators – Long Term Conditions Management – CVD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CVD Secondary Prevention:</strong> Percentage of enrolled patients with known cardio-vascular disease who are on triple</td>
<td></td>
<td>70%</td>
<td>56% (↓ 1%)</td>
<td>62% (↓ 3%)</td>
<td>59% (↓ 1%)</td>
<td>1,152</td>
</tr>
</tbody>
</table>

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

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Auckland and Waitematā DHBs Community and Public Health Advisory Committee Meeting 07/08/19
3.2.4 Waitematā DHB Performance

The Waitematā DHB picture over quarter three 2018/19 is more positive with performance remaining relatively stable since December 2018 and small widespread gains in glycaemic control apparent for Māori (1%), Pacific (1%) and at a total population level (2%).

For Māori, no change in performance was seen in blood pressure control in those with diabetes and there was no change for CVD clinical indicators. A slight decline (1%) was seen in microalbuminuria management for Māori with diabetes.

Results for Pacific peoples are more positive with a slight improvement (1%) in blood pressure control in those with diabetes. No change was seen in microalbuminuria management for Pacific peoples with diabetes and there was no change in the CVD clinical indicators.

Table 3: Waitematā DHB performance against the MACGF Diabetes and CVD Clinical Indicators as 31 March 2019\(^2\) compared to performance as at 31 December 2018.

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Goal</th>
<th>Waitematā DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Total</th>
<th>Total number required to reach the indicator target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Indicators – Long Term Conditions Management – total population with diabetes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c Glycaemic control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months</td>
<td>80%</td>
<td>50% (↑ 1%)</td>
<td>51% (↑ 1%)</td>
<td>62% (↑ 2%)</td>
<td>2,991</td>
<td></td>
</tr>
<tr>
<td>Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is &lt;140mmHg</td>
<td>80%</td>
<td>63% (no change)</td>
<td>66% (↑ 1%)</td>
<td>65% (↑ 1%)</td>
<td>2,519</td>
<td></td>
</tr>
<tr>
<td>Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have</td>
<td>90%</td>
<td>76% (↓ 1%)</td>
<td>77% (no change)</td>
<td>76% (no change)</td>
<td>565</td>
<td></td>
</tr>
</tbody>
</table>

\(^2\) Data Source: Numerator and denominator are extracted from the PHO enrolled data. The denominator is different than that for previous CPHAC reports and Ministry of Health reports.

---

Auckland and Waitematā DHBs Community and Public Health Advisory Committee Meeting 07/08/19
<table>
<thead>
<tr>
<th>microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Indicators – Long Term Conditions Management – total population with CVD or with a &gt;20% risk of CVD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVD Secondary Prevention: Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)</td>
<td>70%</td>
<td>59% (no change)</td>
<td>66% (no change)</td>
</tr>
<tr>
<td>CVD Primary Prevention: Percentage of enrolled patients with cardio-vascular risk ever recorded &gt;20%, (aged 25 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)</td>
<td>70%</td>
<td>49% (no change)</td>
<td>56% (no change)</td>
</tr>
</tbody>
</table>

### 3.2.5 Activities to improve performance against the MACGF diabetes and CVD clinical indicators

As reflected in Tables 2 and 3 above, gaining traction against clinical indicator targets remains challenging. However, it is encouraging to note that as the MACGF data set becomes more complete all stakeholders have greater visibility of these challenges.

As outlined in the quarter two CPHAC paper *Community Based Diabetes Care Programme Update* there are a number of different work programmes being led by DSLA that aim to improve diabetes outcomes and achieve the above MACGF diabetes and CVD clinical indicators. It is expected that it will take several quarters before we start to see significant shifts towards achieving these goals. However, DSLA is discussing the challenges and variability in performance at both a practice and PHO level and learnings are starting to be promulgated.

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

The data quality achieved by primary care has improved relative to the quarter two 2018/19 upload.

The quarter three (March 2019) upload identified and resolved a number of data issues which has further improved the quality and completeness of the data. This data correction has improved the denominator for a number of the indicators which has resulted in an increase in the numbers needed to treat to achieve the associated target. This is evident across all indicators.

There continues to be data extraction issues that resulted in data not being available for 29 out of 237 (12%) practices across Auckland and Waitematā DHBs. The PHOs are working to resolve these issues, but for a small number of practices these issues will not be resolved until the practices move to a new practice management system.
3.2.7 Summary of each indicator by DHB and ethnicity

Auckland DHB - by Ethnicity

1. HbA1c Glycaemic Control

2. Blood Pressure Control

3. Management of Microalbuminuria

4. CVD Secondary Prevention (Total CVD)

5. CVD Primary Prevention (Total CVD)
Waitematā DHB - by Ethnicity

1. HbA1c Glycaemic Control

2. Blood Pressure Control

3. Management of Microalbuminuria

4. CVD Secondary Prevention (Total CVD)

5. CVD Primary Prevention (Total CVD)

Ethnicity
- Maori
- Other
- Pacific
- Auckland
3.3 Cardiovascular Disease (CVD) Risk Assessment

3.3.1 CVD risk assessment in total population

As shown in Figure 2, below, Auckland DHB has achieved and sustained the 90% CVD risk assessment target at a total population level since September 2014. Waitematā DHB had also achieved and sustained the 90% CVD risk assessment target at a total population level since September 2014. However, since July 2018 Waitematā DHB CVD risk assessment rate has declined and as of 30 June 2019, the CVD risk assessment rate was 83.8% (↓4.3%), as compared to quarter three 2018/19.

The main cause for this decline continues to be the significant number of people who received a CVD risk assessment between July and September 2014 in order to achieve the 90% target in 2014 and these people are now falling due for 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, in 2017-2019 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 74.2% (↓2.1%) and 67.4% (↓2.3%) for Auckland and Waitematā DHBs respectively at the end of quarter four, 2018/19. The decreases noted are relative to quarter three, 2018/19.

Activities that the PHOs have undertaken over the 2018/19 year to work towards achieving this target include:

- Providing their practices with lists of Māori men aged 35-44 years who have not received a CVD risk assessment
- Collecting clinical data opportunistically in younger Māori men to allow virtual CVD risk assessments when these men turn 35 years. This allows practices to identify who is at risk and would benefit from being recalled into clinic
- Incentivising patients via petrol vouchers to come into general practice for a CVD risk assessment.

To date, these activities have had mixed results. PHOs have identified the main barriers to achieving the 90% CVD risk assessment target in Māori men aged 35-44 years which include the following:

- Many of these young men do not attend primary care. Rather, they attend Emergency Departments or after-hours clinics for acute issues
- Due to the transient nature of many of these young men, the contact details are not correct and therefore practices are struggling to invite these young men in for CVD risk assessments.
- Practices continue to receive lists of Māori men aged 35-44 years who are overdue their CVD risk assessment but they are finding those who remain overdue their CVD risk assessment are those the practice have tried to contact multiple times using a variety of contact methods i.e., text, email, phone and letter.
3.4 Influenza Immunisation in Community Pharmacy

In 2017, The Pharmaceutical Management Agency (PHARMAC) announced that people aged 65 years and over and pregnant women would be eligible for a free influenza vaccine from community pharmacies.
pharmacies. People in these eligible categories can now choose to receive their funded vaccine from either their general practice or a community pharmacy. All DHBs throughout New Zealand supported this change by funding the pharmacy administration fee for those eligible to receive a funded vaccine in a community pharmacy.

The influenza vaccine service was delivered by 40 pharmacies in Auckland DHB and 45 pharmacies in Waitematā DHB in 2019. Over 6,000 eligible people received the influenza vaccine administered by a community pharmacist across Auckland and Waitematā this year. As shown in Figure 3 below, this represents a growth of 168% in Auckland DHB and 60% in Waitematā DHB in comparison to the last influenza season in 2018. This increase, particularly in Auckland DHB, is a significant achievement.

Figure 3: Number of influenza vaccinations administered by community pharmacies in the metro Auckland region

4. Child, Youth and Women’s Health

4.1 Immunisation

4.1.1 Immunisation Health Target

Provisional results for the Immunisation Health Target for Quarter 4 2018/19 indicate that neither DHB achieved 95% of babies fully immunised by 8 months of age. However, both remain well above the national average of 90% with both Auckland and Waitematā reaching 93%.

Auckland DHB coverage is lower than that achieved in the same quarter 2017/18. Coverage for tamariki Māori has fallen over this quarter to 81.8%, whilst Pacific coverage fell to 92%.

Waitematā DHB coverage is higher than for the same quarter in 2017/18 (91.8%), and the last two quarters. Māori coverage is 84.9% and Pacific is 96.7%, both higher than the national average.

Tamariki Māori decline rates continue to be of concern. 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 Quarter 3 2018/19. We are undertaking an analysis of each milestone age for Tamariki Māori to identify practices that have strategies to learn from and those that need more support. New immunisation posters developed as part of the Māori co-design work...
have now been printed and are being distributed to primary care practices. We are also actively seeking additional display areas for the posters. Initial feedback has been very positive.

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 is estimated to be 93% (down from 94% in Quarter 3) while there has been an increase at 5 years of age to 89% (from 87% in Quarter 3). Waitematā DHB continues an upwards trend at 24 months, increasing to 93% (up from 92% in Quarter 3) and to 89% for 5 years of age (up from 86% in Quarter 3).

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 service is now continuing to the end of 2019.

The Waitematā DHB Immunisation Case Review group was a finalist in the Matariki Awards for the “with compassion” category. This group has a monthly hui to review engagement with other child health services for tamariki Māori turning 6 months of age who are not yet fully immunised. Through sharing of updated contact details, this group reconnects whānau.

4.1.2 Measles
As of 23rd July, there have been 237 confirmed cases in the Auckland region, of which 33 were Auckland DHB. The majority of new cases are now within Counties Manukau.

As of 11 June, Auckland Regional Public Health Service (ARPHS) announced that the 15-month Measles, Mumps and Rubella (MMR) vaccine could be given from 12 months. Immunisation Coordinators have been working with practices to support this change, along with a request to recall children under 5 years of age who have not had at least 1 MMR vaccine. Our analysis shows that 465 Auckland domiciled children had their vaccine early in the four weeks since 11th June (an additional 162 had already done so before the change was announced).

The Communications team has been creating videos to promote MMR vaccination. A video of a Starship nurse promoting the change in MMR vaccination timing has been very popular.

4.1.3 Antenatal Immunisation
PHARMAC announced that, as of 1st July, access to funded pertussis vaccination in pregnancy has been widened to the second and third trimester of pregnancy (up from only 28-38 weeks). Some of the successful antenatal reminder cards are in the process of being distributed to Lead Maternity Carers (LMCs) with an update on the changes. We delayed the release of the SMILE (Smoke and alcohol free, Mental wellbeing matters, Immunise, Lie on your side and Eat healthily) resource while awaiting confirmation of the change.

There has been a national shortage of flu vaccine which will affect antenatal influenza coverage. The Ministry have confirmed that pregnant women continue to be the top priority for remaining stock and announced on 7th July that a further 55,000 doses will be arriving in NZ.

4.2 National Child Health Information Platform
The project team is progressing the design phase to implement the National Child Health Information Platform (NCHIP). 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.

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In January this year, Auckland and Waitematā DHBs undertook consultation on a proposal for change for universal child health services. The proposed changes included the DHBs forming a Child Health Information Link (CHIL) Hub to connect health services with families. The proposal also included that the CHIL Hub would become responsible for the local administration of the National Immunisation Register (NIR).

Following a review of the feedback from this consultation process and meetings with the most affected stakeholders, the Boards have decided to proceed with the proposed changes, including repatriation of the administration of the NIR to the DHBs. The Outreach Immunisation Service (OIS) will remain with the current provider, HealthWEST. The full report has now been shared with Stakeholders. Auckland and Waitematā DHBs would like to acknowledge the efforts made by HealthWEST in operating a joint Auckland and Waitematā NIR for the last 6 years. A transition plan is being developed to ensure that immunisation coverage for children is not affected by the change in administration.

4.3 Maternity
Maternity services have indicated that staffing for the holiday period is already under pressure as the availability of self-employed midwives in the community is limited. Primary birthing facilities in the community report being predominantly full for postnatal women although capacity for increased numbers of births in primary facilities remains, particularly in the Auckland DHB based Birthcare facility.

The Ministry of Health (MoH) has signalled that a consultation on the primary maternity service commissioning model design, including the role of a National Maternity Provider Organisation, is due to commence soon.

A review of the National Breastfeeding Strategy is underway, led by MoH. Tongue tie guidance for infants is also under development by the MoH with input from clinical leaders. Both of these are expected to be completed late 2019.

4.4 Healthy Housing
The Kāinga Ora (Healthy Housing) service has a priority focus on pregnant women and those with young babies. Work to ensure all eligible pregnant women are referred to the service is ongoing, building upon steady referrals over the past 2 years. As at June 20 2019, Auckland and Waitematā DHBs have received 1696 referrals to Kainga Ora. 6,836 family members have had access to healthier home interventions. Of the referrals received, 578 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 and are being utilised across the districts.

Kāinga Ora in partnership with the other Healthy Homes Initiative Services around the country are finalists for the State Services Commission’s Spirit of Service awards, in the category of Better Outcomes. Collaboration with Otago University, to support the national Healthy Homes Initiative evaluation, continues with preliminary results due in September 2019.

4.5 Cervical and Breast Screening
The National Cervical Screening Programme (NCSP) has indicated that the age of entry to the programme will change from 20 to 25 years later in 2019. The increase in age of entry to the screening programme was originally signalled to occur alongside other changes in the screening programme, including test technologies. However, whilst some of those programme changes have been pushed out into later years, the decision to implement the age change is moving forward.

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Internationally, most programmes now start at 25 or 30 years of age as evidence supports the later starting age. This is because, although cervical screening programmes have been highly successful at reducing cervical cancer incidence and mortality, for the under 25 years age group, the programmes are shown to not demonstrate the same benefits and effectiveness.

The Coordination service is supporting the change by working alongside the National Screening Unit to agree a change programme, and to promote and link communications from the National Screening Unit to primary care and other cervical screening providers and stakeholders. The Cervical Screening Coordination service continues to work with prioritised primary care services to support quality improvement in systems for invitation and recall and the provision of cervical screening.

4.6 Fertility
Northern Region Fertility Services provides publicly funded fertility services for people in the four Northern DHBs according to the Ministry of Health Service Specifications. Governance of the programme is supported by the Northern Region Fertility Services Advisory Group which meets bi-monthly. The three contracted service providers deliver treatment for biological infertility for people experiencing infertility, pre-implantation genetic diagnosis for a number of severe conditions as well as fertility preservation under certain circumstances, such as prior to cancer treatment.

5. Health of Older People

5.1 Aged Residential Care
Planning, Funding and Outcomes has hosted recent forums for Auckland DHB and Waitematā DHB Aged Residential Care (ARC) facilities. Auckland Regional Public Health Service (ARPHS) presented at each forum on managing gastroenteritis in ARC facilities and the role of ARPHS. There was also a focus on influenza and the importance of staff vaccination. It was recognised that the rate of staff vaccination is low and strategies to increase staff immunisation rates were discussed. Resident vaccination uptake is high.

There are a number of ARC facility new builds that have opened recently or are opening in the next month in both DHBs. In Waitematā: The Sands Oceania will open in Browns Bay with 44 dual (rest home/hospital beds). In Auckland: Elizabeth Knox in Epsom has an extension of 23 hospital beds; Blockhouse Bay Home has an extension of 40 dual beds: and a new Ryman facility, Murray Halberg, will open in Lynfield with 114 dual beds and 38 secure dementia beds.

Planning, Funding and Outcomes has a representative on the Aged Care Complaints Working Group. The Group has developed a new residential care complaints information web page that has important information for residents, whānau and providers. In addition, it contains some new resources to help residents and their whānau identify and work through the most appropriate method for making a complaint if they are dissatisfied with the care they are receiving in an ARC facility. The process also gives reassurance to staff who have received the feedback or the complaint that it will be managed appropriately.
5.2 Aged Residential Care Audits
The table below has the audits undertaken in quarter 3 and 4 of 2018/19 and the resulting corrective actions.

<table>
<thead>
<tr>
<th></th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ADHB</td>
<td>WDHB</td>
</tr>
<tr>
<td>Total number of audits</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Unannounced audits (surveillance)</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Average number of corrective actions / audit</td>
<td>5.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Facilities &gt; 5 corrective actions</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Facilities with no corrective actions</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Facilities achieving continuous improvement*</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

| Number of complaints DHB received on ARC | 4 | 8 | 1 | 3 |

* The gold standard attainment against an audit criterion is ‘continuous improvement’ (CI). CI is achieved when a criterion is fully attained and continuous improvements against the Health and Disability Sector Standards are demonstrated indicating quality improvement processes in place against service provision and consumer safety or satisfaction.

ARC facilities are certified for a set period of time (the exact length depends on how well the facility performs at the certification audit). Provisional (new build) audits always receive 12 months. The certification period graphs below highlight that over the last five years there has been a slow but sustained increase in aged care facilities receiving 48 months certification.

Auckland DHB Certification periods
5.3 Home and Community Support Services
Home and Community Support Services (HCSS) providers at both DHBs are now using the Stop and Watch tool. The tool is used by support workers to report a small change in a client such as ‘seems different from usual’, eats less and talks less. The number of reported escalations from the Stop and Watch tool has increased in 2019.

5.4 Falls Prevention
Referrals to the falls prevention programmes have been lower than expected and it has been clear that older people who would benefit from these services are not being referred. Over the last quarter a project manager has undertaken extensive data analysis including referral source to understand referral patterns. There has been engagement with PHO clinical leads and other leaders to identify and support approaches to increase awareness of, and referrals to, the falls prevention programmes. PHOs have requested practice level referral data to assist their follow up, which will be provided. Further work is underway to ensure the falls screening/risk tool on the Patient Dashboard (or equivalent) in general practice is simple and effective to use.

Feedback has been positive from participants of the falls prevention programmes. The in-home strength and balance programme is being delivered to people at highest risk of falls and two thirds to three quarters of participants are completing the programme with large improvements in TUG (time up and go test) and number of falls. Harbours Sport is overseeing the community group exercise classes and there are now 130 and 157 classes, approved by ACC, operating within Auckland DHB and Waitematā DHB respectively.

6. Mental Health and Addictions

6.1 Government Inquiry into Mental Health and Addiction Services and the Wellbeing Budget
On 29 May 2019, the Government formally responded to He Ara Oranga (report of the Government Inquiry into Mental Health and Addiction Services). He Ara Oranga contained 40 recommendations, which apply to health, the wider social sector and society as a whole. The Government has accepted in principle, or agreed to further consideration of 38 of the recommendations. In a release from the Government, a high level summary of recommendations accepted included:
• Significantly increase access to publicly funded mental health and addiction services for people with mild to moderate needs
• Commit to increase choice by broadening the types of services available
• Urgently complete the national suicide prevention strategy
• Establish an independent commission to provide leadership and oversight of mental health and addiction
• Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992

On 30 May 2019, the Wellbeing budget announced 1.9 billion over four years for mental health and addictions (1.5 billion for Vote Health). These allocations included:
• $455M for a new frontline service for people with mild to moderate mental health and addiction issues. Services to be delivered from General Practice (GP) practices, iwi health services and other health services.
• $40M for Suicide Prevention, to give intensive support to people at risk, including better recognition and support for people who have self-harmed.
• 14M for expanding access to addiction treatment, with a focus on access to early support through primary care (in up to four regions, based on community need).
• $44M to improve and enhance existing specialist drug addiction services
• $19.6M to extend nurses in schools programmes
• $197M for Housing First initiatives, funding 1,044 new places over the 4 years
• $124M to increase mental health and addictions support for offenders both in prison and the community.

Further advice, received on 9 July 2019, from the MoH Deputy Director-General Mental Health and Addictions, signaled that expanding access to primary mental health and addiction support will be a key priority, with an expectation that services be developed collaboratively between DHBs, PHOs, NGOs, Māori, Pacific peoples, those with lived experience and whānau. The MoH will issue an Expression of Interest for the collaborative development of these integrated models (based around general practice). The Auckland DHB and Waitematā DHB’s Awhi Ora and Fit for the Future initiatives will provide a strong framework to respond to this.

It has also been signalled that the MoH intend to work with the Addictions sector to develop a new national model of care for addiction recovery; to progress budget 2019 initiatives to expand primary level alcohol and drug interventions, including brief interventions in Emergency Departments and community settings; and to fund DHBs to improve financial sustainability of residential alcohol and drug services, including detoxification services.

6.2 Primary Mental Health Initiatives (Awhi Ora, Health Improvement Practitioners and Health Coaches)

In April 2019 there was agreement for the continuation of three key primary mental health initiatives, Awhi Ora, Health Improvement Practitioners (HIPs) and Health Coaches. These initiatives were originally implemented under the MoH funded Fit for the Future pilot which finished in September 2018. All three programmes/interventions will now continue to be delivered from 1 July 2019 for 12 months.

Awhi Ora is a co-designed preventative and early intervention approach to support people with mild to moderate mental health and addiction issues. This is achieved through the integration of NGO support services within general practice and other community settings to deliver psychosocial support and navigation services. HIPs are registered mental health practitioners (usually psychologists), based in general practice, who provide brief support to people with a wide range of behavioural issues. Health Coaches are non-clinical roles, also based in general practice, that help

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people build knowledge, skills and confidence to manage health conditions that are often co-morbid and chronic.

Following independent evaluation, all three interventions have been shown as effective in responding to mild to moderate mental distress, they also align strongly with many of the recommendations within He Ara Oranga (the Government Inquiry into Mental Health and Addictions). With the Government accepting these recommendations and the budget announcement of $455 million to expand access and choice of primary mental health and addiction support, these proven models could be key to both DHBs quickly and effectively responding to this area of high need.

6.3 Suicide Prevention and Postvention

6.3.1 The Suicide Prevention Strategy and Action Plan for Aotearoa New Zealand 2020–2030 (“Every Life Matters”):

The Ministry of Health is working urgently to present “Every Life Matters”, a draft suicide prevention strategy and action plan to Government. The development of the draft strategy and action plan will take into account feedback from public consultation and the He Ara Oranga recommendations. The Minister has indicated this strategy and action plan will be completed and in place this year. The Auckland and Waitematā DHBs’ Suicide Prevention and Postvention Governance Group will ensure that a review of the current Waitematā and Auckland DHB Suicide Prevention Action Plan 2019/2024 will ensure alignment with “Every Life Matters”.

Of note, a new Suicide Prevention Office has been established in the Ministry and a Director role to this Office is being recruited to.

6.3.2 Waitematā and Auckland DHB Suicide Prevention and Postvention Governance Group:

The Auckland DHB and Waitematā DHB Suicide Prevention Advisory group and the Inter-agency committee have undergone a review and reformed with the two forums combining to establish a Governance body. This group will be the key leadership and advisory body to provide oversight and direction with the aim of contributing to efforts to reduce suicide in the Auckland and Waitematā DHB regions. Membership of this group includes mental health and addiction services, youth services, NGOs, Police, Ministry of Education, Oranga Tamariki, Justice, Primary Care, and Funders and Planners. The current chairperson for this group is the WDHB Mental Health and Addictions Clinical Director.

6.4 Mental Health and Addictions Support Worker Pay Equity

The 18/19 pay equity rates were derived by a bespoke method, whereby individual Human Resource data was analysed by provider and by pay equity eligible purchase unit codes and these rates were put into contract as of 1 December 2018.

The subsequent stages of work in implementing pay equity currently completed or underway are:

- The completion of a reconciliation and wash-up to backdate contract payments to 1 July 2018 to ensure correct contract price uplift and pay equity rates have been applied.
- Pay Equity into contracts for 19/20 has been agreed and implemented as 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.
- The Collaborative Partnership group comprising DHB Chief Executive Officers (CEOs), Non-Governmental Organisations (NGOs) CEOs and Funder General Managers (GMs), has been tasked to address longer term issues including national consistency of price and service specifications, and commissioning for outcomes. Currently a national working group is identifying and analysing inconsistency in pricing nationally.
6.5 Health Workforce New Zealand Development Fund Registration of Interest
In June 2018 Auckland DHB and Waitematā DHB Planning, Funding and Outcomes team submitted a first stage Registration of Interest (ROI) to Health Workforce New Zealand, for a workforce programme targeting the Kaiāwhina (unregulated support work and peer support) workforces. In April 2019 an invitation was made to submit a second stage proposal by 21 May 2019. The proposal submitted was based on an innovative approach to strengthening the Kaiāwhina (support) sector through strategic, integrated, co-produced training and workforce development across the service framework including acute responses to primary healthcare. Although subsequently the MoH advised that unfortunately the proposal had not been successful, the development work will be useful for a range of other considerations.

6.6 Individual Placement Support Project Waitematā DHB
Individual Placement and 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 provided investment (via the Ministry of Social Development) for an initial prototype of the model within Waitematā, which has now led to a wider trial of the model for 500 people. The principal investigator of this trial is Dr Sheryl Jury.

Following a competitive process, three providers have been selected to deliver the trial over the next 23 months, utilising eight full-time equivalents in total. Ember Korowai Takitini (formerly Connect and Framework), Workwise and Emerge Aotearoa have been chosen and delivery of the model which started in 1 July 2019. Employment consultants are co-located within adult mental health teams in the West, North and Rodney areas. Additionally, consultants are based with Moko and Isa Lei services.

During the term of the trial, an evaluation of model impact will take place including assessment of cultural appropriateness for Māori. Additionally, a fidelity review will be undertaken. Research shows services with higher alignment to the model are more successful in producing positive outcomes. To support the rollout of the trial, a project co-ordinator has been seconded from the provider arm at 0.5 FTE for an initial six months.

7. Māori Health Gain

7.1 Iwi-DHB Partnership Board
Establishment of the Iwi-DHB Partnership Board is awaiting further advice and guidance from our Iwi partners. They have provided in-depth feedback on the most recent version of the Terms of Reference for this group and these require further consideration. It is important that sufficient time is given, for Iwi and DHB representatives, to comprehensively address the feedback provided by Iwi so we can move forward collectively.

7.2 Health Babies Healthy Futures
The Healthy Babies Healthy Futures (HBHF) Programme has been extended for another year by the Ministry of Health recognising the successful delivery of the programme. The programme provided nutrition (including breastfeeding) and physical training advice to nearly 400 whānau, hosted 48 workshops around Auckland, supported peer groups to host their own health workshops, and engaged 900 whānau through the TEXTmatch initiative. A key focus for the upcoming year will be to extend the current suite of services provided by partnering with providers and services offering care to pregnant women and women with pre-school aged children. The programme is a partnership

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7.3 Improving Practice around Community Treatment Orders
The Māori Health Gain Team continue to work with Auckland DHB Mental Health Directorate on Community Treatment Orders (CTOs), with a group established to provide oversight of an action plan to reduce CTOs. The group have agreed upon two main areas of current focus:

- Examining timeliness of release from Community Treatment Orders (CTO) for Māori
- Considering whether there may be a range of alternative options to CTOs for Māori whaiora.

The other workstreams in the plan continue to progress, including rolling out unconscious bias training as well as working with clinicians.

7.4 Māori Pipeline Projects
The Māori health pipeline is currently progressing proposal development in a range of areas. A summary of recent Māori Health Pipeline activity is below:

- Lung cancer screening - Study 1 (qualitative study) is now underway with planning and recruitment underway for the initial focus groups being established for late August. The survey has been revised after pilot testing with Māori staff and a Māori Respiratory Nurse Specialist, and will be piloted again before being finalised. Planning for survey data collection is underway, with progress towards involvement of Māori medical students in face to face data collection. The workstreams for the broader project (including Study 2, the planned demonstration lung cancer screening project) continue to progress and report regularly to the project governance under the leadership of Associate Professor Dr Sue Crengle (University of Otago) in collaboration with a range of Māori clinicians, academics and other partners. Working with key experts the Māori health equity re-analysis of the cost effectiveness model for lung cancer screening in New Zealand is nearly complete.
- Alternative community cardiac rehabilitation model – the close-off meeting with the stakeholders to assess the project against the evaluation KPIs has been undertaken, and planning for next steps is underway. Academic publication work continues.
- Alternative community pulmonary rehabilitation model – further planning with leadership from Dr Sandra Hotu, respiratory physician, and a Māori consumer and kapa haka expert has been undertaken. Opportunities to link the work with Te Matatini (kapa haka competition in Auckland 2021) is being explored. Physiotherapist visits to a range of kapa haka groups are being arranged and work is underway to determine what options there are for integration of kapa haka and pulmonary rehabilitation in order to achieve the goals of each. Tikanga advice is being sought throughout this process. Next steps will be the development of a research protocol.
- Northern region breast screening datamatch (‘500 Māori women campaign’) – the data has been received and analysed. The total number of Māori women either not screened or overdue for screening for the Northern region is 5,274. We are undertaking an additional match to identify women not enrolled in a PHO and have strong positive engagement with the three BreastScreen Aotearoa Lead Providers. Based on feedback, the data collection tool has been refined and contacting women will begin shortly. The project is expected to take approximately 6 months. This will be the first demonstration project nationally and will have important learnings for the BreastScreen Aotearoa programme.
- Māori provider and PHO datamatch – Data sharing agreements with the nominated iwi representatives have been drafted for review and approval. A privacy impact assessment is underway.
- 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 purpose 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.

- High grade cervical screening project - recruitment of screening operations team is underway, and the project is progressing through various approvals and data requests. The data request to the National Screening Unit has been made and discussions with Counties Manukau about inclusion of data for women in metro Auckland are positive.

Additional areas of work will be included over time.

8. Pacific Health Gain

8.1 PHAP Priority 2 - Pacific people are Smoke free
The Primary care, Pacific Health Gain teams, Enua ola and Healthy Village Action Zones networks has considered the next steps to support the Pilot Smoke free champions programme. This will include follow up workshops with smoke free champions to understand what they learnt as smoke free champions in their local church and community groups and the barriers encountered.

8.2 PHAP Priority 3 - Pacific people eat healthy and stay active
A significant number of Enua ola groups located in West Auckland completed the Aiga Challenge 8 weeks competition. A total of 24 out of 25 Enua Ola groups joined the competition and 867 community people registered to compete. A total of 59% (508) of participants were female, 31% male. Out of the 24 groups, 10 of them have participated in the Aiga Challenge for the last four consecutive years.

8.3 Diabetes Co-design project
Work has started by Shore & Whariki (University of Massey) as the evaluators of the Diabetes Co-design Project. The Pacific team is participating in the co-design project and recently provided critique of the Diabetes Care Survey that was translated into Samoan and Tongan. Work is ongoing.

8.4 Healthy Village Action Zones and Enua Ola programmes
A service review of the Healthy Village Action Zones and Enua Ola programmes is being undertaken. The review will consider how and to whom the HVAZ and Enua Ola services are being delivered, the strengths of the community-led development services and recommendations for the future. Key stakeholders are engaged in the process. The project is scheduled to end in October.

8.5 Pacific Health pipeline
The purpose of the Pacific health pipeline is to accelerate priority work to improve equity in Pacific health outcomes. A number of key projects and areas of focus has been identified by the steering group that will improve equity across the metro Auckland District Health Boards. Future work will include the development of project briefs and business cases.
9. Asian, Migrant and Refugee Health Gain

9.1 Increase Access and Utilisation to Health Service

9.1.1 Indicator: Increase by 2% the proportion of Asians who enrol with a PHO to meet 71% (Auckland DHB) and 87% (Waitematā DHB) target by 30 June, 2019

The Auckland DHB Asian PHO enrolment rate for Quarter 4 2018/19 was 69% with 2,184 new enrolees between Quarter 3 and Quarter 4. The interim target was not reached for 2018/19 largely due to the high international student population ineligible to enrol diluting the denominator. The Waitematā DHB Asian PHO enrolment rate for Quarter 4 2018/19 has increased by 1% to 91% with 3,134 new enrolees between Quarter 3 and Quarter 4.

Preliminary findings from the Healthy Eating and Oral Health Questionnaire to Indian, Chinese, Filipino and Middle Eastern Parents or Caregivers will be shared with the Preschool Oral Health Group. South-Eastern Asian, Chinese and Middle Eastern populations have higher rates of caries and mean decayed, missing and filled teeth (DMFT), compared to other ethnic groups such as Indian (and European). Awareness of the New Zealand Health System to new migrants from Indian, Filipino and Middle Eastern families was highlighted as an area for targeted effort.

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

The team have been engaging with the Ministry of Business, Innovation and Employment (MBIE) on their revised off shore/on-shore screening model for quota refugees to manage the increase in the quota refugee intake to 1500 in 2020.

Over 50 primary health professionals attended the health forum on Social wellbeing – understanding welfare entitlements for former refugees & asylum seekers and how we can improve their access to it. The next forum will be on Trauma Informed Care (in response to the Christchurch Attack) planned for 29 August.

The team presented at the national Asylum Forum (30 May) on ‘The role and perspective of a family doctor (GP) in supporting the mental health & wellbeing of asylum seeker patients.’ There are over 130 successful claims annually for refugee or protected persons status, in which the majority choose to live in Metro Auckland.

Note: Partners across the refugee and asylum seeker sector have agreed to use the term ‘former refugee’ in replace of ‘refugee’ to minimise any distress caused by use of this term in the resettled communities.