Community and Public Health Advisory Committees Meeting

Wednesday, 24th July 2013

2.00pm

Venue

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

E te Kaihanga e te Wahingaro
E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika
I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.
AGENDA

KARAKIA

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
All recommendations/resolutions are subject to approval of the ADHB and WDHB Boards.

2.00pm  (please note agenda item times are estimates only)

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES
2.05pm 2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 12/06/13 ................................................................. 1

3 DECISION ITEMS
2.10pm 3.1 Oral Health .............................................................................................................................. 9

4 INFORMATION ITEMS
2.20pm 4.1 Rheumatic fever Prevention and Intervention programme in Auckland and Waitemata DHBs .......... 20
2.35pm 4.2 The Development of a Model of Care for Palliative Care Services in the Waitemata District .............. 33
2.50pm 4.3 Health Risks of Cell Phone Antennas ..................................................................................... 37

5 STANDARD MONTHLY REPORTS
3.00pm 5.1 Planning and Funding Update ................................................................................................. 40

3.10pm 6 GENERAL BUSINESS

3.15pm 7 RESOLUTION TO EXCLUDE THE PUBLIC ............................................................................... 60
## REGISTER OF INTERESTS

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<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
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</table>
| **Lester Levy**  | Professor (Adjunct) of Leadership – University of Auckland Business School  
                    Co-Director – New Zealand Leadership Institute  
                    Deputy Chair – Health Benefits Limited  
                    Independent Chairman – Tonkin & Taylor  
                    Chair – Auckland District Health Board  
                    Chair – Waitemata District Health Board  
                    Chairman – Auckland Transport | 01/11/12 |
| **Max Abbott**   | Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology  
                    Patron – Raeburn House  
                    Board Member – Health Workforce New Zealand  
                    Board Member, AUT Millennium Ownership Trust  
                    Chair – Social Services Online Trust  
                    Board Member – The Rotary National Science and Technology Trust | 28/09/11 |
| **Jo Agnew**     | Professional Teaching Fellow – University of Auckland  
                    Casual Staff Nurse – Auckland District Health Board | 12/10/11 |
| **Peter Aitken** | Pharmacist  
                    Shareholder/Director, Consultant - Pharmacy Care Systems Ltd  
                    Shareholder/Director – Pharmacy New Lynn Medical Centre | 15/05/13 |
| **Judith Bassett** | Nil | 09/12/10 |
| **Pat Booth**    | Consulting Editor – Fairfax Suburban Papers in Auckland | 24/06/09 |
| **Susan Buckland** | Self employed – Writing, editing and public relations services  
                    Professional Conduct Committee member – Medical Council of New Zealand  
                    Professional Conduct Committee member – Occupational Therapy Board  
                    Member – Northern Regional Ethics Committee | 12/10/11 |
| **Chris Chambers** | Employee – Auckland District Health Board (wife employed by Starship Trauma Service)  
                    Clinical Senior Lecturer – Anaesthesia Auckland Clinical School  
                    Associate – Epsom Anaesthetic Group  
                    Member – ASMS  
                    Shareholder – Ormiston Surgical | 20/04/11 |
| **Sandra Coney** | Elected Member – Chair, Parks Committee, Auckland Council | 02/05/11 |
| **Rob Cooper**   | Board Member – Auckland District Health Board  
                    Board Member – Waitemata District Health Board  
                    Chief Executive – Ngati Hine Health Trust  
                    Advisory Board Member – James Henare Research Centre, University of Auckland | 19/09/12 |
| **Warren Flaunty** | Member of Henderson – Massey, Rodney and Upper Harbour Local Boards, Auckland Council  
                    Trustee - West Auckland Hospice  
                    Trustee - Waitakere Licensing Trust  
                    Shareholder - Metlifecare  
                    Shareholder - EBOS Group  
                    Shareholder – Pharmacy Brands Ltd  
                    Shareholder – Westgate Pharmacy Ltd  
                    Chair – Three Harbours Health Foundation  
                    Director – Trusts Community Foundation Ltd | 20/03/13 |
| **Lee Mathias**  | Managing Director – Lee Mathias Ltd  
                    Director – Midwifery and Maternity Providers Organisation Ltd  
                    Shareholder/Director – Pictor Ltd  
                    Director – John Seabrook Holdings Ltd  
                    Governance Advisor – AuPairlink Ltd  
                    Council member – NZ Council of Midwives  
                    Chair – Tamaki Transformation Transitional Board  
                    Chair – Health Promotion Agency Board  
                    Governance Advisor – Health Vision Ltd | 18/09/12 |
### Register of Interests continued…

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<tr>
<th>Name</th>
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<tr>
<td>Robyn Northey</td>
<td>Project management, service review, planning etc. – Self employed Contractor</td>
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<td>Board member – Hope Foundation Northern Region</td>
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<td>Trustee, A+ Charitable Trust</td>
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<td>Christine Rankin</td>
<td>Member - Upper Harbour Local Board, Auckland Council</td>
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<td>Director – The Transformational Leadership Company</td>
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<td>CEO – Conservative Party</td>
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<td>Allison Roe</td>
<td>Shareholder – Optimisewellbeing.com</td>
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<td>Founding member – Breast Health Foundation</td>
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<td>Gwen Tepania-Palmer</td>
<td>Chairperson – Ngatihine Health Trust, Bay of Islands</td>
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<td>Committee Member – Lottery Northland Community Committee</td>
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<td>Co-opted Members</td>
<td>Dr Tim Jelleyman</td>
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<td>Head of Division (Medical) - Child Women and Family Services, WDHB</td>
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<td>Member - Active Clinic Network for Greater Auckland Integrated Health Network</td>
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<td>Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland</td>
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<td>Eru Lyndon</td>
<td>Honorary Research Fellow – Auckland University</td>
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<td>Member – AUT Business School Industry Advisory Committee</td>
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<td>Regional Commissioner, Social Development, Northland - Ministry of Social Development</td>
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### Auckland and Waitemata District Health Boards

#### Community and Public Health Committees

#### Member Attendance Schedule 2013

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Co-opted members

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* ✓ absent
^ leave of absence
* attended part of the meeting only
# absent on Board business
2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 12th June 2013

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 12th June 2013 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 12 June 2013

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.02 p.m.

COMMITTEE MEMBERS PRESENT:

Lee Mathias (Committee Chair) (ADHB Deputy Chair)
Warren Flaunty (Deputy Committee Chair) (WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair) (present from 2.10 p.m)
Max Abbott (WDHB Deputy Chair)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Susan Buckland (ADHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Rob Cooper (ADHB and WDHB Board member)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Allison Roe (WDHB Board member)
Gwen Tepania-Palmer (WDHB Board member) (present from 2.20 p.m)
Tim Jelleyman (Co-opted member)

ALSO PRESENT: Debbie Holdsworth (WDHB, Chief Planning and Funding Officer)
Denis Jury (ADHB, Chief Planning and Funding Officer)
Naida Glavish (ADHB and WDHB, Chief Advisor, Tikanga)
Janine Pratt (WDHB, Group Planning Manager)
Stephanie Muncaster (WDHB, Programme Manager, Chronic and Palliative Care)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Tim Wood (WDHB, Group Manager, Funder NGOs)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Anne Curtis, Health Link North
Tracy McIntyre, Waitakere Health Link
Brian O’Shea, ProCare
Aroha Hudson, Health West

APOLOGIES: Apologies were received and accepted from Eru Lyndon and Ailsa Claire, together with an apology for late arrival from Gwen Tepania-Palmer.

KARAKIA

Naida Glavish led the meeting in a karakia.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no identified conflicts of interest for the open part of the meeting.
WELCOME

Lee Mathias welcomed those present.

The Committee congratulated Lee on being recognised for services to health and business in the Queens Birthday Honours List.

1. AGENDA ORDER AND TIMING

   Items were taken in the order listed on the agenda.

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 1 May 2013 (agenda pages 1-9)

   With regard to page 6 of the minutes (first sentence) it was noted that it had not been feasible to provide an update on progress with Palliative Care Services in the Waitemata District for the June meeting and therefore the Action Arising on page 9 of the minutes had been updated for this to occur at the July CPHAC Meeting.

   Resolution (Moved Judith Bassett/Seconded Jo Agnew)

   That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 1 May 2013 be approved.

   Carried

   Matters Arising:

   Fencing of Swimming Pools Legislation – Denis Jury advised that the Auckland Regional Public Health Service had made a submission in support of the submission by the Paediatric Society on the proposed legislation. It agreed with all the points made by the Paediatric Society, and was particularly opposed to moving the fencing requirements for swimming pools into the Building Act. A copy of the full submission by the Auckland Regional Public Health Service will be circulated to Committee members.

   Auckland Council Unitary Plan – a copy of the submission by the Auckland Regional Public Health Service had been circulated with the agenda.

3 DECISION ITEMS

3.1 Child and Youth Mental Health Services Update (agenda pages 10-17)

   Helen Wood (GM Mental Health and Addictions, Waitemata and Auckland DHBs), Jean-Marie Bush (Programme Manager Mental Health, Asian Health, Refugee and Migrant Health Services, Waitemata DHB), Hilary Carlile (Planning and Funding Manager Mental Health and Addictions, Auckland DHB) and Lee Reygate (Programme Manager, Mental Health, Waitemata DHB) were present for this item.

   Denis Jury introduced the item.
Helen Wood summarised key features of the report. She noted the slightly different focus between the two DHBs. Waitemata DHB’s workstream focused on building on an existing five year plan for child and youth services and had a particular interest in addressing complex long term needs. Auckland DHB’s approach had a broader focus. A draft report has been completed from the Waitemata DHB workstream and the Auckland DHB’s workstream’s draft report is expected in July. There are certainly common themes, including working together across both DHBs.

Helen Wood and Denis Jury spoke of the high degree of inter-agency involvement in both workstreams, including some NGOs.

In answer to a question, Helen Wood advised that there is definitely an intention to think about front end services alignment for Child and Youth Mental Health Services across the two DHBs, although in each DHB there may be specific needs that need to be addressed.

The Committee strongly supported the development of common systems and approaches across both DHBs and therefore passed the following resolution.

**Resolution** (Moved Lee Mathias/Seconded Jo Agnew)

1. That the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees receive this report describing the work undertaken to date in the mental health child and youth work streams.

2. That the Committees recommend to the Auckland and Waitemata DHB Boards:
   
   That the Board endorse an approach for Child and Youth Mental Health Services based on the objective of designing common systems and processes across both the Auckland and Waitemata DHBs by September 2013.

**Carried**

4. **INFORMATION ITEMS**

There were no information items.

5. **STANDARD MONTHLY REPORTS**

5.1 **Primary Care Update Quarter 3 2013** (agenda pages 18-54)

Dr Stuart Jenkins (Clinical Director Primary Care, Waitemata and Auckland DHBs) and Tim Wood (Group Manager Funder NGOs, Waitemata DHB) presented this report, noting that Andrew Coe is on extended sick leave.

The Committee Chair congratulated those involved on the New Lynn Integrated Family Health Centre becoming operational. Stuart Jenkins advised that there had been an initial problem with the phone system that had been resolved and that work is continuing to locate additional services in the Health Centre.

Tim Wood advised of a correction to the agenda report relating to Waitemata DHB CVD Risk Assessment agreements. On page 51 of the agenda, first paragraph in section 9.3, the statement: “this funding is only sufficient to reach approximately 60%” is misleading in that the PHOs were funded to reach the 75% target.
The meeting was updated on PHO performance towards the 75% CVD screening target for primary care. ProCare is confident of meeting the 75% for both Auckland and Waitemata DHBs, based on the data they have. There are some technical issues with that data. Waitemata PHO is unlikely to meet 70% and there has been a steady decline in performance on this target. Auckland PHO is around 70%. AH+ has just exceeded 75%, making it the first of the PHOs in the Auckland/Waitemata DHB area to achieve that. The overall picture is that both DHBs look close to achieving the 75% target by 30 June, but are likely to be slightly under target.

Matters covered in discussion and response to questions included:

- With regard to Waitemata PHO performance on CVD assessments, Tim Wood advised that the PHO had been slow to pick up on some approaches that were working well for other PHOs, such as putting in additional CME sessions on CVD management. Procare had successfully employed a number of nurses available to go into practices, do assessments and also pull out information on assessments already done by the practice over the preceding six months.

- Committee members raised the issue of a need for a wider approach to achieving CVD risk assessments than relying just on those done in GP practices. Tim Wood advised that the PHOs are actively following up patients and encouraging them to come in for CVD risk assessments. Both DHBs had screening programmes in their hospitals. Waitemata DHB had programmes for inpatients and for staff members and Auckland DHB had begun a programme for staff. There are also discussions taking place about work place screenings. The Board Chair referred to the active approach some employers take, for example the active programme at Auckland Transport. The support for CVD screening by Vehicle Testing New Zealand was also noted, with pamphlets and posters in their waiting rooms. A member of the public referred to an outreach screening bus, organised by Health West, which used to provide a mobile service in West Auckland.

- The Committee Chair emphasised the importance of CVD checks becoming part of normalised GP behaviour. In response, Stuart Jenkin noted that a big part of the answer lies in reporting performance of individual practices and GPs. That had been effective elsewhere in New Zealand.

- With regard to the impact of the new PHO contract on CVD assessments, Tim Wood advised that the contract itself does not immediately impact on that issue, however it would form part of the dialogue that would be needed shortly on implementation of the contract. He noted that notice had already been given to the PHOs that the after hours issue will need to be discussed.

- The Committee Chair requested that for the next CPHAC meeting a timetable be provided on how it is intended to progress the afterhours issue.

- Section 8 of the report, outlining current SIA and Health Promotion spend, was referred to. It was noted that the new PHO Contract provides a great opportunity to clarify expectations and be more prescriptive. Alliance agreements are intended to achieve a more effective primary care system. There is also a need to think about stronger data requirements.

- A request was made that it be checked that those Accident and Medical sites which receive additional funding to reduce fees, targeting particular groups, do correctly administer that. The Committee Chair requested that the Committee be kept informed on the results of that.

- Stuart Jenkins advised that a workstream of GAIHN is looking at acute demand and urgent care, with a view to establishing a metro-wide model for this.

- Following discussion as to why Care Plus funding for Waitemata PHO showed “no plan”, Denis Jury advised that his understanding was that Care Plus funding (unlike SIA and Health Promotion funding) did not require a plan for how it was to be spent – it was passed on to the PHO based on numbers of patients who met the criteria of having two or three long term conditions. The different models dated back to different Government initiatives and one of the benefits of the new PHO contract will be to standardise such matters.
• Denis Jury commented that the incentivised funding from Auckland and Waitemata DHBs for increasing the rate of CVD screening is payable only when PHOs reach close to the target. A very strong suggestion had been made to the PHOs that they should put in place people who would work at practice level and provide useful advice. Experience had been that there is a very worthwhile role for practice nurses or similar working across a number of practices.

• Committee members expressed concerns at a lack of ethnicity data in reporting to CPHAC and HAC. In response it was explained that a strong effort is made by staff to extract the ethnicity data included in the Scorecard reports (such as that on page 20 of the agenda), however there is an issue with getting ethnicity data at the national level. The Maori Leadership Team has been working very hard to try and obtain that. In addition Tim Wood advised that they are working with the PHOs to try and get ethnicity data from them. The Committee Chair and Board Chair emphasised that every effort needed to be made to resolve this issue including approaches to the National IT Board and dealing directly with the PHOs. In view of concerns, the following resolution was passed.

Resolution (Moved Lee Mathias/Seconded Susan Buckland)

That the Auckland and Waitemata DHB Community and Public Health Advisory Committees recommend to the Auckland and Waitemata DHB Boards:

That the Boards request the Auckland and Waitemata DHB Chief Executives to report to the Boards on obstacles to accessing ethnicity data and remedies to overcome those obstacles.

Carried

Other matters covered in discussion of the report included:

• Auckland Regional Dental Service (page 52 of the agenda) – there seemed to be a discrepancy between the comments about difficulties with an aging workforce and problems filling vacancies and the confidence expressed that the 10 per cent arrears target will be achieved by June 2013. There was no clear indication of how that would be achieved. At the suggestion of the Board Chair it was agreed that a comprehensive report on the School Dental Service be provided to CPHAC (in the context of the significantly increased expenditure that has gone into Oral Health) on how the service is doing, the issues to be addressed and what is being done to address them. The issue of why there is such a high DNA (did not attend appointment rate) and what is being done to address that was also raised for inclusion in the above report. The question was also asked as to whether the workforce profile described in the report was the same across the region as a whole or varied within the region?

• In answer to a question regarding immunisation, Denis Jury advised that the Ministry of Health will supply at practice level data on who has been immunised, but not on who has not been immunised.

• It was noted that the new PHO Contract is available for inspection by members but had not been e-mailed to them because of its size. Lee Mathias requested an e-mailed copy for her reference.

The Primary Care Report was received.

5.2 Planning and Funding Update (agenda pages 55-58)

Janine Pratt (Group Planning Manager, Waitemata DHB) provide a brief update on progress with finalising the Annual Plans. She advised that was almost completed, however a few more questions had been received from the Minister’s Office and they were being worked through.
With regard to the Auckland DHB section of the report, Denis Jury noted that for the NGO provider contracts, in addition to the nutrition clause referred to in the agenda report, requirements had also been included relating to smokefree policy and achieving Maori health outcomes.

Gwen Tepania-Palmer said that for the record she would like to acknowledge the work of the PHOs. It was good to see the PHOs actively involved in working towards the outcomes in the Maori Health Plan.

The report was received.

6. General Business

It was noted that reporting on unspent moneys held by the former PHOs had not occurred in recent months. An update was requested for the next CPHAC meeting.

7. Resolution to Exclude the Public

Resolution (Moved Robyn Northey/Seconded Gwen Tepania-Palmer)

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Confirmation of Public Excluded Minutes of CPHAC Meeting of 1 May 2013</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Confirmation of Minutes As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&amp;D Act.</td>
</tr>
</tbody>
</table>

The Committee Chair thanked those present for their participation in the meeting.

The meeting concluded at 3.31 p.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 12 JUNE 2013

_________________________________ CHAIR
## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 15th July 2013

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPHAC 01/05/13</td>
<td>4.1</td>
<td>Palliative Care Services in the Waitemata District – Committee to be kept informed on progress</td>
<td>Tim Wood</td>
<td>CPHAC 24/07/13</td>
<td>Item 4.3 in this CPHAC agenda.</td>
</tr>
<tr>
<td>CPHAC 12/06/13</td>
<td>2.1</td>
<td>Fencing of Swimming Pools Legislation – copy of Auckland Regional Public Health Submission to be circulated to Committee members.</td>
<td>Denis Jury/Paul Garbett</td>
<td></td>
<td>Actioned. E-mailed 19/06/13</td>
</tr>
<tr>
<td>CPHAC 12/06/13</td>
<td>5.1</td>
<td>Primary Care Update - Primary Care after hours issue – timetable on how it is intended to progress this to be provided to next CPHAC meeting.</td>
<td>Andrew Coe/Stuart Jenkins</td>
<td>CPHAC 24/07/13</td>
<td>Item 2.1 of the public excluded CPHAC agenda 24/07/13.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- A and M Services - check to be made to see if A and M sites receiving additional funding to reduce fees, targeting particular groups, are correctly administering that. CPHAC to be informed of results.</td>
<td>Andrew Coe/Stuart Jenkins</td>
<td>CPHAC 24/07/13</td>
<td>Item 4.2 of this CPHAC agenda.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Auckland Regional Dental Services – comprehensive report to be provided to CPHAC including how the service is doing, issues and how they are being addressed; the high DNA rate and what is being done to address that; advice on whether the workforce profile varies across the region.</td>
<td>Linda Harun</td>
<td>CPHAC 24/07/13</td>
<td>Actioned. E-mailed 27/06/13</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Former PHOs Unspent Funds - update for next CPHAC meeting.</td>
<td>Andrew Coe/Stuart Jenkins</td>
<td>CPHAC 24/07/13</td>
<td></td>
</tr>
</tbody>
</table>
3.1 Oral Health

Recommendation

That the Committee:

a) Notes that the facility development programme of the Oral Health Business Case is completed.

b) Endorses the activity being undertaken by the Auckland Regional Dental Service across the region to address arrears and DNAs.

Prepared by: Linda Harun (General Manager Child Woman and Family) and Helene May (Operations Manager, Auckland Regional Dental Service)

Endorsed by: Debbie Holdsworth (Chief Planning and Funding Officer)

Glossary

ARDS - Auckland Regional Dental Service
Arrears - Children overdue
Attendances - is the number of clinic visits made in a given period
Completions - is the number of patients seen where their treatment has been completed
DHB - District Health Board
DMFT - Decayed Missing Filled Teeth
DNA - Did Not Attend
IDC - Individualised Dental Care
MoH - Ministry of Health
NRA - Northern Regional Alliance
Treatments - may be preventive e.g. fluoride application or restorative e.g. a filling. A patient may have multiple treatments at one attendance.

1. Background

Auckland Regional Dental Service (ARDS) is the regional provider of dental services for children from birth to 18 years of age. ARDS provides screening, early detection, preventive, restorative and surgical dental services. From birth to year 8 (age 12-13), services are provided at some targeted pre-schools, primary and intermediate schools in the three District Health Boards (DHBs) throughout the Auckland region.

ARDS also provides a regional adolescent coordination service that facilitates and coordinates the transfer of Year 8 children on to contracted dentists who provide care for adolescents (13-18 years). Waitemata and Auckland DHBs, together with the Northern Regional Alliance (NRA), administer the contracts with the Waitemata and Auckland district adolescent oral health providers. Counties Manukau DHB in conjunction with the NRA manages and administers the contracts with adolescent oral health providers in their DHB area. Those adolescents at high risk of poor oral health, of low utilisation or those who wish to are able to remain with ARDS as a provider.

Any child requiring treatment outside the scope of ARDS or adolescent services, including the use of a general anaesthetic, is referred to services at Greenlane Clinical Centre.
Oral health business case

In 2006, the government announced new funding and a major new direction for oral health services in New Zealand. The government’s vision is ‘for high-quality oral health services that promote, improve, maintain and restore good oral health, and that are proactive in addressing the needs of those at greatest risk of poor oral health’ (Good Oral Health for All, for Life – The Strategic Vision for Oral Health in New Zealand, 2006). There are a number of key action areas through which the vision is to be achieved:

1. Re-orientating child and adolescent oral health services
2. Reducing inequalities in oral health outcomes and access to oral health services
3. Promoting oral health
4. Building links with primary care
5. Building the oral health workforce
6. Developing oral health policy and research, monitoring, and evaluation.

The purpose of the Oral Health Business Case funding was to address the above six areas. It sets out a plan for improving oral health in the district via new or refurbished facilities, an updated model of care and strategies to address workforce recruitment and retention. The re-orientation of the service focuses on a population-based approach to education, prevention and early intervention. The re-orientation of child and adolescent oral health facilities in the Waitemata and Auckland DHB district was successfully implemented over three years. The oral health service delivery increases have been phased over five years.

This business cases address a number of service delivery and infrastructure issues. The improvements include:

- Increased capacity to examine and treat children
- Modern purpose built facilities
- Increased mobile fleet for rural areas and areas of high need for Waitemata DHB, including the purchase of seven new mobile diagnostic vans
- Auckland DHB has purchased six new mobile diagnostic vans
- Improved accessibility with increased opening hours
- Better access to sedation facilities, negating the need for some consumers to travel to Greenlane Clinical Centre
- Changed model of care to meet individual needs and aim for ‘four handed dentistry’. Four handed dentistry is a technique in which a dental assistant works directly with the dental therapist on the procedures being done in the mouth. This model enhances productivity and effectiveness by synergising the transfer of instruments, minimising the dental therapist’s movement and reducing the amount of time the patient spends in the chair.

2. Progress/Achievements/Activity

2.1 Waitemata and Auckland DHB Oral Health Business Case implementation

The implementation of the Oral Health Business Case is now complete and the following facilities are operational.
### Waitemata DHB

<table>
<thead>
<tr>
<th>Clinic/venue</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glenfield Intermediate: four-chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Henderson Intermediate: six-chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Edmonton Intermediate: two-chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Belmont Intermediate: two chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Northcross Intermediate: two chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Silverdale Primary: two chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Forrest Hill Primary: two chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Birkenhead Primary: two chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Westgate Shopping Centre: four chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Albany Junior High: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Glen Eden Intermediate: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Transportable Dental Unit</td>
<td>Fifteen units are complete and in service</td>
</tr>
<tr>
<td>Level one, one chair diagnostic mobile vans</td>
<td>Seven</td>
</tr>
</tbody>
</table>

### Auckland DHB

<table>
<thead>
<tr>
<th>Clinic/venue</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sylvia Park: two chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Pt England: four chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Otahuhu: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Stonefields: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Balmoral: two chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Avondale: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Blockhouse Bay: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Royal Oak: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Ponsonby: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Wesley: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>May Road: three chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Orakei: two chairs</td>
<td>Open</td>
</tr>
<tr>
<td>Waiheke: one chair</td>
<td>Open</td>
</tr>
<tr>
<td>Greenlane Clinical Centre: number of chairs still to be decided</td>
<td>Open</td>
</tr>
<tr>
<td>Level one, one chair diagnostic mobile vans</td>
<td>Six Diagnostic screening vans are operating</td>
</tr>
</tbody>
</table>

### 2.2 ARDS activity/performance

The following information provides an overview of ARDS activity and performance in five areas:
1. Workforce
2. Arrears
3. DNAs
4. Enrolment
5. Productivity-attendances, treatments, completions.

#### 2.2.1 Workforce

There has been significant increase in the ARDS workforce across the region as part of the Oral Health Business Case implementation. Clinical processes have changed to meet current best practice guidelines. One significant area of change is the increase in the ratio of dental assistants to dental therapists. A substantial piece of work (The Dental Assistant Work Book) was completed in 2012 to ensure this ratio increase is used to optimum efficiency. The workbook
provides clear guidelines around work processes and expectations and is used across the service for training purposes and as a reference point.

The second significant area of change is the 2.2FTE increase in community dentists. Community dentists are able to treat children whose treatment needs fall outside the scope of the dental therapists. Work undertaken by community dentists includes treating children with special needs, those requiring conscious sedation and those requiring more complex treatment such as pulpectomy, extractions of permanent teeth and prescribing of antibiotics. This enables patients to stay with the community dental service rather than be referred to other providers. Oral health care can be continued in a timely way and remain accessible.

Dental Therapists are usually only available to recruit from the new graduate pool at the end of each year from AUT and Otago education institutes. Recruitment continues throughout the year, however, we seldom attract applicants prior to when new graduates are available in November.

Dental assistant recruitment has been maintained as no previous training is required for this position and generally there are many applicants for advertised positions. Any parental leave for dental assistants and community dentists is usually able to be covered.

Table 1 shows the marked increase in therapy assistants in ARDS since 2007. The total number of dental assistants has increased from 54.3FTE to 151 FTE.

Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>New Graduates Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>23</td>
</tr>
<tr>
<td>2010</td>
<td>25</td>
</tr>
<tr>
<td>2011</td>
<td>16</td>
</tr>
<tr>
<td>2012</td>
<td>13</td>
</tr>
<tr>
<td>2013</td>
<td>14</td>
</tr>
</tbody>
</table>

**Action Plan**

Continue to recruit throughout the year and actively recruit from AUT and Otago from October with a start date at the beginning of the year.
2.2.2 Arrears

A child is considered in arrears if they have not been examined within more than one month outside their recall period. The Ministry of Health has a target of 10%. The arrears at Waitemata is currently 18% and at Auckland 20%.

The disruption caused by the building programme over the past three years, and the development of new systems and processes using new equipment has been reflected in increased arrears rates in many DHBs, as shown in table 2.

![Oral health arrears rates comparison by DHB](image)

**Table 2 (30 May 2013)**

MoH has been working closely with all DHBs recognising the impact that the building programme has had on the arrears rates.

ARDS had achieved close to 10% arrears at the start of the building programmes and has seen deterioration since that time (table 3). Arrears for Maori had been as high as 29% in 2009 and reduced to averaging 13% in 2011 before increasing again to 17% in 2013. Pacific arrears rates were 28% in 2009 with current rates of 18% in 2013.

![Arrears & by Ethnicity](image)

**Table 3**
**Arrears Action Plan**

The following actions are being implemented by the service to reduce the arrears to MoH target of 10%.

- Individualised dental care (IDC) is an assessment tool that informs the recall period. High risk has a six month recall; medium risk a one year recall period and low risk an eighteen month recall period. IDC is designed to spread the demand of the service by the use of recall times to suit the risk status of the child. A higher than expected number of children are being recalled after six months and less than expected are being recalled at eighteen months. This is contributing to an over demand on the service. All staff have been provided further training on individualised dental care to ensure that the risk status and recall times are used appropriately. This will be audited regularly.

- A production plan for chair utilisation is being developed, with assistance from decision support. This plan will be similar to that used for theatre utilisation and will be operational in Quarter 2 2013/14. This will clearly demonstrate capacity and ensure chairs are used optimally. This planning approach has not been used before by ARDS.

- Targeted clinics will be opened for extended hours to provide more appointments and increase accessibility. Extended hours will start from August in the following clinics: Westgate, Edmonton, Glen Eden, Henderson, and Greenlane.

- A data quality project is being undertaken by the Team Leaders to ensure that the arrears total accurately reflects the current state.

- The Operations manager is monitoring the arrears situation weekly.

2.2.3 **Enrolment**

In 2012/13 the service exceeded the MoH enrolment target of 50%. An action plan has been put in place to ensure the 2013/14 target of 75% is achieved.

The graph below (Table 4) shows the number of 0-4 year olds both eligible and enrolled. Also the percentage enrolled of the eligible population. All areas are exceeding the Ministry of Health targets in this area. The percentage increase on the previous year demonstrates the considerable effort that has been dedicated to enrolling pre-school children.
Preschool programme coordinators were introduced in 2010. One of their key functions is to build relationships with Well-child providers in the area to encourage early enrolment in the service and early referrals from other providers when appropriate. The coordinators visit early childhood centres in targeted areas, and Kohanga and Pacific Language Nests. Children are assessed, diagnosed and referred as appropriate.

In WDHB area the coordinator visits the postnatal wards at both North Shore and Waitakere hospitals to introduce the service, give positive health messages early and to enrol babies. This targeted earlier intervention enables children with high clinical needs to be referred at an earlier age.

The programme was evaluated in June 2012 with data showing a 10% increase in enrolments since the introduction of the programme (Table 5). One of the areas of biggest impacts is the increase in enrolments for Maori and Pacific ethnicities. This demonstrates the preschool programmes’ achievement of one of its primary purposes to reduce the utilisation gap between ethnic groups.

![WDHB Preschool Enrolment Growth % by Ethnic Group](image)

**Table 5**

![0-4yr % Enrolment 2012](image)

**Table 6**
The data in table 6 shows the percentage of 0-4 year old children enrolled by ethnicity. The percentage enrolment for Maori is less than other groups across the region.

**Action Plan**

To improve early enrolment the service has implemented a pre-school oral health strategy which focuses on:

- Increasing enrolment and examinations of pre-school children particularly Maori and Pacific.
- Targeting hard to reach populations to ensure the service provided is accessible and appropriate.
- Twice a year visits to early childhood centres (Kohanga Reo and language nests) in high risk areas.
- Increasing health education to parents and caregivers.
- Active follow up of non-attendance.

**2.2.4 Did Not Attend rates**

The did not attend (DNA) rates, for Maori and Pacific children, are higher than Asian and other ethnic groups (table 7). In December 2012 the percentage of DNAs across Auckland Regional Dental Service (ARDS) was 21%. Statistics trend similarly across the region, the south area have higher DNAs by age group and ethnicity, with all areas having significantly higher DNA by Maori and Pacific with the lowest DNA rates within the 5-13 year age group (table 8).
DNA Action Plan
- To reduce DNAs the following actions are being undertaken: Specific clinics are extending their hours to better meet the needs and expectations of the communities, with a particular focus on improving service accessibility and uptake for children, adolescents and their families and whanau.
- Envelopes for appointment letters have been changed to make it obvious that the letter contains information regarding a free dental appointment. The use of an alternative appointment card will be explored.
- Client centred booking is being implemented. This enables appointments to be negotiated and is more likely to end with an attendance.
- Text reminders are sent to all preschool appointments, and school children at parent’s request.
- High risk families are contacted by telephone to arrange appointments; follow up phone calls are made to pre-school families in high risk areas or persistent DNAs when the diagnostic van is in the local area. The preschool programme targets preschools in areas of high risk. After initial contact these patients are directed into hub clinics for any treatment as required.
- The dental service profile is promoted by visits to parents on the postnatal wards. Raising awareness of early oral health intervention will contribute to parents’ uptake of preschool appointments. The intention is for this model to be extended to ADHB and CMDHB areas.
- The viability of On-line booking will be explored in the coming months.

2.2.5 Productivity
There has been an increase in productivity for attendances, completions, new enrolments and treatments. Table 9 shows a comparison of productivity between the same periods in 2012 and 2013. Productivity has increased in these measures. The small increase shown in attendances can be attributed to more interventions being completed at each visit. More preventive intervention has been made possible through the enduring consent process, introduced in October 2012. Consent is obtained for examination, x-ray and preventive treatments on enrolment so that all can be offered at the same appointment.

![Attendance Chart](chart.png)

Table 9

3. Risks/Issues
Currently 83% of children are being seen within an appropriate time frame. The risks for the seventeen percent not seen is an increase in these patients seeking relief of pain appointments, an increase in the number of appointments required due to more acute treatments when the child is seen and potentially more hospital admissions for children under five years of age due to unresolved dental caries.
4. **New Service Initiatives**

Free oral health services are planned for high risk pregnant women up to nine months post-partum using DHB community oral health facilities.

The 2009 Ministry of Health (MOH) report (Maternal and Child Oral Health – Systematic Review and Analysis) identified that ‘all pregnant women should be targeted for oral health promotion, with additional resources to develop programmes for socially disadvantaged women and those from high risk populations’.

ARDS is successfully implementing a two year pilot, funded by MoH, to provide free oral health services for high risk pregnant women up to nine months post-partum. The objectives of the service are:

- To establish whether an oral health service for at-risk pregnant and post-partum women can be run successfully in existing community-based oral health facilities;
- To identify the operational factors involved in running such a service;
- To identify the cost of establishing and running the service (excluding the cost of capital-related expenditure);
- To identify the cost-effectiveness and cost-efficiency of the service;
- To identify the impact on access to service, oral health literacy and oral health-related quality of life.

The service uses the oral health community facilities. Women are seen at Westgate, Henderson and Glenfield clinics. They are assessed by a community dentist and receive treatment from the community dentist and the hygienist, as appropriate. WDHB Maternity services are engaged in the project and welcome the new service provision. Independent Lead Maternity Carers, GPs and Maori and Pacific providers refer women to this service. Uptake of this service has been positive. One hundred and eighty nine women have been enrolled and seen to date.

5. **Conclusion**

Now that the oral health business case building programme has been successfully implemented, focus is being given to addressing the issues described in this paper.

ARDS priorities are:

1. To achieve the 10% arrears target by the following actions:
   - Appropriate use of the Individualised Dental Care (IDC) assessment. All staff have been provided further training on individualised dental care to ensure that the risk status and recall times are used appropriately. This will be audited regularly.
   - The development of a production plan for chair utilisation, with assistance from decision support. This plan will be similar to that used for theatre utilisation and will be operational in Quarter 2 2013/14. This will clearly demonstrate capacity and ensure chairs are used optimally. This planning approach has not been used before by ARDS.
   - A data quality project is being undertaken by the Team Leaders to ensure that the arrears total accurately reflects the current state.
   - The Operations manager is monitoring the arrears situation weekly.

2. To decrease the DNA rate by the following actions:
   - Extending clinic hours to better meet the needs and expectations of the communities, with a particular focus on improving service accessibility and uptake for children, adolescents and their families and whanau.
• Using envelopes for appointments clearly identified by ‘Free Oral Health Care’ on the outside. The use of an alternative appointment card will be explored.
• Implementing client centred booking. This enables appointments to be negotiated and is more likely to result in an attendance.
• Continued use of text reminders for all preschool appointments, and school children at parent’s request.
• The dental service profile is promoted by visits to parents on the postnatal wards. Raising awareness of early oral health intervention will contribute to parents’ uptake of preschool appointments. The intention is for this model to be extended to ADHB and CMDHB areas.
• The viability of On-line booking will be explored in the coming months.

3. Specific Strategies for Maori and other high needs groups:
• The preschool programme targets preschools in areas of high risk. Regular onsite visits are made to provide examinations and preventive treatments to targeted high needs Child Care Centres, Kohanga Reo and Pacific Language Nests.
• On site treatment at schools in high needs areas via transportable dental units.
• Ensure eligible high needs pregnant women access the Maternal Oral Health programme and receive oral health education, oral health examination and dental treatments as appropriate. That following delivery this service is extended to their children.
• Continue to train Plunket nurses and other Well-Child providers on Oral assessment and referral. This ensures that high risk children, not yet accessing the oral health service, are enrolled with the service and early intervention can be offered.
• High risk families are contacted by telephone to arrange appointments; follow up phone calls are made to pre-school families in high risk areas or persistent DNAs when the diagnostic van is in the local area.
• Increasing enrolment and examinations of pre-school children particularly Maori and Pacific.
• Targeted clinics will be opened for extended hours to provide more appointments and increase accessibility. Extended hours will start from August in the following clinics: Westgate, Edmonton, Glen Eden, Henderson, and Greenlane. A particular focus is to improve service accessibility and uptake for children, adolescents and their families and whanau.
4.1 Rheumatic Fever Prevention and Intervention Programme in Auckland and Waitemata DHBs

Recommendation

a) The Committee receive this report providing an update on the prevention and intervention programme for Auckland District Health Board and Waitemata District Health Board, for the reduction of Acute Rheumatic Fever in our populations.

b) The Committee note the progress made regarding implementation the Rheumatic Fever prevention programme in Auckland and Waitemata District Health Boards.

Prepared by: Carol Stott, Strategy and Planning Manager, Auckland DHB; Dr Alison Leversha, Community Paediatrician, Auckland DHB; Kirsty Walsh, Project Manager, Planning and Funding, Auckland DHB; Leani Sandford, Pacific Health Manager; Marty Rogers, Maori Health Gain Manager; Tim Wood, Group Funding Manager, Waitemata DHB; Vicki Scott, Programme Manager, Waitemata DHB; Dr Tim Jelleyman, Head of Division (Medical), Waitemata DHB; Dr Sue Crengle, Maori Health Advisor, Waitemata DHB; Martin Dawe, Project Manager, Waitemata DHB.

Glossary

ADHB - Auckland District Health Board
ARF - Acute Rheumatic Fever
CCHADS - Community Child Health and Disability Service
CHW - Community Health Worker
CFA - Crown Funding Agreement
CMDHB - Counties Manukau District Health Board
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
EECA - Energy, Efficiency and Conservation Authority
FTE - Full Time Equivalent
GAS - Group A Streptococcus
GP - General Practitioner
HPA - Health Promotion Agency
HVAZ - Healthy Village Action Zone
MoH - Ministry of Health
NHC - National Hauora Coalition
PHN - Public Health Nurse
PHO - Primary Health Organisation
RF - Rheumatic Fever
RHD - Rheumatic Heart Disease
WDHB - Waitemata District Health Board

1. Executive Summary

In June 2012, the Government announced 10 Better Public Service targets each focused on outcomes. Reducing the incidence of Rheumatic Fever (RF) by two thirds to 1.4 cases per 100,000 nationally by 2017 is one of the targets. The New Zealand incidence of Acute Rheumatic Fever (ARF) is currently 4.1:100,000. The MoH report the Auckland District Health Board (ADHB) rate as 3.5:100,000 and Waitemata District Health Board (WDHB) rate as 2.3:100,000. Figure 1 demonstrates the change in rates required to hit the Better Public Service target in 2017.
Auckland and Waitemata DHBs are taking an integrated whole of population approach to reducing the incidence of Acute Rheumatic Fever (ARF). Both District Health Boards (DHBs) have a very variable incidence rate across the populations with some areas of high incidence and others with zero incidences. This requires a multi-faceted prevention and intervention programme, which will address the geographically dispersed incidence of the disease across the DHBs.

Both DHBs have been allocated MoH funding for school-based sore throat swabbing programmes and have committed existing resources and/or budget to supplement the comprehensive programmes across the different work streams. Funding for Waitemata and Auckland DHB’s for both the school-based service and the rapid response/drop in clinic service will be received in one Crown Funding Agreement (CFA) in October 2013.

Both DHBs are progressing the planning and implementation of the DHB’s Rheumatic Fever (RF) prevention programme which strongly aligns with the strategic approach plan outlined and endorsed by the Community Public Health Advisory Committee (CPHAC) in the November 2012 CPHAC report. This approach includes the following strategies:

- Working with other sectors to improve housing conditions and reduce crowding
- Improving the skills and knowledge of our community regarding RF
- Improving the skills and knowledge of our workforce regarding RF
- Targeted and opportunistic throat swabbing
- Treatment programmes for sore throats, ARF and Rheumatic Heat Disease (RHD)

Interventions are targeted at high risk communities, namely, Māori, Pacific and families in low socio-economic settings with children aged 5-19 years of age (or age 4 when a child is visiting a prospective school).

Early identification and treatment of Group A Streptococcus (GAS) is essential in the prevention of ARF. Both ADHB and Waitemata DHB are therefore implementing a school based sore throat swabbing programme in specific high risk schools. This will facilitate early identification and treatment of GAS, a necessary precursor of RF.

The impact of a targeted school-based throat swabbing programme depends on the density of the disease burden. In contrast to Counties Manukau DHB where >85% of their cases of RF children attend decile 1 schools, ADHB and Waitemata DHB have a more dispersed disease burden but still with identifiable clusters where the disease is more prevalent. A school-based throat swabbing programme in the high risk schools in ADHB is estimated to likely reach only 35% of vulnerable children and in Waitemata DHB less than 10%. Therefore the school-based programme is only one component of an overall RF prevention plan in both Auckland and Waitemata DHBs.

ADHB will undertake a phased approach during 2013/14 to implement school-based throat swabbing and skin infection programmes in 16 high risk schools in decile 1 and 2 areas located in three clusters across the catchment area. These clusters are Glen Innes/Panmure, Otahuhu and Mt Roskill. Undertaking opportunistic throat swabbing in decile 1 & 2 secondary schools that have funded school health nurses is also being considered. A Sore Throat Swabbing Service Alliance with the four ADHB Primary Health Organisations (PHOs) is being
established. The scope of the Service Alliance includes the school-based throat swabbing programme and a primary care based throat swabbing programme for children out of school times and for young people up to 19 years. A Steering Group oversees and provides direction for all ADHB RF activities.

Waitemata DHB is implementing a RF prevention programme that has initially focused on establishing a school-based sore throat swabbing in the four identified high risk schools and an outreach programme for children aged 5-14 years, which includes skin infection checking aligned with the approach taken by Counties Manukau DHB (CMDHB). As RF has a dispersed distribution in Waitemata DHB, a proactive outreach model is under development that is integrated with the school based approach and supports active follow-up of high need cases.

A comprehensive approach involving five inter-related work streams has been established and is being actively overseen by a Steering Group consisting of Waitemata DHB Planning and Funding, Te Whanau o Waipereira Trust, West Fono, HealthWEST, Waitemata DHB Child and Family Service, ADHB Planning and Funding, Waitemata PHO, ProCare PHO, and other community stakeholders.

As part of the whole of system approach, the DHBs are also collaborating with a wide range of stakeholders (including primary care, Energy, Efficiency and Conservation Authority (EECA), Ministry of Social Development (MSD), Auckland Council and Housing New Zealand) across the region to design a healthy homes referral and advice centre. This is expected to provide a package of interventions for children and young people at high risk of RF to reduce both functional and structural crowding and thus reduce risk of transmission of GAS.

2. **Background**

In June 2012, the Government announced 10 Better Public Service targets each focused on outcomes. Reducing the incidence of RF by two thirds to 1.4 cases per 100,000 nationally by 2017 is one of the targets. The New Zealand incidence of Acute Rheumatic Fever (ARF) is currently 4.1:100,000. ADHB must reduce from the current rate of 3.5:100,000 to 1.2:100,000 and Waitemata DHB from 2.3:100,000² to 0.8:100,000 by 2017/18.

As previously noted, the Ministry of Health (MoH) strategy has identified three levels of intervention necessary to achieve this goal within the next five years. These are:

1. **Primordial prevention.** Reduce levels of crowding in houses and reduce the transmission of streptococcal bacteria in schools.
2. **Primary prevention.** Ensure Group A Streptococcus (GAS) sore throats in all high risk children are identified and treated early. Promote effective and timely management of sore throats in children at high risk of developing ARF.
3. **Secondary prevention.** Prevent the recurrence of ARF. Review cases of ARF to identify reasons and take action to improve prevention strategies.

The 2013 Budget released on 16 May 2013 announced further funding for RF prevention with a targeted focus on the Auckland region for the next four years. This included:

- Nurse-led rapid response services/clinics
- Pacific health literacy/community awareness raising
- Healthy homes advice and referral.

The MoH is currently leading the planning and development of these initiatives with the intention that the implementation of these initiatives commence by October 2013. ADHB and Waitemata DHB representatives are actively working with the MoH and others to ensure the initiatives are effective for high risk individuals and communities across the districts.
3. **Ministry of Health’s National Strategy**

**Budget 2013: Additional $21.3m to fight Rheumatic fever**

The Government’s strategy to reduce New Zealand’s high rate of RF among children received an additional $21.3 million over four years in Budget 2013.

Budget 2013 funding includes:

1. **$11.25 million over four years for nurse-led sore throat drop-in clinics.** This nurse-led service will reach high risk families whose children or young people do not attend schools with throat swabbing services or when it’s out of school term. The free clinics will be based in general practices and other community settings in parts of greater Auckland and Porirua. This programme extends the target age group to 19 years of age.

   Currently the MoH is leading planning with regional stakeholders on the nature of this new initiative with the view that it will commence from October 2013.

   Auckland DHB is working collaboratively through a RF Sore Throat Swabbing Service Alliance with its four PHOs to develop free nurse-led rapid response outreach services for the Auckland high risk population. Alliance Health + will be the lead provider of this programme. ADHB is considering extending the sore throat swabbing programme to include opportunistic swabbing in identified low decile secondary schools and alternative education facilities where there are DHB funded school nurses. This would capture approximately 8000 more at risk youth.

   Waitemata DHB is working with and through the DHB RF Prevention Steering Group to ensure strong linkages, accountabilities and integration embedded into the roll out of the DHB programme. Waitemata DHB is working with PHOs and local providers such as Te Whanau o Waipereira Trust, West Fono and HealthWEST. Stronger linkages, with other school-based nurses in the DHB are occurring as part of the work undertaken by the Youth Hub.

2. **$4.72 million over four years for an awareness campaign, including home visits and information resources,** to help vulnerable families understand how to protect their children from this disease. This programme is targeted to Pacific children and youth. The MoH intends to undertake a procurement process to secure a lead provider of this service. The service will coordinate activity across the region to target Pacific communities. The MoH aims to commence this service from October 2013.

3. **$1.6 million into research on a RF vaccine.**

4. **$3.75 million over four years towards an Auckland wide healthy homes referral and advice service.** Poor quality housing and household over-crowding are contributors to this disease, particularly in Auckland. This project will align with other budget initiatives including $100 million for insulation of households identified with high health needs (delivered by EECA), a Housing NZ pilot to trial a Warrant of Fitness for housing, and the transfer of needs assessment for social housing to MSD. The MoH has worked with regional stakeholders to develop a service delivery model and service specification. The MoH aims to progressively implement this service from October 2013 linking new and existing service providers (e.g. insulation) through a referral hub and local providers.
4. **RF Prevention Programme – Waitemata DHB**

Waitemata DHB is undertaking a comprehensive and integrated approach involving five inter-related work streams as below. This is undertaken with the direction, guidance and endorsement of the DHB Steering Group:

i. School-based throat swabbing;

ii. Outreach and follow-up/home visiting (related to school-based activity, community-based/rapid response clinics and opportunistic throat swabbing, and inpatient follow-up);

iii. Community awareness raising and primary care communications (health literacy);

iv. Healthy communal living and housing;

v. Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) secondary care assessment, management and liaison with primary care/community-based follow-up.

4.1 **School based throat swabbing**

Waitemata DHB has established a school-based programme which is delivered by the Waitemata DHB Child and Family Service under the guidance of the Steering Group. In May 2013 a Clinical Governance Group was initiated to provide clinical oversight to this initiative. This forum is able to capture issues and develop an agreed action plan to resolve clinical issues regarding implementation of the school-based swabbing programme. PHOs and outreach/community providers are and will continue to be part of the clinical governance process.

Swabbing in the three school-based programmes occurs three times per week in each school. The school-based programme is currently operating at Birdwood Primary, Ranui Primary and Pomaria Road School. Nga Kakano will commence at the start of term three (July 2013). The programme targets children aged 5-14 years. It occurs on Mondays, Wednesdays and Fridays to allow follow-up and other activity on the other days. Once a student has been identified with a GAS positive (or other streptococcus throat infection) result, the parent/guardian is encouraged to take their child to their General Practitioner (GP) to receive the prescribed antibiotics and appropriate follow-up. A standard letter is sent to the GP from the school-based programme either indicating that antibiotics have been dispensed or that the family will be seeking treatment from the GP. Where a parent/guardian is unable (for whatever reason) or would prefer the Public Health Nurse to dispense the antibiotics, these are dispensed under Standing Order in accordance with Heart Foundation guidelines. This approach has been developed and agreed with ProCare and Waitemata PHOs. To date, the family/whānau have chosen to take their child to their GP to receive treatment in over half of the children identified as having a GAS positive result. This early interaction with primary care further facilitates ongoing follow up of the child/whānau.

Where the parent/guardian chooses to take their child to their GP, the Public Health Nurse also contacts the GP to determine a visit has been made. Regardless of treatment approach the Public Health Nurse follows up with the family/whānau to determine that the antibiotics are taken as a full course.

The Child and Family team involved in the programme includes senior managers, a Medical Officer, Public Health Nurses, Health Care Assistants, Community Health workers, Social Workers and Health Promoting School coordinators. While a team approach is taken, specific staff has been assigned roles in the planning and roll-out to date. Key roles are as follows:

- Health Promoting Schools Coordinator – baseline surveys of RF knowledge and overall planning of health education/promotion activity;
- Medical Officer – oversight of clinical processes and delivery of education sessions (children, school staff and family/whānau, local health professionals, other providers);
- Public Health Nurses (approximately 1.8 FTE across the four schools) – liaison with schools, swabbing and clinical follow-up/other referrals (see below). Nurses have been
assigned specific schools and the whole team is planned to be trained in swabbing to allow back-up and cover as required.

- Health Care Assistants – administrative and other support for the Public Health Nurses within the school programme;
- Social Workers – home visiting follow-up (TBD in relation to Public Health Nurse and other provider Whānau Ora/other worker follow-up);
- Managers/Team Leader – overall planning, documentation of operational processes, protocols, standing orders and liaison with stakeholders.

School based opportunistic swabbing
Longer term plans to include medium risk schools such as Henderson South will be reviewed by the Steering Group once the four high risk schools are fully operational. This will occur during August/September 2013. To support this extension to the programme and ensure comprehensive support for the two dedicated school-based swabbing nurses, all Waitemata DHB Public Health Nurses have been trained in swabbing and related competencies to operate under the Standing Orders (to dispense antibiotics for RF and skin infections). Further opportunistic swabbing in schools is currently being planned.

Data capture, monitoring and reporting
Waitemata DHB has developed an overall programme measurement framework of the school-based swabbing programme. This aligns to the monthly reporting requirements outlined by the MoH and measures to assist overall programme evaluation. The data will be used to monitor and refine the programme over time, especially during the initial stages of implementation and to inform primary care and wider community communications.

Patient notes and related data are entered electronically and can be reported in real time at a patient level or in summary across the programme. A range of reports are currently being developed to provide the Steering Group with improved data that covers all activity within school. Data is also captured in the DHB system to enable clinical access from secondary care and the Child and Family Service Medical Officer. Once an outreach service is established, the intention is that the data will be combined to provide an integrated and overall summary of activity throughout the district.

May and June 2013 swabbing results
Results from the first two months of the Waitemata DHB school based programme are outlined in the figure 1 below. The percentage GAS positive rate is higher than expected compared to other areas. This could be a result of seasonal peaks and the early stage of the programme, but does highlight the importance of targeting high risk schools.

<table>
<thead>
<tr>
<th></th>
<th>May-13</th>
<th>Jun-13</th>
<th>Total</th>
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<tbody>
<tr>
<td>Number of swabs</td>
<td>180</td>
<td>320</td>
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<tr>
<td>Number of GAS positive</td>
<td>36</td>
<td>94</td>
<td>130</td>
</tr>
<tr>
<td>Percentage GAS positive</td>
<td>20.0%</td>
<td>29.4%</td>
<td>26.0%</td>
</tr>
</tbody>
</table>

*Includes swabs from Birdwood and Ranui
**Includes swabs from Birdwood, Ranui and Pomaria (from 17 June 2013)

Ethnic breakdowns of the above summary of results are presented in the figure 2 below. The breakdown shows that 46% of swabs were taken from Pacific children, followed by 34% from Maori children, 10% from European, 6% from Asian and 4% from other ethnicities. In terms of GAS positive rates per swab from these children the breakdown is as follows: Pacific, 26.8%, Maori, 23.8%, European, 34.7%, Asian, 26.7%, and Other, 13.6%.
Age breakdown for the number of swabs and subsequent swab results are outlined in figure 3 below. The age groups are aligned to the age group able to access to free GP consultations, i.e. children up to 6 years are free at a GP. To date around 28% of swabs have been taken for children aged 5-6 years, but children aged 7-14 years have a higher GAS positive swab rate 29.6% opposed to 17.1% of 5-6 year olds.

GAS positive swab rates in the 3 current schools outlined in figure 4 range between Birdwood School at 18.9% and Ranui School at 25.8% for May and June 2013 and Pomaria Road School at 33.1% for June 2013.
Table 4

<table>
<thead>
<tr>
<th>Number of Swabs</th>
<th>May 2013</th>
<th>June 2013</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Birdwood School</td>
<td>69</td>
<td>63</td>
<td>132</td>
</tr>
<tr>
<td>Pomaria Road School</td>
<td></td>
<td>139</td>
<td>139</td>
</tr>
<tr>
<td>Ranui School</td>
<td>111</td>
<td>118</td>
<td>229</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of GAS positive</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Birdwood School</td>
<td>12</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Pomaria Road School</td>
<td></td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Ranui School</td>
<td>24</td>
<td>35</td>
<td>59</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage GAS positive</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Birdwood School</td>
<td>17.4%</td>
<td>20.6%</td>
<td>18.9%</td>
</tr>
<tr>
<td>Pomaria Road School</td>
<td></td>
<td>33.1%</td>
<td>33.1%</td>
</tr>
<tr>
<td>Ranui School</td>
<td>21.6%</td>
<td>29.7%</td>
<td>25.8%</td>
</tr>
</tbody>
</table>

4.2 Outreach and follow-up/home visiting (related to school based activity, community-based/rapid response clinics, primary care and opportunistic throat swabbing, and inpatient follow-up)

Planning is underway regarding the development of an integrated and collaborative outreach model. This involves, Te Whanau o Waipereira Trust, West Fono, Healthwest, Waitemata PHO, ProCare PHO and the school-based programme.

Te Whanau o Waipareira Trust has agreed to pilot outreach/community based swabbing amongst high needs families in West Auckland as an adjunct to the school-based programme. It is likely that the age range for the outreach and rapid response programmes will be extended to include children/young people aged 4-19 years. Agreements with other providers are progressing.

Agreement in principle between providers has been reached regarding a referral pathway. This will include a home visiting and assessment process that will ultimately link with the regional Healthy Homes initiative being planned by the MoH.

4.3 Community awareness raising and primary care communications (health literacy)

As part of the rollout of the Waitemata DHB school-based programme local and targeted community awareness raising and health literacy has been undertaken. This has involved a baseline survey of health literacy within the school communities (families/whanau), school pupils, and school staff. Education sessions have been provided for families/whanau, staff and pupils along with gaining 100% parental consent to the programme in all four schools.

Liaison with local GPs and pharmacies in conjunction with the PHOs has been undertaken and local CME/CNE sessions through ProCare have been delivered. Further work is planned as the programme progresses.

Broader community awareness raising, will be augmented through updated material from the Health Promotion Agency and the regional initiative being planned by the Ministry of Health for commencement in October 2013.

4.4 Healthy communal living and housing

Waitemata DHB is actively involved in the regional initiative being planned by the Ministry of Health for an October 2013 start, along with some initial planning with local providers regarding home visit follow-up.
This initiative will coordinate referrals to a healthy housing hub, which will oversee and monitor delivery of insulation and other housing improvements for families/whanau meeting high health needs. Referrals will be facilitated through school based programmes, outreach, hospitals and community based providers.

4.5 **Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) secondary care assessment, management and liaison with primary care/community-based follow-up**

Waitemata DHB is currently piloting a new form to capture detailed case information for ARF hospital admissions to assist with improved diagnosis, management and disease coding along with a case review process to identify potential system improvements along the pathway. Two recent cases are currently being reviewed under this pilot. A case review process is being developed and will initially involve regular meetings to review new cases and monitor progress of existing cases. Primary care has been invited to participate in this review process to ensure a ‘whole of system’ perspective is undertaken.

5. **RF Prevention Programme – Auckland DHB**

Auckland DHB currently provides a limited sore throat programme in two decile one schools in the Mount Roskill area; Wesley Primary School and Wesley Intermediate with a combined role of 317 pupils of whom 88.4% identified as either Maori or Pacific Island ethnicity. This programme will be enhanced to ensure alignment with the new model and standard operating procedures.

Auckland DHB is taking an integrated approach to reducing the incidence of RF in its community including:

- School-based sore throat swabbing and treatment
- Outreach activities including home visiting and community-based primary care led sore throat swabbing clinics
- Opportunistic school-based sore throat swabbing in decile 1-4 secondary schools that have funded school nurses
- Health literacy and promotion activities that are integrated across all activities
- Healthy communal living and housing activities
- A comprehensive communications plan
- Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) secondary care assessment, management and liaison with primary care/community-based follow-up.

5.1 **School-Based Throat Swabbing**

Like Waitemata DHB, Auckland DHB is implementing an integrated sore throat swabbing and treatment programme and skin infection identification and treatment programme modelled on the Counties Manukau DHB RF programme. A Steering Group was established in 2012 along with a Clinical Governance Group and a project team.

The MoH has approved a Business Plan for the delivery of a school-based sore throat swabbing programme in 16 identified low decile schools in the Auckland DHB area. Implementation will be phased over a 12 month period in 2013/14.

Clinics will be held 3 days per week with the other 2 days focussing on follow-up, education, skin sepsis, housing, treatment, medication compliance, outreach services, health literacy, and data collection. Consented children will also be checked and treated for any skin infections as part of the school-based throat swabbing programme.
As outlined above, following a positive GAS result, family/whanau will be contacted and others in the household swabbed and treated if appropriate, through home visits. A home visit will also be offered for children diagnosed with skin infections where appropriate.

This programme will be delivered by ADHB’s Community Child and Disability Service (CCHADS) using Public Health Nurses and community health workers. As a result some reallocation and redirection of current resources is required.

As required by the MoH a Manual of Operations has been developed that sets out in detail the standards of service delivery.

Health promotion activities will be undertaken at school with the child and in the home with household members. Health promotion resources will be provided in appropriate languages e.g. Te Reo, Tongan, Samoan, Cook Island Maori, and health promotion messages will be delivered to the broader community via Healthy Village Action Zone (HVAZ) nurses, Whanau Ora navigators, local community events, markets, fairs, Pasifika, Marae, Churches, and Kapa Haka events.

Sponsorship by the Starship Foundation has been confirmed to provide packs for children with a positive throat swab or a skin infection that requires treatment. These packs will contain health promotion messages and resources.

Education to the school communities will be provided through presentations to Boards of Trustees, school events/assemblies, parent-teacher evenings and through information sent home with the child.

Options for data collection, reporting and clinical documentation are currently being scoped and an options analysis is being prepared for consideration. The aim is to utilise current systems that would work in this type of community setting.

5.2 Primary Care management of Sore Throats
Work is underway to ensure that primary care management of sore throats aligns with the National Health Foundation Sore Throat Management Guidelines. This will occur through channels such as Healthpoint, Primary Care Newsletter, Auckland DHB Staff Newsletter and internal PHO communications. DHBs are working collaboratively with primary care through the Greater Auckland Integrated Health Network (GAIHN) as a member of the Northern Region Child Health Network which has RF as one of 5 child health priorities.

5.3 Outreach activities including home visiting and community-based primary care led sore throat swabbing clinics
The MoH has confirmed funding ($2.7 million over 4 years) for Auckland DHB to establish a primary care led community-based outreach sore throat swabbing programme that will extend the age range for sore throat swabbing and treatment to 19 years. The programme will focus on children 5-14 years with sore throats outside of the school term and older young people. The MoH requires an annual plan for this programme to be developed by September 2013 with implementation to occur from 1 October 2013.

Auckland DHB and its four PHOs are establishing a Service Alliance to manage both the school-based sore throat swabbing programme and the primary care-based programme. Alliance Health+ will be the lead provider of the primary care community-based programme supported by the other PHOs.
5.4 Health literacy and promotion activities that are integrated across all activities
Health promotion activities to increase health literacy will be undertaken as outlined above. ADHB is collaborating closely with both the HPA and the MoH to ensure an aligned approach is taken. Baseline surveys of community understanding about sore throats and skin infections are planned prior to the introduction of the programme. The Community Paediatrician has been actively involved with Workbase (contracted by the MoH) in developing health literacy resources on skin sepsis. Resources include posters, parent and child information leaflets, and curriculum resources for the schools. These teaching resources have been distributed to the participating schools and have been incorporated into the curriculum as part of the school-based programme.

5.5 Healthy communal living and housing activities
Auckland DHB is taking the lead in working with the MoH to establish an Auckland-wide healthy homes initiative to help address factors leading to structural and functional household crowding. The Auckland DHBs will work collaboratively with a housing referral and advice centre that will accept referrals of individuals with high health needs from the 3 Auckland paediatric hospitals and from the school-based sore throat programmes. Clinical pathways to ensure children (and their family/whanau) who meet the eligibility criteria for referral are being developed.

A home assessment will be undertaken by a local community-based health worker and referral for services e.g. house insulation, curtains, heating assistance, minor repairs etc. made to the appropriate provider. All types of households will be eligible – private, rental or Housing NZ owned.

This programme will be offered in collaboration with EECA, Auckland Council, Housing NZ, DHBs and the Ministries of Social Development and Business, Innovation and Employment.

5.6 Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) secondary care assessment, management and liaison with primary care/community-based follow-up
Work is underway to develop streamlined and consistent hospital and discharge procedures irrespective of which service or hospital children and young people with ARF are admitted under. All new cases of ARF will undergo a significant event review. Primary care has been invited to participate in this review process to ensure a ‘whole of system’ perspective. A working group is examining clinical recording and coding. Quality improvement activities are in place to ensure the secondary prophylaxis programme is delivered effectively such that secondary recurrences are rare.

A separate workstream is reviewing the current Auckland Region Rheumatic Fever Register. This Register was developed in order to facilitate secondary prophylaxis to prevent recurrences of RF. The register has developed over time but has had insufficient resource allocated to ensure it is robust, responsive, and future proof. The MoH are considering development of a national register to perform the same function.

5.7 Communication Plan
ADHB has formulated a communication plan which could also be extended to the Auckland Metro DHBs. It is a local communication plan developed in consultation with the MoH and HPA to ensure alignment with the national approach and is underpinned by regional and national messages. ADHB and WDHB are exploring ways of collaborating on a regional communication plan and discussions have been positive to date. The Regional Child Health Network has also expressed support.
There has already been an interest from local community media and the NZ Herald with regard to RF and the prevention programme with local stories from ADHB requested.

ADHB has confirmed the Warriors as key campaign partners for the duration of the programme and is confident that this will resonate with our target audience including children, parents/caregivers, community and schools. Negotiations are also underway with other potential partners. Health promotion focused activities are planned for a number of high profile community events.

6. Funding

Both DHBs have been allocated MoH funding for school-based sore throat swabbing programmes and have committed existing resources and/or budget to supplement the comprehensive programmes across the different work streams.

The MoH has indicated that it will not fund ADHB and Waitemata DHB for RF prevention and intervention activities beyond 31 December 2016. DHBs are expected to continue to fund activities to meet Government targets for the reduction of rheumatic fever beyond this date.

6.1 Waitemata DHB

Waitemata DHB is in the process of completing an integrated proposal to the MoH that is inclusive of the three new initiatives that will operate alongside the school-based programme. To date the school-based programme has been resourced by re-prioritising the work programme of the Waitemata DHB Child and Family Service to deliver the programme. This is supported by the DHB to secure resources and associated set-up costs. Waitemata DHB has also allocated some funding to further support coordination, outreach and broader opportunistic swabbing in addition to MoH funding.

6.2 Auckland DHB

The MoH will fund the Auckland DHB RF School-Based Throat Swabbing programme at $135 per child on the school roll per annum from 1 July 2013 to 31 December 2016. Auckland DHB is expected to cover any additional costs to providing the programme.

Auckland DHB’s contribution to the RF School-Based Throat Swabbing has been estimated at up to approximately $400,000 per annum over this period allowing for some phasing as the school roll out occurs. The majority of the additional cost relates to the skin infection identification and treatment programme. Costs relating to all other components of the RF Prevention programme will be fully covered by the MoH.

7. Conclusion

ARF is to a large extent, the outcome of a combination of crowded conditions and socioeconomic deprivation, the presence of rheumatogenic GAS and barriers to accessing primary health care services. High risk families are Māori, Pacific and those in low socioeconomic areas; therefore the programme needs to be focused on these families to ensure a high level of engagement.

The identification and treatment of GAS will contribute to reducing, but will not eradicate ARF. To achieve the government’s target, there needs to be a cohesive intersectoral approach, which both ADHB and Waitemata DHB committed to as the DHB programmes are rolled out.
The national Rheumatic fever prevention strategy includes a primordial prevention stream and the DHBs are actively supporting the MoH in planning initiatives aimed at addressing underlying issues of damp and crowded housing. Until these social factors are resolved, there will always be a need for a focus on throat swabbing for at risk children and their families/whanau together with increased education and awareness amongst all population groups to contain the incidence of ARF.

The geographically dispersed incidence of the disease within Auckland DHB and Waitemata DHB also means that opportunistic and outreach initiatives will be critical to the effectiveness of the programme overall. The work undertaken by both DHBs to date in the high risk areas will inform and steer the programmes as they are extended and then implemented in the medium and lower risk areas.

Relationships and integration with local Māori, Pacific and primary care providers as key service delivery agents are fundamental to the success of any prevention programme. The delivery of the programme requires a pragmatic and integrated approach as the incidence of ARF decreases over the longer term. Good progress in being made across the agreed spectrum of prevention strategies.

It should be noted that reducing rates of Rheumatic fever is one of the five regional child health priorities (Regional Child Health Plan) and the Northern Region Child Health Network is providing umbrella oversight of activities across the region, including Northland.

References

1. MoH Presentation to Planning and Funding General Managers, September 2012

References

2. MoH Presentation to Planning and Funding General Managers, September 2012.
4.2 The Development of a Model of Care for Palliative Care Services in the Waitemata District

Recommendation

That the report be received.

Prepared by: Sarmila Gray (Project Manager, Planning & Funding, Waitemata DHB)

Glossary

DHB - District Health Board
PHO - Primary Health Organisation

1. Executive Summary

The purpose of this paper is to provide the Community & Public Health Advisory Committee with an update on the Development of a Model of Care for Palliative Care Services in the Waitemata District.

2. Background

Waitemata DHB wishes to ensure that the provision of palliative care within the district is timely, high quality, equitable, efficient, and sustainable. To realise this, Waitemata DHB Planning and Funding in late 2012 commissioned a project to develop a district wide palliative care model of care that is consistent, integrated and coordinated. A report describing the future model of care including a workforce plan and an outcomes framework is due to be submitted to management by September 30, 2013. An information paper on this project pertaining to the period between late 2012 till the end of April 2013 was presented to the Community & Public Health Advisory Committee in May 2013.

3. Reporting Timeframe

This report relates to activities pertaining to the months of May and June 2013.

4. Progress To Date

4.1 Engagement

The Independent Chair and the Project manager have been meeting with a range of stakeholders within and outside of the Waitemata district over May-June 2013. It has been a useful exercise for the purposes of gathering information, developing relationships, exploring ways of creating regional consistency and ensuring that services provided in the Waitemata district are in line with the national direction.
Following are the stakeholders we have engaged with:

- Portfolio Manager, Health of Older People, Planning and Funding, Auckland DHB
- General Manager, Primary Care, Planning and Funding, Counties Manukau DHB
- Clinical Director, Palliative Care, Counties Manukau DHB
- Chief Executive, Mercy Hospice, Auckland
- General Manager, Warkworth Wellsford Hospice, Auckland
- Maori Health Gain Portfolio Manager, Planning and Funding, Waitemata/Auckland DHB
- Managing Director, Bupa NZ
- Senior Project Manager, Innovations & Reform, Health Workforce New Zealand, Ministry of Health (Lower North Island regional Managed Clinical Network)
- Director of Palliative Care, Mary Potter Hospice, Wellington
- Palliative Care Specialists currently working within the Waitemata District
- Chief Executive, Te Omanga Hospice in the Hutt Valley
- Clinical Lead, Wellington Regional Hospital Palliative Care Service
- Director of Clinical Services, Mary Potter Hospice.

4.2 Project Management Structure
To guide, review and facilitate the project, two project teams have been established – a governance group and a clinical working group. The project teams are supported by a Project Manager employed by Planning and Funding.

**Waitemata District Palliative Care Clinical Governance Group**
The main purpose of the governance group is to provide guidance and oversight of the development of the model of care and ensure that the project is successfully delivered on time. The final project report will require sign off from this group before it is submitted to the DHB.

This is a relatively small group consisting of seven members and is chaired by an Independent Chair, John Robertson. While engaging with stakeholders, potential members were identified and invited to join the group based on the contributions they could make in guiding and leading this work, and not as a representative of any particular stakeholder.

The governance group reports to the Waitemata DHB Executive Leadership Team and meets every three weeks, for approximately an hour. The group had its first meeting on June 06, 2013 and has had two meetings so far.

The invited members of the group are as follows:
- Gina Langlands, Director, Quality and Risk, Bupa NZ
- John Hurihanganui, Maori Health Gain Portfolio Manager, Planning & Funding, Waitemata DHB
- John Robertson (Chair)
- Jonathan Christiansen, Head Of Division, Medicine and Health of Older People, Waitemata DHB
- Lannes Johnson, Clinical Director, Waitemata PHO
- Linda Cooper, Chair, Hospice West Auckland
- Tim Wood, Group Manager, Planning & Funding, Waitemata DHB (Project Sponsor).

**Waitemata District Palliative Care Clinical Working Group**
The primary responsibility of this group is to work out the clinical and practical details of the future Model of Care. Reporting to the governance group this group is chaired by the Medical Director of one of the hospices and consists of a range of senior clinicians who are directly involved with the provision of palliative care on a day to day basis. The group meets weekly for 2 hours.
It is the responsibility of the working group to keep the governance group updated on the progress of the project and to ensure that confirmation is sought from the governance group before key decisions are made.

Members have been selected to join the group based on their clinical and technical knowledge and expertise; they represent the clinical discipline they belong to (e.g. specialists, GPs, nurses, counsellors) not any particular stakeholder.

The appointed members are: (Others may be co-opted or requested to attend and /or be present)

- Mike Harris (Chair), Medical Director, Hospice North Shore
- Rowanne Bridge, Charge Nurse Manager Rodney District Nursing & Continence and Ostomy Service, Waitemata DHB
- Carol Frankson, Manager. Anne Maree Court (Aged Related Residential care)
- Paula Garner, Clinical Nurse specialist & Team Leader, Warkworth Wellsford Hospice
- Sandra Notley, Clinical Nurse Specialist, Hospital Palliative Care Team, Waitemata DHB
- Annette Ogles, Clinical Service Development and Quality Manager, Hibiscus Hospice
- Karen Talbot, Director, Clinical Services, Hospice West Auckland
- John Wellingham, GP, Apollo Medical Centre
- Maxine Pye, Family Support Leader, Hospice North Shore
- Gail Keane, Practice Nurse, Dodson Medical Centre
- Moira Camilleri, Hospice West Auckland, Hospice North Shore and University of Auckland.

The working group has made arrangement to access expert advisors as and when needed. Members are required to network with wider stakeholders within their discipline and beyond as appropriate to ensure maximum engagement. This will be valuable in informing the future model of care. The expectation is that the working group will develop a model of care by September 13, 2013 to allow sufficient time for completion of the final project report on time.

4.3 Key decisions to date

The governance has set the following parameters for the working group to follow:

- The model of care being developed will not address funding methodology or quantum nor would it include an implementation plan. Should the DHB accept the recommendations of the governance group, a piece of work to develop a funding model and an implementation plan will likely be commissioned.
- While the Waitemata DHB, with its large population (560,000 plus residents), its diversity and relatively high growth projections, its four hospices and its many age related residential care providers present some challenges, experiences from other regions would assist in the development of a model of care for the DHB to consider.
- A Hub and Spoke approach relating to the provision of the more scarce palliative care resources was preferred for the District, while for other areas of the palliative care, a different model might be appropriate.

4.4 Milestones & Timeframe

The following table lists the milestones by status and timeframe.

<table>
<thead>
<tr>
<th>Item</th>
<th>Status</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm the Terms of Reference of governance group</td>
<td>Completed</td>
<td>06/06/13</td>
</tr>
<tr>
<td>Confirm the Terms of Reference and the Brief of the working group</td>
<td>Completed</td>
<td>21/06/13</td>
</tr>
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<td>Confirm the Principles of the Model of care</td>
<td>Completed</td>
<td>27/06/13</td>
</tr>
<tr>
<td>Confirm the standard Definitions to be used for this work</td>
<td>Completed</td>
<td>28/06/13</td>
</tr>
<tr>
<td>Confirm the list of references to be used for this work</td>
<td>Completed</td>
<td>28/06/13</td>
</tr>
<tr>
<td>Item</td>
<td>Status</td>
<td>Timeframe</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Confirm a framework for the development of the model of care</td>
<td>Completed</td>
<td>27/06/13</td>
</tr>
<tr>
<td>Networking by the working group members</td>
<td>Ongoing</td>
<td>31/08/13</td>
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<tr>
<td>Develop and agree on a ‘work plan’</td>
<td>Completed</td>
<td>28/06/13</td>
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<tr>
<td>Palliative Care Needs Analysis for the DHB</td>
<td>In progress</td>
<td>12/07/13</td>
</tr>
<tr>
<td>Current state analysis</td>
<td>In Progress</td>
<td>12/07/13</td>
</tr>
<tr>
<td>Consumer engagement</td>
<td></td>
<td>August/September 2013</td>
</tr>
<tr>
<td>Development of a provisional model of care</td>
<td></td>
<td>15/08/13</td>
</tr>
<tr>
<td>Development of the detailed model of care</td>
<td></td>
<td>13/09/13</td>
</tr>
<tr>
<td>First Draft of the final project report</td>
<td></td>
<td>15/09/13</td>
</tr>
<tr>
<td>Submit Final Project Report to the DHB</td>
<td></td>
<td>30/09/13</td>
</tr>
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</table>

5. **Conclusion**

Waitemata DHB is committed to ensuring for its population timely access to high quality, equitable, cost-efficient and seamless palliative care services. To achieve this Waitemata DHB Planning and Funding in conjunction with key stakeholders has embarked on developing a model of care that is evidence based and ensures sustainable, seamless and coordinated care for all who would benefit from palliative care services. Under the guidance and oversight of the governance group, the clinical working group has commenced work to develop the future mode of care for the district including a workforce plan and an outcomes framework, which will be submitted in a report to the DHB by September 30, 2013.
4.3 Health Risks of Cell Phone Antennas

Recommendation

That the report be received.

Prepared by: Dr Lavinia Perumal (Public Health Physician, Auckland Regional Public Health Service)

Glossary

ARPHS - Auckland Regional Public Health Service
CPHAC - Community & Public Health Advisory Committee
DHB - District Health Board
HRA - Health Risk Assessment
ICNIRP - International Commission on Non-Ionising Radiation
NSH - North Shore Hospital
RF - Radiofrequency

1. Introduction

On 22nd May 2013, the Waitemata DHB Board was asked to approve the renewal of a lease with Telecom for its antenna on the North Shore Hospital (NSH) tower. The renewal of the lease was approved as it is a critical piece of equipment for our emergency pager system. Concerns were however raised about the potential health effects to staff working in the building and it was recommended a summary of the current evidence was made available to Board members.

ARPHS was approached to prepare a review of the evidence around the potential health risks associated with cell phone antennae and associated equipment. This is presented for information only.

2. Background

Cellphones connect to the main telephone network through a cellsite, which are also known as cellphone towers or base stations. Cellsites may be considered as relatively low-power multi channel two way radio systems. They comprise transmitter and receiver systems and the transmit-receive antennas. These antennas produce radio frequency radiation and emit electromagnetic radiation. This electromagnetic energy is characterized by its frequency (in Hz) and wavelength. Radio frequency waves occupy the frequency range 3 kHz to 300 GHz. The exposure levels are generally low, because the communication system made up from the mobile phone and base station is considered a low power system.

Radio frequency radiation is non-ionising because the energy levels associated with it are not high enough to cause ionisation of atoms and molecules.

At the ground level, the intensity of radiofrequency radiation from cellsites are less than one thousandth of those from mobile phones and are generally much less than those from the local radio and television stations. This is because cellsites are designed to send most of the radio signals away from the site, not to the area right next to it. They automatically adjust their
power, so they use just enough to handle calls going through the site and can’t transmit above a maximum power level.

Measurements have been taken around several hundred cellsites in New Zealand. At most sites, the highest exposure is less than 1 percent of the limit in the New Zealand exposure standard. Where exposures are higher, they are rarely more than a few percent of the limit. None has been above 10 percent. Exposures are even lower if there is no direct line of sight to the cellsite.

Maximum exposures generally are not any stronger even where cellsites are close together. Each cellsite only has a small area where the exposure is highest. Radiofrequency fields quickly get weaker outside that area and it would be unusual for two or more sites to have those areas fall close together.

### 3. Overall evidence about health effects

The Interagency Committee on the Health Effects of Non-Ionising Fields monitors research into extremely low frequency electric and magnetic fields and radiofrequency fields. This committee reports to the Director-General of Health. The membership includes representatives from government, industry, academic and consumer groups.

It is also noted the World Health Organization (WHO) has a continuing project investigating possible health effects of electromagnetic fields. This includes the low frequency fields from power lines and other electrical equipment and cabling, and radiofrequency fields from radio transmitters. The WHO is currently preparing a review on radiofrequency fields and health and it is expected to be published in 2014.

A quick review of what has already been prepared by the Ministry of Health on low-level radiofrequency electromagnetic fields was undertaken. The following summarises their key findings and advice.

- The balance of current research evidence indicates that exposures to the radiofrequency (RF) electromagnetic fields produced by WiFi, cellphones and other types of radio transmitters (cell sites, TV and FM radio transmitters etc) do not cause health problems provided they comply with international guidelines.
- This area has been researched for more than 50 years. Reviews have not found persuasive evidence of any adverse effects of exposure at levels consistent with international guidelines.
- The Ministry of Health recommends strict application of the exposure Guidelines published by the International Commission on Non-Ionising Radiation (ICNIRP).
  - These Guidelines were published in 1998 and reaffirmed in 2009 following a review of more recent research data.
  - ICNIRP is composed of scientists working in government, universities and other independent research establishments, and is recognised by the World Health Organization for its expertise in this area.
  - The exposure guidelines recommended by ICNIRP have been adopted in the New Zealand Standard 2772.1:1999 Radiofrequency Fields Part 1: - Maximum exposure levels 3 kHz - 300 GHz.
- Despite the above, the Ministry of Health notes that there is a not a huge body of evidence on very long term exposures. However, even if future research was to
demonstrate health effects from electromagnetic field exposures, these would almost certainly be very small because more than fifty years’ research has provided no clear evidence of effects.

- Nevertheless, in view of the residual scientific uncertainty, low cost measures can be voluntarily applied to avoid or reduce exposures.
  - If there are differing options available when designing or siting a radio transmitter, then those resulting in the lowest incidental exposures around the site should be chosen, all other things being equal.

- The Ministry of Health does not favor arbitrarily imposing exposure limits lower than those recommended by ICNIRP or in the New Zealand Standard. This perspective is consistent with the advice of World Health Organization.

4. Conclusion

Health impacts of low level radiofrequency radiation have been researched for over 50 years and there is no persuasive evidence there is a negative health impact. Telecom have confirmed in writing the antenna in question complies with the exposure Guidelines published by the International Commission on Non-Ionising Radiation (ICNIRP). Therefore is it concluded the cellphone antenna sited on the roof of the North Shore Hospital tower does not present a significant health risk to staff. It is also noted there are national and international agencies that continue to research this area and provide regular updates to regulatory bodies.

References

5.1 Planning and Funding Update

Recommendation:

That the report be received.

Prepared by: Dr Denis Jury (Chief Planning and Funding Officer ADHB), Dr Debbie Holdsworth (Chief Planning and Funding Officer WDHB), Julie Helean (Manager Planning and Service Development ADHB), Janine Pratt (Group Planning Manager WDHB), Tim Wood (Group Funding Manager WDHB) and Cliff La Grange (Group Finance Manager WDHB), Marty Rogers (Maori Health Gain Manager ADHB & WDHB)

Glossary

DHB - District Health Board
MHP - Maori Health Plan
NHB - National Health Board
PHO - Primary Health Organisation

1. Summary

This report updates the Committees on Auckland and Waitemata DHBs’ Planning and Funding activity.

2. Summary of activities in common

2.1 Planning

The Minister approves the 2013/14 Annual Plans and Waitemata DHB has now received approval. Auckland DHB is awaiting approval.

2.2 Primary Care

PHO Agreements

From 1 July 2013, a new PHO agreement came into effect. An agreement has been reached with each PHO. The most significant requirement of the agreement is that all PHOs are also to be in an Alliance Agreement from 1 July 2013 (see below).

Alliance Agreements

There are two parallel processes underway with respect to Alliance Agreements. The first process relates to the formation of a new Alliance between the Auckland and Waitemata DHBs with our Maori partners and the five PHOs operating within the two districts. These PHOs are; (i) Alliance Health+, (ii) Auckland PHO, (iii) National Hauora Coalition, (iv) ProCare, and (v) Waitemata PHO. A workshop has been held with the Chief Executives and Clinical Directors of each PHO, Ngati Whatua representation, along with Ailsa Claire, lead CEO Primary Care, and the Chief Medical Officers of the two DHBs. Te Whanau o Waipareira representation was invited to participate but did not attend.

An ‘in principle’ agreement has been reached to develop the Alliance. The Alliance agreement will include provisions covering the following area:

1. Focus on Maori Health Gain
2. Focus on Pacific Island and high need population health gain
3. Information sharing to measure both quality and performance
4. Enables and supports implementation of self directed care
5. Enables and supports implementation of localities
6. Enables and supports delivering on the District Annual Plan, including Health Targets
7. How we will work with each other.

It was agreed there is a need to develop a strategic direction for primary care. Development of this will commence shortly. There are a few areas where further dialogue will be required to reach an understanding.

The second process is to develop an Alliance Agreement between Waitemata PHO and Waitemata DHB. It has been agreed that this Alliance Agreement will be a transitional arrangement until such time the aforementioned Alliance is agreed.

All other PHOs in the two districts are already parties to an Alliance. Consequently, there is no requirement to put anything in place for them.

**Localities**

A Localities Establishment Governance Group (LEGG) has been in place for several months. The purpose of LEGG is to oversee the development of localities in Auckland and Waitemata DHB districts. This group is developing an agreed approach for the development of localities. CPHAC will be provided with an update when this approach is ready for approval. A draft is attached.

Work plans are being developed for each locality. These will incorporate elements to support self directed care and the implementation of shared care plans.

**Review Clinical Governance**

Dr Allan Moffitt, Clinical Director Alliance Health+, is leading a review of clinical governance arrangements. This review will provide advice on future options. It is anticipated that this will lead to a consolidation of existing arrangements and will align with the direction of the Alliance and LEGG.

### 2.3 Maori Health Gain

**Planning**

All changes have been made and the Māori Health Plan has been submitted within the required timelines to the MOH. Both MOU partners and PHO representation signed off the plan and acknowledgement has since been received from the MOH on the timeliness and quality of the plans submitted by Auckland and Waitemata DHBs.

**Whanau Ora**

Work continues on the development of a Whanau Ora Outcomes Framework to inform planning and funding activities at Auckland and Waitemata and with support from our MOU partners, hui have been held with providers to inform this work.

**Primary Care**

Under the new agreement, PHOs are required to sign up to the DHB Maori Health plan, and the DHB is to work with PHOs to ensure delivery of activities contained therein to advance positive Maori health outcomes. Key activities in the 2013-2014 MHP include the roll out of the Ethnicity Audit Tool. Engagement with PHOs has started and we expect to have a draft work plan in place for submission to the MOH by 20 July 2013.
Another requirement of the new agreement is the development of an Alliance. The Maori Health Gain team are participating in these discussions and it is hoped that there will be a Whanau Ora work stream as part of the Alliance that will allow for further developments across the Auckland and Waitemata region.

Cancer
Participation in the regional cancer network through the Maori Leadership Group continues. Contribution and critique has been given to the national tumour standards, redesign of the Regional Cancer Network structure and terms of reference, and the continued development of Maori input across the work streams.

Contracting initiatives
Maternal and Child Health Nutrition (MOH contract). It is expected the contracts to roll out community action under this kaupapa will be in place by late August 2013 for a term of 3 years, (Auckland & Waitemata DHB).

Rheumatic Fever
Negotiations have begun with Wai Health and HealthWEST for a 3 month pilot approach to a community settings swabbing programme. It is hoped that this will be in place before the end of July (Waitemata DHB only).

Hauora Rangatahi
The Rangatahi Service provides a range of general health, education and promotion, advisory liaison and co-ordination of (cross sector) activities specifically targeted at Rangatahi. A key objective of the service is to ensure that the activities of existing health professionals are coordinated and effectively targeted for Rangatahi and that Rangatahi are assisted to access those services (Waitemata DHB only).

3. Waitemata DHB Update

3.1 B4 School Checks
The final coverage for the Waitemata B4 School Check programme in 2012/13 against a target of 80% is 70% high needs and 68% total population. The lead provider of this service changed from Waitemata PHO to Royal New Zealand Plunket Society (Plunket) at the beginning of May following a competitive tender process.

Plunket began delivering the nurse component of the B4 School Check programme on 6 May 2013. They were quickly able to develop their service and achieved 85% of the two month target. They completed 906 nurse checks, compared to the targeted 1072 nurse checks. This is an outstanding effort and demonstrates their ability to successfully engage with families to ensure children receive their B4 School Check. Plunket and the Waitemata Vision and Hearing team are working closely together to ensure that children receive both components of the check and in a timely manner. From 9 September 2013 there will be some joint clinics between Plunket and Vision and Hearing.

A quality plan for the B4 School Check programme is being developed. This aligns closely with the Ministry of Health draft Well Child Quality Framework. It will also have Waitemata specific indicators. The quality plan has a strong equity focus and on timeliness of the check and referral pathways.

In 2012/13 the Waitemata B4 School Check programme had a much lower coverage for Maori (51%) and Pacific (54%) compared to other (73%). In 2013/14 there will be a strong focus on ensuring Maori and Pacific children have the same or greater coverage than other.
To achieve this Plunket have begun engaging with the Maori and Pacific providers in the district to look at how they can work together to ensure all four year olds receiving a B4 School Check.

The targets for 2013/14 will increase to a minimum of 90% of children receive their B4 School Check.

3.2 Funder Finance

The May 2013 consolidated core result for the Waitemata Funder was $1.3M favourable to budget for the month and $11.1M favourable to budget for the year to date.

Funder NGOs

The May 2013 core result for Funder NGO was $0.6M favourable to budget for the month and $6.3M favourable to budget for the year to date.

The year to date favourable position includes an upside of $2.3M relative to PHO First Contact Capitation Services and PHO Fee for Service deductions receivable. The Community Pharmacy position continues to improve and is now $1.7M favourable to budget for the year to date. The favourable NGO position now also includes an adverse variance of $1.9M from within Health of Older Persons Services. This is mostly a consequence of Age Related Residential Care Services being paid for three fortights in the month instead of the usual two. It also includes an amount set aside for the settlement of a recently advised adverse year end wash-up position relating to the regional risk share agreement for Long Term Support – Chronic Health Conditions Services. Mental Health Services ($685k) and Primary Care Demand Services ($1.2M) continue to be favourable to budget.

Funder IDF’s

The May 2013 core result for Funder IDF was $0.75M favourable to budget for the month and $4.8M favourable to budget for the year to date.

The main factor contributing to the favourable result continues to be the positive inpatient wash-up position receivable through the MOH default wash-up process. This is mostly reflective of lower acute utilisation by Waitemata domiciled patients at Auckland DHB facilities.

4. Auckland DHB Update

4.1 Immunisation

ADHB continues to exceed the 85% national target for 2012/13 for immunisation of 8 month old babies with coverage at 6 June at 90% overall (Maori 79%, Pacific 87%, Asian 94%, Other 91% and NZE 92%). Coverage at age 2 as at 6 June remained at 93% (Maori 88% - a 2% drop over May, Pacific 93%, Asian 95%, Other 93% and NZE 92%).

4.2 Before School Check Programme

As at 6 June ADHB performance was 84% of the target or the total target population but only 68% for the quintile 5 population target. Locating quintile 5 families remains a major challenge and although every effort is being made to improve performance, it is very unlikely that either target will be met by year end.

The service alliance has decided to hold a workshop with a wide range of stakeholders to identify the barriers to success and develop an action plan. The service alliance remains
committed to the programme. Budget 2013 included significant additional funding to support expansion of the target from 80% to 90% of the eligible population.

4.3 Funder Finance
For the month of May 2012 the funding accounts show a deficit of $4.8m compared to a budget deficit of $5.2m, a favourable variance of $0.4m.

YTD the actual surplus is $17.8m compared to a budgeted surplus of $5.8m a favourable variance of $12.0m.
1. Introduction

Through 2008 and 2009 both Auckland and Waitemata District Health Boards (DHBs), together with primary care, consulted extensively on their respective Primary Health Care Plans (ADHB 2009, WDHB 2009). Both Boards achieved a high level of cross sector and community support for their plans and they were signed by all the Primary Health Organisations (PHOs) in each district and by Te Runanga o Ngati Whatua.

Both Plans made a commitment to a neighbourhood/locality approach.

Such an approach was to respond to the desire of communities for a more locally nuanced approach to health service planning and delivery than the existing district wide model. They wanted to feel more involved in decisions and see local services being provided to meet local needs. From an organisation point of view, the approach is an opportunity to partner more closely with patients, families, communities and providers across the system to improve health and the quality of healthcare through reducing variation and a whole of system focus.

Since that time, significant progress has been made in refining the approach in both DHBs including the development of the West Auckland Health Network and associated entities, and the development of a locality based community engagement model in ADHB.

This plan consolidates activity to date and sets our locality approach squarely in the context of ‘self directed care’ as we plan for 2013/14 and beyond.

2. Purpose & Approach

“Working together we will create the conditions in which individuals, families/whānau and communities can take greater control over their lives to maximise their health & wellbeing”.

This plan acknowledges that achieving our vision will take time. Our intent in the 2013/14 year is to build on the foundation of work already developed to deliver a series of key projects that moves us clearly in this direction. It is important to note that our locality approach is just one way for us to maximise the health and wellbeing of our communities. There will still be a need for higher level activity, for example the regional clinical pathway activity through the Greater Auckland Integrated Health Network (GAIHN).

The locality approach will see enhanced community engagement, clinical leadership, and use of health information, with a sharp focus on putting individuals, their families/whānau and communities’ front and centre.

Supporting the people of Auckland & Waitemata to maximise their health and well being we will ensure:

- people will control and be empowered to maximise their own health and well being and enhance the quality of their life
- peoples different beliefs about their health or their role in care will be respected

1 Feedback received during consultation on the Auckland DHB Primary Health Care Plan, 2008
• services will be prioritised based on patient / whānau need and we will work with the community to deliver services that meet their expressed health needs
• people will have rapid and convenient access to high quality cost effective evidence based services
• a focus on reducing health inequalities
• responsiveness to the aspirations of Māori and other ethnic communities such as Pacific and Asian peoples
• a focus on whānau ora approaches

People will see:
• Health care that is adapted to their needs - as they see themselves
• Where possible a choice of services which are efficient and provide value for money
• Delivery of seamless, integrated, individualised or whānau based care, no matter where they touch the system
• Person centred (rather than disease centred) case management of individuals /whānau within a whole health system with the Medical Home (General Practice) as the central care provider
• Improved quality of care, reduced variation and achievement of the National Health Targets

The high level approaches that will deliver these outcomes are:
• Partnership with local communities including deliberate strategies to connect with local populations in a continuous rather than episodic way to facilitate shared health service planning & delivery;
• Meaningful engagement with providers across the whole spectrum of care;
• Enhanced local government engagement through structured links with elected Local Boards; and
• An inter-sectoral approach with other government and non-government agencies who have an influence on health and its broader determinants

Appendix 2 contains more information about the principles that underpin the locality approach.

3. What is a ‘locality’?

Definitions

A locality is defined as one of the Auckland Council Local Board areas. These are geographically defined and encompass all people usually resident in the area.

Our locality approach has two related but distinct features:

Locality planning is a population health approach which puts communities and their experiences of health and healthcare at the centre of planning decisions and, crucially, engages those communities in action to improve health. This concept goes further than consulting local people on planned changes or development instead seeking to actively engage them to shape and define the public value, that is, what matters most in terms of health priorities. In general, locality planning is tightly bound to locality boundaries to allow for meaningful population data analysis and intersectoral working, and is part of our broader community engagement strategy.

Locality provision is the better co-ordination and integration of health and related services at the locality level. Importantly this encompasses more than traditional primary care, representing instead a microcosm of all health service activity, inclusive of hospital and primary care and other health and social sector services, operating at a local level. Locality provision is not tightly bound to locality boundaries to allow the development of functional networks around existing or potential provider relationships and to accommodate known movements of patients.

For operational purposes the localities may be aggregated.

The infrastructure and governance that is planned to support the approach is outlined in Section 6.
Table 1: Auckland DHB & Waitemata DHB Localities

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<thead>
<tr>
<th>Locality</th>
<th>Population</th>
<th>District Health Board</th>
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<td>Rodney</td>
<td>54,100</td>
<td>Waitemata DHB</td>
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<tr>
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<td>Waitemata DHB</td>
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<td>57,300</td>
<td>Waitemata DHB</td>
</tr>
<tr>
<td>Henderson-Massey</td>
<td>109,600</td>
<td>Waitemata DHB</td>
</tr>
<tr>
<td>Waitakere Ranges</td>
<td>49,000</td>
<td>Waitemata DHB</td>
</tr>
<tr>
<td>Whau</td>
<td>76,400</td>
<td>Waitemata and Auckland DHB</td>
</tr>
<tr>
<td>Albert / Eden</td>
<td>98,800</td>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Puketapapa</td>
<td>56,100</td>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Waitemata</td>
<td>70,000</td>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Waiheke Island</td>
<td>8,420</td>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Great Barrier Island</td>
<td>820</td>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Orakei</td>
<td>81,100</td>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Maungakiekie Tamaki</td>
<td>73,000</td>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Mangere-Otahuhu</td>
<td>75,900</td>
<td>Auckland and Counties Manukau DHB</td>
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</table>

Rationale for taking a geographic approach

Whilst community based care must care for multiple different populations there are a number of reasons why we should increase focus on locality populations:

- “Localities are strong natural communities of interest;
- Health services are by their nature geographically located and deliver services within a locality;
- Primary care is by its nature generalist and comprehensive and tends to provide these services within a limited geographic area rather than providing services to more specific groups over a larger area;
- Primary care is strongly linked with local communities. Enhancing this linkage can lead to better involvement with the community and improved access;
- Primary care clinicians need to work closely with other people caring for their patients. This is most easily enhanced through a locality population. Organising primary care, secondary care, and other health providers around the same local populations will greatly assist integration of services.”

A focus on geographic localities enables us to understand and address health priorities from communities’ perspectives. We are able to partner directly with patients families/whānau and the public in the design and ultimately the delivery of health services in defined areas. Existing approaches, such as to diseases (e.g. diabetes) and to whānau ora and the aspirations of Māori can also be interwoven into a locality approach.

* Population numbers are rounded estimates based on Statistic NZ 2009 projections
The locality approach does not replace existing relationships, such as with our iwi partners; existing community networks or programmes such as HVAZ; or existing disease specific planning, such as for diabetes or cardiovascular disease.

A locality approach seeks to complement them, where appropriate, to further improve health outcomes and reduce inequalities.

Rationale for using local government boundaries

Localities with a population of between 50,000 - 100,000 people are estimated to be required to gain the full benefits of a locality approach. This population size aligns well with the Local Board areas defined for the Auckland Council which has advantages in being able to work closely with our local government partners with common populations.

In determining local government boundaries the Local Government Commission identified three communities of interest: perceptual (a sense of identity with an area); functional (reasonable economy of scale to meet requirements for physical and human services); and political (ability of elected body to represent interests). These communities of interest are also relevant to achieving an integrated health system.

We have elected to use Local Board areas rather than Wards, as the Local Boards provide a ready community interface for locality planning. In many cases there is a single Local Board for a Ward but where they have been split, the separation also makes sense from a health perspective. For example, this would mean considering the ward of ‘Waitemata and Gulf’ as three localities (Waitemata, Waiheke Island and Great Barrier Island) [refer Table 1].

5. How are we going to do this?

Delivering our vision will require the integration of activity internal and external to the DHB across three broad areas:

1. Better use of health information;
2. Enhanced community engagement (including iwi and MoU partners); and
3. Local service provision & development

As shown in Figure 1, the three areas overlap, for example the use of community engagement tools to provide health information, but they are a useful frame for grouping action.

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3 Healthy Village Action Zones
5 Tasks and Approach on Auckland Governance Reforms, Local Government Commission, 2009
Health Information
We are awash with data across the health sector but relatively little is translated into meaningful information and less still into a form that is able to inform decision making.

In a locality context the functional component ‘health information’ refers to two broad areas.

1. The first is at a population health level where we are working to gain a better understanding of health need and utilisation patterns of our resident population at a locality level. To enable integration with other sectors we are using Auckland Council Local Board boundaries as the functional unit. To do this it has been necessary to reconstruct existing datasets and as part of this process we have been working to make the information more accessible and dynamic (as presented to the March 2012 CPAHC meeting).

2. The second area is data about enrolled populations held within primary care, at both practice and PHO levels. Emerging analysis is providing valuable insights into health variance across providers within similar areas and with similar populations. Targeted data analysis will be used to inform specific quality improvement activity. This will reduce avoidable admissions and improve service delivery in key areas such as diabetes management, CVD risk management, smoking cessation and child health.

A number of uses for information in a locality context have been identified, including:

1. **Individual patient management**: Sources include disease registers and/or population registers for preventive and long term condition proactive care.
2. **Improving practice/practitioner quality**: Focus could start with regional network KPIs first, data sources vary but include individual practice and PHO registers
3. **Local service delivery & integration (community)**: There is a need to stocktake services including defining GPs with special interests (GPWSIs), specialist nurses and the need/demand for such, primary care allied health, self-management support – group or otherwise, Family Planning, sexual health, After-hours, youth, community pharmacy etc
4. **Local service delivery & integration (hospital)**: There is a need to understand current volumes of service delivery, scale required for efficient service, current local provision, and alternative models
5. **Health promotion/community development**: Need to identify local issues & local resources. Community engagement activity is key and needs to be driven “bottom up”
6. **Inter-sectoral understanding and synergy**: Starting with Auckland Council and MSD, but useful to consider others, including ACC, Housing, Education etc
Funding and planning: Provision of information for health needs assessment to guide locality planning processes at Integrated Health Network level.

Wider community understanding & engagement: Sharing of locality level information with Local Boards and community groups is already proving a welcomed engagement mechanism as we seek to work more closely across the system.

Improving the utility of health information will ensure that DHBs and service providers have more precise information about service access, health need, and variance in service delivery and at a finer level of detail than previously. This will enable us to better forecast demand and more accurately tailor our service planning and improvement activity.

Analysis will be focused to ensure all localities can answer:

- **How healthy?** Reducing health inequalities and improving health outcomes now and in the future. How healthy/unhealthy is my population in relation to my benchmarks?
- **What is really happening in this system?** Information at the right time and to the right person to protect the vulnerable and to ensure the right care is given.
- **How much?** Improved financial information including budgeting and planning so we know we are spending on the right things with the right provider.
- **How do we compare?** Challenge the current state through benchmarking and comparison in order to improve clinical outcomes.
- **Are the providers who serve our population delivering quality care?**
- **How could things be better?** What are our patients telling us? Focus on patient stories — and keep the focus on what it feels like and what people want for themselves, keep the moral high ground and the shared objective.
- **What difference have we made?** Have we improved health outcomes? Have we reduced inequalities?
- **Responsiveness to Māori?** How are localities working with iwi and MoU partners to maximise Māori Health Gain?

Community Engagement

Community engagement is a very broad concept and we already have numerous mechanisms for engaging with our community and gaining information to inform healthcare planning decisions, service provision and how to improve the patient experience. However many of these activities occur in an ad hoc, or project specific way.

A key feature of the locality approach is planned and proactive ongoing partnership with patients, whānau, iwi and community networks and representatives resident in a geographic locality. The value that the locality approach will add is that it will enrich the relationships and information flow between those who use services and those who develop and provide them. It will facilitate genuine conversations with our stakeholders/NGOs and public (consumers) that is appropriate to each locality.

The locality approach acknowledges communities of individuals as equal partners in service planning.

The key enablers for enhanced community engagement are:

- **Knowledge** of community leaders, networking meetings and appropriate access pathways for minority communities.
- **Good will**: intention of all parties to share, consider and utilise information.
- **Health Literacy** as two way, culturally appropriate, verbal and written communication.
- **Sector leadership** identified and known, available and accessible.
- **Communication**: Transparency and consistent communication between all parties.
- **Collaboration** with local government, other Government organisations (MSD, Housing etc).
• **Co-ordination** of touch points with individuals (consumer voice), NGOs, communities (public voice) and ensuring the feedback loop is managed.

• **Accountability** mechanism/ indicators of genuine conversations.

The locality approach provides a rigorous framework and enduring connections to engage patients, whānau and representatives and leaders of local communities in three distinct areas:

1. **Local perceptions of health status**

   Such an assessment will be used to inform the qualitative component of local health needs assessments/profiles. Engagement in this area could also be used to help us understand variability in health status between and within localities.

2. **Patients’, families and communities experience of service delivery.**

   This topic area would usually be explored at the service level. From a patient/family point of view:
   
   a. what’s working well?
   
   b. what needs to be improved?
   
   c. how can we best do that?

   This information will directly influence service re-design. The degree of involvement could be extended to directly involving patients and community representatives in the design of local services (ie: “co-design”). Engagement in this area could also serve performance monitoring purposes: we will draw on service users’ experiences of service delivery to help us understand the reasons for service performance variability between and within localities.

3. **Patients’, families and communities understanding of value**

   This topic area would usually be explored at the level of planning and strategy in the Integrated Health Networks. From patients and communities’ points of view:
   
   a. what matters most for patients, families and communities?
   
   b. for what health conditions is the system delivering value for patients and where is it not?
   
   c. what maximises outcomes (including the sustainability of health benefit) for patients and their families/whānau?

   Engagement in this area will influence decision-making at the system-wide level, for example, sector integration and strategy.

   Patients will see the DHBs and PHOs keeping in touch with their views and experiences across these three topic areas and, where appropriate, their input factored into service development and improvement activity.

**Service Provision & Development**

The service provision & development component of the approach is where the health system responds to the signals that have been generated through looking at the available health information and engaging communities in conversations about their health, priorities and value. It is where the ‘rubber hits the road’ in terms of service integration and a locality approach offers real potential to allow a significant departure from current models of service delivery, including the potential to ‘co-produce’ services with communities.

Co-Production goes beyond factoring community input/ feedback into service design and improvement. It

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6 Defined as the health outcomes achieved per dollar spent. *A Strategy for Health Care Reform - Toward a Value-Based System* (Porter 2010).

involves designing and delivering services collaboratively. There is a growing body of evidence to show that such an approach can deliver benefits across service accessibility, quality, outcomes and costs in a range of settings and service areas. While true co-production will take time, antecedent concepts such as co-design are an achievable first step.

It is through this function that we will begin to describe the role and function of primary care practices as access and care coordination points. Such functions may include:

- Population focus with targeted population based interventions
- Locality linkages to ensure population access to extended services and subspecialisation within primary care
- Care navigation based in primary care
- Services accessed via primary care or direct access eg access to talking therapies
- Attached staff e.g. district nurses, rapid response services
- Access to diagnostics and near patient testing
- Telecare and telehealth
- Extended access
- Multi modal consults (video, phone, email)
- Interdisciplinary practice and model
- Extended team eg, clinical pharmacist, health care assistants, extended scope nurses.
- Clinical partnership with community pharmacy
- Partnership with residential homes
- End of life care

It is also here that we will explore how hospital provided care may evolve, for example:

- What needs to be different in secondary care initially and how secondary care services are to be accessed by localities and how secondary care will support localities?
- How do we create a system instead of secondary and primary care?
- How to we monitor & evaluate services?
- Staff trained in supporting ‘my plan’ and motivational approaches
- Open referrals and follow up
- Services close to me (e.g. telecare and telehealth)
- Two way digital communication
- How will Whanau Ora be realised?

6. **Form to deliver function**

Implementation of the Locality Approach described will require the formation of new groups based around new partnerships and ways of working. Form should however follow function and an evolutionary approach to the required structures is suggested. As a principle, existing structures and groups will be utilised where practical. As noted, each Auckland Council local board area will be designated a locality. For operational efficiency these may be aggregated into groups.

**Governance**

The overall approach will initially receive its governance from a Locality Establishment Governance Group (LEGG). Each locality will develop its own clinical governance process which will be linked to a system of broader clinical governance (to be established).

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8 Within a health context, co-design (also known as experience based design) is “… a method of designing better experiences for patients, carers and staff”. It involves patients and staff exploring the care pathway and the emotional journey patients experience along it, capturing experiences, then working together to understand these experiences and improve them. (NHS Institute for Innovation and Improvement, 2009).
**Structures**

Within each locality we will develop separate vehicles for locality planning – **Local Health Partnerships** (LHPs), and locality provision – **Local Clinical Networks/Clusters** (LCNs). At least one Local Health Partnership and one Local Clinical Network/Cluster will be established in each locality with. While in most cases we expect LHPs to exist within locality boundaries, exceptions will be made where these boundaries are not sensible (e.g. Rodney and Hibiscus & Bays). Local Clinical Networks/Clusters will focus on the enrolled populations of their constituent General Practices’. Again, while in many cases they will exist within locality boundaries by their nature they will have ‘soft edges’ to allow flexibility across where this makes sense.

Figure 2 shows how the different pieces come together. As noted previously, an evolutionary approach to the required structures is suggested to allow for local flexibility and to ensure we do ‘what works’.

**Figure 2: DRAFT Organisational Diagram**

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7. **Next Steps**

1. Embed a governance structure (LEGG) for the approach across Auckland & Waitemata DHBs which involves key stakeholders from primary care (PHOs), secondary care, DHB Planning and Funding, local boards, local iwi partners, whanau ora and other key stakeholders from primary care and the community.
   - This overall governing body will need to approve an action plan and communicate the vision, terminology and definitions regarding key aspects of the process.
Introduce an alliance between health providers, which would include a Memorandum of Understanding and Data Sharing Agreement between PHOs, local iwi, secondary care and funders to agree a framework for progressing the primary/secondary care integration journey.

The governing body will investigate the potential for funding models to work more practically across primary/secondary care, as well as the potential for intersectoral funding, and provision of a framework for community-held budgets to support self-directed care.

2. Continue to develop relationships at a locality, DHB and regional level to support service changes required including engaging with key provider stakeholders across the whole of system and working with our communities to ensure consistency where this makes sense.

3. Agree common terminology across the approach.

4. Continue development of local health partnerships in each local board area in association with the existing Healthlinks in Waitemata and the developing HealthLinks in Auckland.

5. Complete the analysis and reporting of the Local Health Need Survey data.

6. Work with the Māori Health Team and other representatives to understand and align the developing Māori map of the population and the planned whanau ora centre developments.

7. The further development of Local Clinical Networks/Clusters across Auckland & Waitemata creating enduring partnerships between service users, providers and funders to better integrate health and social services in the community. These Local Clinical Networks, through defined groups of stakeholders, will work in partnership with the community (via the local health partnerships) to:

   - undertake locality planning,
   - determine local health priorities and identify priority populations
   - determine how to implement national and regional priorities, including health targets, at a locality level
   - identify and assess opportunities for integration activities
   - enabling data sharing with electronic patient files visible to all key workers and the individual as appropriate
   - co-design new models of care based on defined (by communities, providers, MOH or DHB) priority populations
   - drive quality improvement initiatives
   - create intersectoral networks

8. Develop a Business Plan to describe how we will operationalise our intent ensuring alignment with and specific reference to our 2013/14 Annual Plan commitments.
Appendix 1: Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Cluster</td>
<td>Refer ‘Local Clinical Network’</td>
</tr>
<tr>
<td>Community (as in the shared ADHB/WDHB Public consultation and engagement policy)</td>
<td>Community can be defined by place, identity and shared interest. In the locality context, the emphasis is on communities of place.</td>
</tr>
<tr>
<td>Community Representative (and community leader)</td>
<td>Community Representative means a person who has the mandate of a community (as defined above) network or organisation to represent the community’s views. A community representative might also be a community leader in the sense that they have a mandate from their community to make decisions on behalf of their community (such as an elected official).</td>
</tr>
<tr>
<td>Consumer</td>
<td>For the purpose of consumer involvement in service planning or improvement activity, consumer means a person who uses or has used the type of health and/or disability service being planned or improved. Because health service managers and clinicians are employed to fulfil a professional role with regard to the delivery of health services, they cannot be considered to offer the views of service consumers.</td>
</tr>
<tr>
<td>Consumer Representative</td>
<td>Consumer Representative means a person who has the mandate of a consumer organisation or network to represent their views.</td>
</tr>
<tr>
<td>Engagement (as in the shared ADHB/WDHB Public consultation and engagement policy)</td>
<td>Engagement is not a legislated process. It can take many forms and serve many purposes that allow patients and other community stakeholders to inform and/or participate in decisions that affect their health and the development of services that they receive. Informing the community does not, in itself, constitute engagement. Engagement requires dialogue and building relationships. Consultation is one form of engagement. It is a legislated process for soliciting public feedback on a proposal and decision-makers being able to demonstrate that they have taken that feedback into account when finalising a proposal. Engagement can also be in the form of one-off or ongoing stakeholder involvement or collaboration in deliberation or in decision-making. It can also involve empowering stakeholders to make a decision.</td>
</tr>
<tr>
<td>Group</td>
<td>An operational grouping of localities. Currently these are being operationalised as Central (seven localities), West (three localities), and North (five localities) but this is subject to change.</td>
</tr>
<tr>
<td>HealthLink</td>
<td>HealthLinks are community driven organisations which promote community participation in healthcare decision making and encourage collaborative relationships between providers and the communities they serve. The core idea is that HealthLinks will provide the forum for patient and community representative input into the Localities. They would contribute informed comment and at times more actively participate in the development of more integrated models of healthcare service delivery. Waitemata DHB has two existing HealthLinks groups, Waitakere HealthLink and HealthLink North. The overall structure of the HealthLinks model for ADHB will be designed in partnership with the community. Once an ADHB model is agreed we will work across both districts and with the existing WDHB groups to discuss the possibility of a combined...</td>
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9 When health professionals are patients they are likely to have a more positive experience than people who are not as familiar with how the system works. When a health professional is a patient, they are more likely to be able to understand the ‘everyday’ language and advice provided by their clinician. They are more likely to have the confidence to speak up if they feel they need to and they are more likely to know the right questions to ask. They are also more likely to know how to access the care they need and have the money to do so. What this means is that when we think about how to improve health care services, the views and experiences of health professionals cannot be taken to represent the views and experiences of people who are not health professionals. However, health professionals’ experiences of being a patient and the knowledge they have about their patients are valuable to reflect on too.
<table>
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<th>Term</th>
<th>Definition</th>
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</table>
| HealthLinks | HealthLinks Forum to provide governance level input. For Auckland, the membership will be responsible for connecting with community representatives within their Local Board area (communities defined and networked by place, interest and identity). It is possible that an NGO Forum could be hosted by the HealthLink (as happens in West Auckland) and this could also extend to include relevant Government agencies such as the Ministry of Social Development through their Community Response Forums which share the same boundaries. The purpose of the ADHB HealthLinks is yet to be fully defined and scoped but is likely to include at a minimum:  
• bringing local views (on proposals, service experience etc) to the attention of the Locality  
• distributing information from the DHB/locality through their community networks  
• participating in service planning and improvement activity through the locality  
• identifying activity that will promote local health outcomes |
<p>| Integration | Integrated care includes both clinical and service integration to bring organisations and clinical professionals together, in order to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home (From the NHB’s Annual Plan Guidelines 2012/13). |
| Integrated Family Health Centres AND Whanau Ora Centres | Localities may contain one or more Integrated Family Health Centres (IFHCs) or Whanau Ora Centres (WOCS). They are both a central part of the Government’s BSMC policy and function as service delivery hubs that allow access to the expanded suite of integrated services at a more local level. Such integrated services are expected to utilise re-designed pathways that span the traditional primary/secondary care divide. These larger centres may be networked with smaller practices using a hub and spoke model giving rise to an Integrated Family Health Network (IFHN). Critical to their development is greater clarity and explicit agreement regarding the flow of patients, resources, and revenue. |
| Locality | A locality is geographically defined, and encompasses all people usually resident in an Auckland Council Local Board area. Localities are the basic building block of the locality approach and maybe aggregated for operational reasons (e.g. in Central, West &amp; North groups). |
| Local Health Needs Assessment | A local health needs assessment is a process for and a product of quantitative and qualitative inquiry for determining the needs (and strengths/protective factors) of a locality’s residents. |
| Local Clinical Networks / (Clusters) | Working description of groups of primary care practices coming together to deliver more integrated care. Established examples include those in West Auckland e.g. New Lynn, Henderson-Massey &amp; Waitakere. They may include community based specialists (doctors, nurses, pharmacists, and allied health professionals) and will help facilitate improved patient navigation and service integration between hospital and community care by empowering the primary care workforce. They will facilitate better support and utilisation of our GPs, nurses, pharmacists, allied health professionals and community based specialists to empower patients and providers to develop practical solutions to the growing demographic demands, increased burden of chronic diseases, and resource limitations that can result in improved service delivery. |
| Local Health Partnerships | Established and operated using co-design principles these groups are specific to each local board area with membership drawn from those who are either working and/or living in the locality. Depending on the locality, membership could include: NGOs, community development organisations, primary health care providers, Plunket, other Government organisations (e.g. Housing, Education, and Ministry of Social Development), Auckland Council’s Local Board, local community members, representatives of specific populations (e.g. Pacific, Refugee, new Migrant) and Māori. The Partnership comes together to share learning and experience of the locality, engage in greater partnership thinking and |</p>
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<th>Term</th>
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<tr>
<td>contribute, through the relevant HealthLinks, to the development of more integrated models of working via the local clinical networks and Clusters. The Partnerships will also be key informants in reviews of services and are central to the needs assessment and locality planning processes. Where possible existing networks and forums will be utilised, but if impractical new networks will be facilitated by the DHBs, ideally utilising the resources of a locality based NGO. Over time servicing of these Partnerships could transfer to a locality based organisation. The Local Health Partnerships provide the forum for patient, family and community input into the Integrated Health Networks, and are the basis for extending the WDHB HealthLinks/HealthVoice model into ADHB.</td>
<td></td>
</tr>
<tr>
<td>Stakeholder</td>
<td>A stakeholder is anyone who may be interested in and/or affected by a health-related activity, proposal or decision to be made. There are many different types of stakeholders. The range of types of stakeholders will vary according to the particulars of a proposal or a decision to be made. Stakeholder types should also be defined according to what is at stake. For example, a stakeholder cannot be considered to be a consumer if they are participating on behalf of an organisation. Some stakeholders will have more at stake than others. How ‘key’ a stakeholder is to a proposal and its engagement plan should be defined accordingly.</td>
</tr>
<tr>
<td>Whanau Ora</td>
<td>He Korowai Oranga (the Māori Health Strategy) defines Whānau Ora as “Māori families being supported to achieve their maximum health and wellbeing”.</td>
</tr>
<tr>
<td>Whanau Ora Centres</td>
<td>Whanau ora centres have many attributes in common with Integrated Family Health Centres the main difference being the emphasis that whanau ora centres place on integrating services across a number of sectors. See also ‘Integrated Family Health Centres’ (above)</td>
</tr>
</tbody>
</table>
Appendix 2: Principles to support a locality approach

The locality approach places communities at the centre of health service planning and delivery
Planning health services at a locality level offers an opportunity to understand community health priorities through meaningful engagement and allow those communities to shape the provision of services that can be delivered locally. There are a number of examples where good community engagement has led to increased community ownership of issues wider than health (e.g. the Ranui project in WDHB and HVAZ in Auckland DHB) and a locality approach allows us to build on learnings from those experiences.

Organisational configuration needs to adapt to support the locality approach described
An extension of the previous principle in that existing organisational boundaries and structures (e.g. DHBs and PHOs) need to adapt to best support community health outcomes.

The locality approach should enhance integration and coordination of care
The approach allows us to link hospital based and community providers with other health service providers working in the community. This might include having named specialists (or identified locality contact numbers) to support primary care practitioners in the area or creating opportunities for discussion across all nursing roles in communities.

The locality approach must maintain a focus on achieving Māori health gain and Whanau Ora
Whilst we may wish to see an increasing focus on locality populations all organisations involved have an obligation to focus on the needs of their Māori populations. Planning, funding, and delivery of services to Māori, either through mainstream services or Māori specific services, could occur at district, locality, PHO or other provider levels. Decisions will need to be made to what extent this responsibility will be undertaken at each level. Further to this, any approaches should be focused on achieving Whanau Ora and maintaining the DHBs commitment to the principles of Te Tiriti o Waitangi:

- **Partnership** – Manawhenua is a partner at the governance level.
- **Participation** – Māori engagement in planning, development and delivery of health and disability services.
- **Protection** – Equity of participation access and outcomes for all Māori. Māori are able to enjoy the same level of health as non-Māori and Māori cultural concepts, values and practices are safeguarded.

In addition the aspirations and needs of our iwi and our Māori MoU partners will be respected and aligned as part of this process. The Māori health plan of the Waitemata and Auckland DHBs includes the development of a spatial map of the Māori population of the two DHBs, the location of Māori providers and the ongoing development of Whanau Ora Centres across the DHBs as a matter of priority. The development of this process will occur in parallel with the development of this locality approach with linkages developed between the two plans.

The locality approach must improve the health of Pacific people.
This approach should strengthen and support the diverse Pacific communities to identify their strengths, needs, and to harness resources and respond in an effective and cohesive way to address them. Opportunities to ensure the Pacific patient/family journey is simple, clear and without barriers will be an aim of this approach. Stronger links between health services and also other agencies at a district, locality and PHO level should better support Pacific families to receive the assistance required.

The locality approach must improve the health of Asian people.
This approach should strengthen and support the diverse Asian communities to identify their strengths, needs, and to harness resources and respond in an effective and cohesive way to address them. Opportunities to ensure the Asian patient/family journey is simple, clear and without barriers will be an aim

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10 A locality approach for Auckland: Paper to Auckland DHB CPHAC October 2010
of this approach. Stronger links between health services and also other agencies at a district, locality and PHO level should better support Asian families to receive the assistance required.

**The locality approach must improve the health of other high needs populations and enhance our ability to reduce inequalities**

Localities offer a great opportunity to focus on other high needs populations such as children, those with long term conditions or other high health needs, refugees and new migrants. Communities should be supported to identify their needs and priorities and harness resources to meet them. The opportunity provided by defining localities geographically will enhance the ability of agencies to work together to better support those people and families who require assistance from multiple organisations.

**Understanding local health needs will be a key feature of the planning process**

National and regional priorities will form the minimum available services at the local level but in addition needs assessments at the local level will increase our understanding of specific community needs within these areas and allow appropriate decisions to be made based on that in-depth knowledge. The Local Government Commission has spent considerable time to ensure local boards represent communities of interest based upon; “residents’ sense of identity with and belonging to a community, the ability to meet residents’ needs for services (both council and non-council services), and the ability to represent the interests and reconcile conflicts of the community.”

**The locality approach should address issues of capability and capacity within primary care**

The implementation of the locality approach will maximise the use of a scarce workforce. There may be ways in which practices can share human and physical resources, a specialist nurse for example, run joint chronic disease management clinics, and/or share equipment (such as spirometry or ECG machines). Better use of the community nursing teams and community support workforce (including social services) should also be an aim of this approach.

**Funding flows will be directed to identified locality priorities**

It is expected that increasingly a proportion of the flexible funding pool currently available to PHOs will be spent at the locality level. The PHOs have recently demonstrated a heightened capability to work cooperatively and it is probable that true “alliance contracting frameworks” will be able to build on the successful ‘special area initiatives’ that some PHOs have in place and be further used to align and incentivise a locality approach while preserving the natural affiliations of providers (not just general practice) to their PHOs.

**The locality approach will be developed in a way that does not unnecessarily increase bureaucracy, costs or delay decision-making**

It is not intended through the locality approach to introduce further structures but to enable better connections and communications. It can be more a way of thinking and implementation than about structure, more of way of linking people across a system and maximising resource currently in different sectors while pursuing the same outcome.
7. Resolution to Exclude the Public

Recommendation:

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following item, for the reasons and grounds set out below:

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minutes of the Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting with Public Excluded 12/06/13</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Confirmation of Minutes As per resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&amp;D Act.</td>
</tr>
<tr>
<td>2. After Hours</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Negotiations The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)] Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]</td>
</tr>
</tbody>
</table>