Community and Public Health Advisory Committees Meeting

Wednesday, 11th June 2014

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.
AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS  
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING  
11TH JUNE 2014

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna  
Time: 2.00pm

COMMITTEE MEMBERS
Gwen Tepania-Palmer – Committee Chair (WDHB and ADHB Board member)  
Lester Levy - ADHB and WDHB Board Chair  
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  
Chris Chambers - ADHB Board member  
Sandra Coney - WDHB Board member  
Warren Flauntly - Committee Deputy Chair (WDHB Board member)  
Lee Mathias - ADHB Deputy Chair  
Robyn Northey - ADHB Board member  
Christine Rankin - WDHB Board member  
Allison Roe - WDHB Board member  
Tim Jelleyman - Co-opted member  
Eru Lyndon - Co-opted member

MANAGEMENT
Dale Bramley - WDHB, Chief Executive  
Alisa Claire - ADHB, Chief Executive  
Debbie Holdsworth - ADHB and WDHB, Director Funding  
Simon Bowen - ADHB and WDHB, Director Health Outcomes  
Naida Glavish - ADHB and WDHB Chief Advisor, Tikanga  
Paul Garbett - WDHB, Board Secretary

Apologies: Lee Mathias, Warren Flauntly and Tim Jelleyman

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

2.00pm  2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 30/04/14 ................................................................. 7

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4  INFORMATION ITEMS

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5  STANDARD MONTHLY REPORTS

2.25pm  5.1 Primary Care Update Quarter 3, 2013/14 ................................................................................................................................. 39

2.50pm  5.2 Planning, Funding and Outcomes Update ................................................................................................................................. 65

3.10pm  6  GENERAL BUSINESS

3.15pm  7 RESOLUTION TO EXCLUDE THE PUBLIC ........................................................................................................................................ 81

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 11/06/14
Auckland and Waitemata District Health Boards
Community and Public Health Committees

Member Attendance Schedule 2014

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Co-opted members

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* absent
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# absent on Board business
## REGISTER OF INTERESTS

<table>
<thead>
<tr>
<th>Committee</th>
<th>Involvements with other organisations</th>
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| Lester Levy | Chair – Auckland District Health Board  
Chairman – Auckland Transport  
Deputy Chair – Health Benefits Limited  
Independent Chairman – Tonkin & Taylor  
Chief Executive – New Zealand Leadership Institute  
Professor of Leadership – University of Auckland Business School  
Trustee– Well Foundation (ex-officio member) | 20/03/14 |
| Max Abbott | Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology  
Patron – Raeburn House  
Advisor – Health Workforce New Zealand  
Board Member, AUT Millennium Ownership Trust  
Chair – Social Services Online Trust  
Board Member – The Rotary National Science and Technology Trust | 19/03/14 |
| Jo Agnew | Professional Teaching Fellow - School of Nursing, Auckland University  
Trustee Starship Foundation  
Casual Staff Nurse - ADHB | 01/03/14 |
| 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 |
| 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: Waitakere Ranges Local Board, Auckland Council | 12/12/13 |
| Warren Flaunty | Member – Henderson - Massey and Rodney Local Boards, Auckland Council  
Trustee - West Auckland Hospice  
Trustee (Vice President) - Waitakere Licensing Trust  
Shareholder - EBOS Group  
Shareholder – Pharmacy Brands Ltd  
Director – Westgate Pharmacy Ltd  
Chair – Three Harbours Health Foundation  
Director - Trusts Community Foundation Ltd | 12/12/13 |
| Lee Mathias | Chair – Counties Manukau District Health Board  
Chair-Unitec  
Managing Director – Lee Mathias Ltd  
Trustee – Lee Mathias Family Trust  
Trustee – Awamoana Family Trust  
Director – Pictor Ltd  
Director – John Seabrook Holdings Ltd  
Chair – Health Promotion Agency  
Director – iAC IP Ltd  
Advisory Chair, Company of Women Ltd | 30/04/14 |
| Robyn Northey | Project management, service review, planning etc. – Self employed Contractor  
Board member – Hope Foundation Northern Region  
Trustee, A+ Charitable Trust | 18/07/12 |
| Christine Rankin | Member - Upper Harbour Local Board, Auckland Council  
Director – The Transformational Leadership Company  
CEO – Conservative Party | 17/05/13 |
### Register of Interests continued...

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<tr>
<th>Name</th>
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<tr>
<td><strong>Allison Roe</strong></td>
<td>Member – Devonport-Takapuna Local Board, Auckland Council</td>
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<td>Member – Board of Kaipara Medical Centre</td>
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<td>Chairperson – Matakana Trail Trust</td>
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<td><strong>Gwen Tepania-Palmer</strong></td>
<td>Chairperson – Ngatihine Health Trust, Bay of Islands</td>
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<td>Life Member-National Council Maori Nurses</td>
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<td>Alumni – Massey University MBA</td>
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<td>Director – Manaia Health PHO, Whangarei</td>
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<td>Board Member – Auckland District Health Board</td>
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<td>Committee Member – Lottery Northland Community Committee</td>
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<td><strong>Co-opted Members</strong></td>
<td>Member - Active Clinic Network for Greater Auckland Integrated Health Network</td>
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<td>Chair - Child Health Network, Northern Regional Health Plan</td>
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<td>Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland</td>
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<td>Member-Board of Kaipara Medical Centre</td>
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<td><strong>Eru Lyndon</strong></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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<td>Director – Tamaki Development Company</td>
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2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 30\textsuperscript{th} April 2014

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 30\textsuperscript{th} April 2014 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 30 April 2014

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

PART 1 – Items considered in public meeting

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair)
Max Abbott (WDHB Board member) (present until 4.10p.m.)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren Flaunty (Committee Deputy Chair) (WDHB Board member)
Lee Mathias (ADHB Deputy Chair)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT:

Dale Bramley (WDHB, Chief Executive)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Marty Rogers (ADHB and WDHB, Manager, Maori Health Gain)
Rachel Mattison (ADHB and WDHB, Associate Planning and Funding Manager)
Jean McQueen (ADHB and WDHB, Primary Care Nursing Director)
Ruth Bijl (ADHB and WDHB, Funding and Development Manager)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
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:

Lynda Williams, Auckland Women’s Health Council
Tracy McIntyre, Waitakere Health Link
Anne Curtis, Health Link North
Tereki Stewart, Te Runanga o Ngati Whatua
Jude Sprott, Procare
Lorelle George, CCL/Waitemata PHO
Samuel Cho, TANI (Asian Network Inc.)
Olivia Shivas, AUT University
Denise Piper, Pharmacy Today Magazine

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 11/06/14
KARAKIA: Gwen Tepania-Palmer led the meeting in the karakia.

WELCOME The Committee Chair welcomed all those present.

APOLOGIES: Resolution (Moved Peter Aitken/Seconded Christine Rankin)

That the apologies from Allison Roe, Ailsa Claire and Naida Glavish be received and accepted.

Carried

DISCLOSURE OF INTERESTS

With regard to the Interests Register, Lee Mathias advised that she had been appointed Chair of Unitec, effective from 1 May. She was congratulated on the appointment.

With regard to the open agenda for this meeting, Warren Flaunty advised of an interest as a pharmacist in item 4.3 – Community Pharmacy Update and as a Trustee of West Auckland Hospice in item 4.4 – Palliative Care. Peter Aitken also advised of an interest as a pharmacist in Item 4.3. The Committee agreed that for these information only items, it would be useful, in terms of the expertise and experience that they bring, for Warren Flaunty and Peter Aitken to remain in the meeting while the items were discussed and participate in the discussion.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as 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 19 March 2014 (agenda pages 1-11)

Resolution (Moved Warren Flaunty/Seconded Jo Agnew)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 19 March 2014 be approved.

Carried

Matters Arising:

No issues were raised.

3 DECISION ITEMS

3.1 Oral Health (agenda pages 12-19)

Helene May (Operations Manager, Auckland Regional Dental Service) and Satha Kanagaratnam (Clinical Director, Auckland Regional Dental Service) presented this report, which was taken as read.
Matters covered in discussion and response to questions included:

- The two year oral health pilot for high risk pregnant women in Waitemata DHB, which concludes on 25 February 2015, will be evaluated by the independent company Litmus, along with two other different pilots addressing this matter elsewhere in New Zealand. Litmus will make a recommendation to the Ministry of Health on the pilots’ effectiveness and efficiency. It will then be up to the Minister of Health to decide whether to run this nationally or not.
- In oral health, “high risk children” are identified by decay levels and oral health practices. Plunket has been provided with an assessment tool which categorises high risk children for referral to ARDS.
- Dr Tim Jelleyman advised that integration of different types of enrolment is being looked at as part of the Well Child Improvement Programme.
- With regard to achievement of pre-school enrolment targets, Helene May advised that the focus for ARDS needs to be 0-2 year olds and Maori children.
- There is a link with the B4 School Check Programme in terms of getting children enrolled with ARDS.

Resolution (Moved Robyn Northey/Seconded Jo Agnew)

That the Auckland and Waitemata DHB Community and Public Health Advisory Committees note that both Waitemata and Auckland DHB are currently exceeding the national target of no more than 10% of children not examined within one month outside their recall period: Auckland and Waitemata currently tracking at 7%.

Carried

Resolution (Moved Lee Mathias/Seconded Max Abbott)

That the Auckland and Waitemata DHB Community and Public Health Advisory Committees endorse the current activity, including strategies and new initiatives, in order to maintain the Ministry of Health targets including:
- Maintaining the Ministry of Health 7% arrears target by continuing current practices and oversight
- Achieving the Ministry of Health target of 85% for pre-school enrolments
- Increasing the number of pre-school examinations completed.

Carried

The Committee Chair thanked Helene May and Satha Kanagaratnam for the paper and work to date.

4. INFORMATION ITEMS

4.1 Rheumatic Fever Prevention and Intervention Programme in Auckland and Waitemata District Health Boards (agenda pages 20-31)

Ruth Bijl (Funding and Development Manager) and Marty Rogers (Maori Health Gain Manager) were present from the start of this item. Alison Leversha (Community Paediatrician, Auckland DHB), Alison Hudgell (Rheumatic Fever Programme Manager,
Planning and Funding) and Sue Crengle (Public Health Physician) arrived during the course of consideration of the item.

Ruth Bijl introduced the item, summarising the main strands of the programme which are detailed in the report.

Alison Hudgell advised that the Ministry of Health is keen to get a youth perspective on the Rheumatic Fever Programme and is also looking at a message to encourage youth participation. The Ministry of Youth Development has been involved and engagement is taking place to make the message about rheumatic fever youth friendly, in the most appropriate way.

Marty Rogers commented that while the Pacific Engagement Strategy had come directly from the Ministry, the Maori Engagement Strategy is developing at the Auckland DHB/Waitemata DHB level following a hui with the Maori stakeholders involved in managing and developing the Rheumatic Fever Prevention Programme across the two DHBs. There was endorsement from the Ministry for this.

Ruth Bijl commented on the Auckland–wide Healthy Housing Initiative. While the referral criteria are strict, the expectation is that the families of most children on the bicillin service will be offered a housing assessment. Referrals are also through the school-based health clinics and review and analysis of cases coming through secondary care (process described on pages 23-24 of the agenda).

Tim Jelleyman also advised that with secondary prevention, as each rheumatic fever case comes through, the intention is to examine the pre-hospital journey, prescribing of antibiotics and whether those antibiotics were taken. It is important that primary care be a participant, as it is their data and stories that are being looked at, but many of the cases have not come through primary care but been identified at the hospitals. Ruth Bijl confirmed that 50% of confirmed cases of rheumatic fever did not present to primary care with a sore throat and Tim Jelleyman advised that about 40% of cases of rheumatic fever won’t get a sore throat symptom.

Matters covered in discussion and response to questions included:

- Concern that there needs to be consistency of messaging about the Rheumatic Fever Prevention Programme.
- It was accepted from the outset that in the Auckland and Waitemata DHB context, that school based throat swabbing was not the most efficient way to approach the problem, however children whose throats are swabbed and given an antibiotics prescription do not go on to develop rheumatic fever. (It was noted that the latter point was not clear in the report.)
- It was suggested that there is an opportunity to get pharmacies involved as providers in the rapid response programme, particularly in areas where there are gaps in the service available.
- Reaching unemployed school leavers is being addressed through the communications strategy and by working through social services, including Work and Income. Also the youth communications strategy involves working through sports organisations and other organisations that young people are involved with.
- Work is being done with the Waitemata DHB Communications team to provide the Health Links with accurate and up to date information on the programme.
- Festivals such as Pacifica are used to engage with the community.
Alison Leversha explained that the existing Auckland Regional Rheumatic Fever Register is an old Access database and as such is not able to continue with the upgrading to Windows 7 currently taking place in the region’s DHBs. There is discussion taking place about introducing a national database, but that is proceeding at a slower pace than needed for the region. Auckland DHB has therefore agreed some funding for developing a regional database and Waitemata and Counties Manukau DHBs are being approached with a request to contribute. The Ministry of Health is also being asked to finance this. There are currently about 1,000 cases on the regional database. It is not a simple exercise to bring them across to another database as there is a need to add clinical utility. The Committee agreed that this is an important issue and progress needs to be made and reported on in the next report to the Committee on the Rheumatic Fever Prevention programme.

In answer to a question as to what might be learned from this programme that might be applicable to other low incidence but devastating diseases, Alison Leversha suggested that one thing would be that it is not appropriate to look at an infectious disease such as this in isolation; other close contact infectious diseases occur similarly in populations with poor high density living conditions. It had been effective to treat skin sepsis in conjunction with the Rheumatic Fever Prevention Programme.

It is probably too early to measure the effectiveness of the programme. Previously there had been a steady increase in cases of rheumatic fever and that seemed to have plateaued in the last year. Also when a programme highlights and goes looking for a disease, it is common to find more cases of it.

Some research indicates that there remains a lack of public understanding about the connection between rheumatic fever and sore throats, even from those who have had rheumatic fever.

Resolution (Moved Robyn Northey/Seconded Max Abbott)

That the updated information provided on the implementation of the Rheumatic Fever prevention and intervention programme for Auckland and Waitemata District Health Boards be noted.

Carried

4.2 Child and Youth Mental Health Services Update (agenda pages 32-36)

Helen Wood (General Manager, Mental Health and Addictions, Waitemata DHB), Mike Butcher (Director Allied Health, Mental Health and Addictions Services, Auckland DHB and previously Clinical Director, Child and Youth Mental Health Services, Auckland DHB) and Simon Baxter (previously Clinical Director Child and Youth Mental Health Services, Waitemata DHB) were present for this item.

Helen Wood introduced the report, referring to the three prioritised areas for alignment of systems and processes across Auckland and Waitemata DHB: multi-agency work; service development for intervening earlier; and workforce development.

Mike Butcher outlined the multi-agency work (detailed on pages 34-35 of the agenda) and in particular the work done to develop guidelines for management of young people who shift place of residence across DHB boundaries while they are in the care of Child, Youth and Family and are receiving mental health services input. While they had not been able to
provide strict rules about transfers that Child Youth and Family had been requesting, they had been able to develop some guiding principles of how services could best be delivered. One thing that had been frustrating over time was that as a leadership group they were often able to reach a joint understanding, but often that did not filter down to the front line. They had therefore tried to get an early escalation process for any issues.

Helen Wood outlined an area identified for service development for intervening earlier – children of parents with a mental illness/addiction issue (COPMIA). Auckland DHB is more advanced in this area and had been able to share its expertise. They are hoping to get parity of service provision, although there are still some differences at present. This is an area that they can try to align more. The principle being followed in this area is to try to minimise any down stream impacts and the need for support for these children in future.

Helen Wood outlined the second area of service development for intervening earlier – Infant and Perinatal Mental Health, involving improving the ability to provide enhanced support for mothers, families and infants where the mother was acutely unwell. This included three beds at Starship, but the main impetus is in developing more community respite options and a community package of care.

Helen Wood also outlined the workforce development taking place, detailed on page 36 of the agenda. Overall, collaboration in Mental Health involved some changes and monitoring of those. There was a keenness to support the relationship with Child Youth and Family. They were not at this stage looking at integrating any service.

Matters covered in discussion and response to questions included:

- Mike Butcher advised that Child and Youth Mental Health Services are no longer to be seen as a “poor relation” in Mental Health. The workforce had expanded and they are in a much better position than in the past.
- Helen Wood advised that Pacific Mental Health services are keen to build expertise to cover the whole of the mental health continuum. Clinical expertise also needs to be built up for Maori mental health.
- General practice involvement with mental health is an area that needs developing, however there had been particular movement on that in the Tamaki Locality Project. Both Auckland and Waitemata DHB Mental Health Services are putting more effort into primary care education, although it had been easier to partner with schools. It is more difficult with GPs as there are so many of them and the sector is more fragmented.

**Resolution** (Moved Pat Booth/Seconded Lee Mathias)

*That the report be received as an update on the progress made to date in aligning prioritised common systems and processes.*

**Carried**

The Committee Chair thanked the presenters for their contribution to an important piece of work.
4.3 Community Pharmacy Update (agenda pages 37-41)

John Kristiansen (Pharmacy Programme Manager Auckland DHB/Waitemata DHB) and Vicki Scott (Programme Manager) presented this item.

John Kristiansen summarised the paper. With regard to the Community Pharmacy Services Agreement Stage 4, he noted that the final elements for formal consultation are subject to a decision by the twenty DHBs. Support will be given to pharmacies to help them understand this final stage of the process, both through consultation and in one on one sessions if required.

John Kristiansen advised that, with regard to the Long Term Conditions (LTC) Service, the overall rate of use by pharmacies had been higher than expected. The Audit and Compliance Unit of the Ministry of Health had visited 16 pharmacies in Waitemata DHB in April. The overall findings were favourable but some process issues had been identified. The Audit and Compliance Unit will develop tools to assist pharmacies in achieving compliance.

Matters covered in discussion and response to questions included:

- Concern was expressed that most pharmacists are still struggling to understand the details of the funding mechanism and can not budget because they do not know what the funding envelope will be. This needs to be resolved quickly.
- With the Community Pharmacy Anti-Coagulant Management Service (CPAMS) (page 40 of the agenda), the DHBs receive monitoring reports from the Ministry of Health.
- The significant changes involved with implementation of the national Community Pharmacy Services Agreement had not had a prior pilot. An audit tool is being developed and the Ministry of Health has an overview of the planning of each DHB. The approach that the Ministry is taking is not to punish pharmacies for not delivering perfectly. The Schools of Pharmacy are interested in looking at the effectiveness of changes and issues involved and are carrying out longitudinal studies each year.

Resolution (Moved Jo Agnew/Seconded Christine Rankin)

That the report be received.

Carried

4.4 Palliative Care (agenda pages 42-49)

Stephanie Muncaster (Programme Manager, Chronic and Palliative Care) and Sarmila Gray (Project Manager, Planning, Funding and Outcomes) were present for this item.

Stephanie Muncaster noted that Auckland and Waitemata DHBs currently have different reporting requirements for hospice services. As they move forward, they will make sure that these are better aligned. She updated the report by advising that Hospice West Auckland, which had been trying for some time to obtain the necessary medical cover to admit patients to its new inpatient unit, was now in a position to admit from 12 May. Hospice West Auckland will also be expanding from two beds to four beds capacity by July.
The Committee noted that Eastern Bays Hospice plays a big role in providing hospice services in the Auckland DHB area. The reason why it was not included in the report is that it does not receive funding from the DHB.

Resolution (Moved Lee Mathias/Seconded Warren Flaunty)

That information relating to the Eastern Bays Hospice be obtained and reported to Auckland DHB.

Carried

Other matters covered in discussion and response to questions included:

- Stephanie Muncaster advised that with the changes to community services, more patients supported by North Shore Hospice are choosing to die at home. As a consequence some of the costs associated with providing 24 hour care at home are rising.
- It was suggested that it is important to be flexible about allowing people to choose where they want to die. Stephanie Muncaster noted that they need to investigate different models of care more before any decision is taken on future directions in palliative care.

Resolution (Moved Lee Mathias/Seconded Peter Aitken)

That the report be received and the Committee note:

a) the commissioning of the inpatient unit at Hospice West Auckland
b) the continuation of the Waitemata DHB model of care work and,
c) the re-establishment of the Auckland District Palliative Care Steering Group

Carried

4.5 Quality Use of Medicines (agenda pages 50-52)

Angela Lambie and John Kristiansen (Project Managers, Quality Use of Medicines Team, Waitemata DHB) were present for this item and briefly summarised the report.

Matters covered in discussion and response to questions included:

- With regard to the Patient Booklets (page 52 of the agenda), these had been translated into Korean, Chinese and Samoan (and one into Tongan), but not into Maori. The reason was that 5,000 Chinese in the Waitemata DHB area can’t speak English and 2,000 Korean can’t speak English, while most Maori can understand English.
- SafeRx* guidelines do include correct use of paracetamol, including in patient resources.
- Sandra Coney advised that with regard to patient booklets her experience in the past (with an NGO contributing to the development of educational resources for cervical screening and breast screening) showed that not just translating words, but also the approach and the way the material was presented were important, particularly for Maori and Pacific populations. Angela Lambie advised that with the translations referred to in this report, the Asian ones had been arranged through Asian Health
services. There were always two people asked to review translations. The information that is to be translated is also reviewed through the Health Links from a consumer viewpoint.

- It was suggested that the ideal approach might be to have specialists from different ethnicities prepare material on particular issues, rather than translating from one source. CPHAC agreed that a report be prepared looking at how the two DHBs prepare consumer information for different ethnicities, including information on websites and resource materials and whether how this is done needs more attention.

- Imelda Quilty-King (Community Engagement Co-ordinator, Waitemata DHB) noted that a pertinent point, raised by the CEOs, is the need to look at the issue of what does a health workforce literate in terms of the communities it serves look like? Waikato DHB is looking at training clinicians on this. A Health Literacy Steering Group led by Tim Wood is looking at these issues. They wanted to be sure that work done on this does not stigmatise people and to make sure that information provided is simple and user friendly.

- In answer to a question, the meeting was advised that most of the material referred to in the report had not been formally evaluated and it was quite difficult to do that, however the Pictorial Asthma Medication Plan had been formally evaluated and the results published in a paper in the New Zealand Medical Journal. The paper showed that families are using the tool and that it is useful to them. Since then there had been a further survey of users and how they are utilising it. However the impact clinically would be difficult to establish. With the Patient Booklets, there are always requests for resupply. The Board Chair commented that the important issue is who are we getting it right for? He suggested that this may be an area that needs more sophistication. Lee Mathias advised that the Health Promotion Agency is expert in this area, using focus groups, developing projects and managing them.

- Imelda Quilty-King confirmed that all information for consumers comes to her and is distributed to the Health Links for consumer review. There is also consultation with clinicians. A record and register is kept of all such documents.

The Committee Chair thanked Angela Lambie and John Kristiansen for their report, and recognised the role that the Health Links and Imelda Quilty-King play.

Resolution (Moved Max Abbott/Seconded Jo Agnew)

That the report be received.

Carried

5. STANDARD MONTHLY REPORTS

5.1 Planning and Funding Update (agenda pages 53-56)

Debbie Holdsworth and Simon Bowen briefly highlighted some aspects of the report, including:

- Progress in collaboration between the two DHBs on the structure for Planning, Funding and Outcomes, with implementation of the final structure anticipated to be in July 2014.

- The expressions of interest process for Healthy Families New Zealand (described on page 54 of the agenda).
• Streamlining contracting with the NGOs (pages 54-55 of the agenda). The challenge has been that the requirements of the health sector are not fully captured in the framework.

Resolution (Moved Warren Flaunty/Seconded Max Abbott)

That the report be received.

Carried

6. General Business

There was no general business.

7. Resolution to Exclude the Public

Resolution (Moved Lee Mathias/Seconded Jo Agnew)

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>
</table>
| 1. Programme Update                      | 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) (ii)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)] | 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)]

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)] |

| 2. Review of 2014/15 Annual Plan and Statement of Intent | 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) (ii)) of the Official Information Act 1982.[NZPH&D Act 2000 Schedule 3, S.32 (a)] | Obligation of Confidence

The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)] |
3.45 p.m - 4.27 p.m - Public excluded session.

4.27 p.m – open meeting resumed.

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

The meeting concluded at 4.27 p.m.
<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>ADHB HAC</td>
<td>11/12/13</td>
<td>5.2 Diabetes Checking – report to be provided on how screening and</td>
<td>Debbie Holdsworth</td>
<td>CPHAC 11/06/14</td>
<td>Refer Report 4.1 – Long Term Conditions.</td>
</tr>
<tr>
<td>(transfer to CPHAC)</td>
<td></td>
<td>monitoring is undertaken for those reported as positive during diabetes checking.</td>
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<tr>
<td>CPHAC</td>
<td>05/02/14</td>
<td>3.1 Healthy Eating and Physical Activity – request to ARPHS to bring</td>
<td>William Rainger</td>
<td>CPHAC 30/07/14</td>
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<tr>
<td></td>
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<td>back a report to CPHAC on opportunities for interventions in the</td>
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<td></td>
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<td>promotion of products that influence levels of obesity.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CPHAC</td>
<td>19/03/14</td>
<td>4.2 Womens’ Health Collaboration – team involved to report back to</td>
<td>Ruth Bijl</td>
<td>CPHAC 11/06/14</td>
<td>Information included in Planning, Funding and Outcomes Update report.</td>
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<tr>
<td></td>
<td></td>
<td>April CPHAC meeting on the specifics for Maori, Pacific and Asian</td>
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<td></td>
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<td>women within this project.</td>
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<tr>
<td>CPHAC</td>
<td>19/03/14</td>
<td>5.1 Primary Care Update – to include some demographic information</td>
<td>Tim Wood</td>
<td>CPHAC 11/06/14</td>
<td>Included in Primary Care report.</td>
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<tr>
<td></td>
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<td>relating to “Access to Diagnostics” in next quarterly report.</td>
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<tr>
<td>CPHAC</td>
<td>30/04/14</td>
<td>4.1 Rheumatic Fever Prevention and Intervention Programme – resolving</td>
<td>Ruth Bijl</td>
<td>CPHAC 30/07/14</td>
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<td></td>
<td></td>
<td>regional database issue to be pursued as a significant issue and</td>
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<td></td>
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<td>reported on in next update report.</td>
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<tr>
<td>CPHAC</td>
<td>30/04/14</td>
<td>4.4 Palliative Care – information relating to Eastern Bays Hospice to</td>
<td>Stephanie Muncaster/</td>
<td></td>
<td>Being prepared for ADHB Board.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>be obtained and reported to Auckland DHB.</td>
<td>Sarmila Gray</td>
<td></td>
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<tr>
<td>CPHAC</td>
<td>30/04/14</td>
<td>4.5 Preparing Consumer Information for Different Ethnicities – report</td>
<td>Tim Wood</td>
<td>CPHAC 03/09/14</td>
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<tr>
<td></td>
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<td>to be provided on how this is done, including information on websites</td>
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<td>and resource materials, and advising on whether how this is done</td>
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<td>needs more attention.</td>
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</tbody>
</table>
4.1 Long Term Conditions

Recommendation:
That the report be received.

Prepared by: Stephanie Muncaster (Programme Manager), Tim Wood (Development and Funding Manager Primary Care) and Dr Sarah Gray (Public Health Physician)
Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

ACEI - Angiotensin-Converting Enzyme Inhibitor
ARB - Angiotensin Receptor Blocker
CFA - Crown Funding Agreement
CVDRA/M - Cardiovascular and diabetes risk assessment/ and management
DAR - Diabetes Annual Review
DHB - District Health Board
GAD - Glutamic Acid Decarboxylase Autoantibodies test (GAD antibodies test) is used to help discover whether someone has either type 1 diabetes or Latent Autoimmune Diabetes of Adulthood (LADA)
HbA1c - A lab test that shows the average level of blood sugar (glucose) over the previous 3 months. It shows how well an individual is controlling his/her diabetes.
IA2 markers - Insulin Antibodies test used in early diagnosis for type 1 diabetes mellitus, and for differential diagnosis between LADA and type 2 diabetes
LADA - Latent Autoimmune Diabetes of Adulthood
MOH - Ministry of Health
PHO - Primary Health Organisation
VDR - Virtual Diabetes Register is a register of the estimated diabetes population in a DHB. The register is managed by the Ministry of Health and is provided to each DHB. It is used by the Ministry of Health as the denominator for the expected number of unique individuals who have type 1 or type 2 diabetes (includes all ages).

1. Executive Summary

Long term condition services across the two District Health Boards (DHBs) focus on the provision of care within the community to reduce the incidence of cardiovascular disease, prevalence of smoking and to improve the management of diabetes. Services are provided by Primary Health Organisations (PHOs), General Practice, Maori providers and the wider community.

Services are also provided by secondary care with some integration with primary health care services, however the focus of this paper are those services provided in a community setting.

Over the last two years the DHBs have focused on reducing the incidence of cardiovascular disease and prevalence of smoking by:

- Identifying the individual heart and diabetes risk of our eligible population
- Identifying people who are currently smoking
Providing brief advice to people who are currently smoking.

This report will focus on what the DHBs are doing to provide care for the population with diabetes. Diabetes is a global problem which places a significant burden on the health budget as diabetes prevalence exceeds service capacity. The report focuses on the current state and in many cases will reflect a different approach taken in the past by both DHBs. It however provides a platform to be considered by both the joint funder and the Alliance in the development of future plans for an integrated and more consistent approach to the management of diabetes.

Diabetes is an endocrine condition that affects a large number of people in our community. The DHBs currently deliver early detection, secondary prevention and primary care based services to achieve the following outcomes:

- Increase the confidence and capability of general practice staff to provide quality care for their patients
- Increase the confidence and capability of people with diabetes to look after their health in conjunction with their health care professionals
- Screen for common secondary complications to prevent other health conditions and permanent disability
- Support life-style change.

2. Introduction/Background

Diabetes is a global health problem. It is estimated that 2.5-15% of the annual health care budget\(^1\) is used to provide care for people with diabetes. The budget is dependent on local diabetes prevalence and the sophistication of available treatments.

![Figure 1 – Diabetes Types](image)

<table>
<thead>
<tr>
<th>Diabetes Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes as a disease includes a number of types. The two most common types are known as type one or type two diabetes.</td>
</tr>
<tr>
<td>- Type one diabetes, that often starts earlier in life, is an 'auto-immune' condition in which the body sets up an attack against the cells within it that makes insulin.</td>
</tr>
<tr>
<td>- Type two diabetes is associated with obesity, often starts later in life, and occurs when either the body doesn’t produce enough insulin, or the cells in the body don’t recognise the insulin that is present. Of concern is the increasing incidence of type two diabetes in children.</td>
</tr>
</tbody>
</table>

The result of both types of diabetes is the same: high levels of glucose in your blood. Insulin is required to keep blood glucose (sugar) levels in the normal range. Although everyone needs some glucose in their blood, if it’s too high it can damage the body over time.

Long term conditions, including diabetes, have been a focus of the health sector since the Primary Health Care Strategy (2000) identified the key indicators of care. In 2012 the focus on Long term Conditions increased with the introduction of:

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\(^1\) World Health Organisation, Fact Sheet, sourced 27 May 2014
The Diabetes Get Checked programme changing to the Diabetes Care Improvement Package (DCIP), 1 July 2012
The More Heart and Diabetes Checks Health Target which commenced, 1 January 2012.

This led to a change in the services available through the District Health Boards.

2.1 Diabetes prevalence

Each year the Ministry of Health provide the DHBs with a virtual diabetes register (VDR). This register provides in December of each year by DHB of domicile - the National Health Identification (NHI), Date of Birth (DOB), and the PHO and practice where each patient is enrolled. Note the VDR is created from national data warehouses and may differ from the Census diabetes or NZHIS data.

The VDR is used by:

- The Ministry of Health to measure DHB performance for diabetes annual reviews and good diabetes management. Good diabetes management is defined as people with diabetes and an HbA1c <64mmol/mol.
- DHBs for planning purposes as it provides information on the level of service provision required for our population.
- DHBs for monitoring purposes to ensure it meets its responsibility to provide services to the domiciled population.
- PHOs to enable them to provide services to their enrolled population.

The following tables based on information from the VDR as at December 2013 show:

- 45% of Auckland DHB population with diabetes is non-European/other.
- 27% of Waitemata DHB population with diabetes is non-European/other.
- The percentage of Maori with diabetes is the same in both DHBs at 7%.
- Pacific people have the next highest prevalence after European.
- Only 1% of the population with diabetes is enrolled with a PHO outside of the metro Auckland area.
- 58% of the people with diabetes are enrolled with ProCare Networks Limited practices and 22% are enrolled with a Waitemata PHO practice.

The 2013 VDR reports an 8% growth in the population with diabetes for each DHB compared to the previous year. This is an increase of 2,048 people with diabetes in Auckland DHB and 2,320 people with diabetes in Waitemata DHB.
2.2 Services to improve diabetes care and patient outcomes

Diabetes is a progressive condition that can be arrested or progress delayed through good control of blood glucose. The management of diabetes is multi-faceted and requires a range of services, intervention and approaches to enable people with diabetes to participate in informed treatment plans and make informed decisions about their care.

Medical treatment includes:
- Monitoring of blood glucose
- Monitoring of other organs to detect secondary complications from diabetes and cardiovascular disease
- Management of blood pressure and cholesterol levels
- Medication to regulate blood glucose
- Medication to prevent other organ damage or the progression of this if it has started.

Health sector research has shown that a number of other interventions can also assist in delaying disease progression. Some interventions focus on increasing patient self-care capabilities. Others focus on the treatment of secondary complications before they cause permanent disability. A range of services are funded by the DHBs and cover all of the following internationally recognised interventions:
- Regular care from a primary health service
- Retinal screening for diabetic eye disease
- Podiatry for people with at-risk feet
• Self-management education and support
• Early detection of the likelihood of having a cardiovascular event in the next five years.

3. Meeting Care Needs: Service Provision and Availability of Services

3.1 Providing patient centered care

Once a person is diagnosed with diabetes they will need to receive support to assist them to manage their condition. Factors that will influence their need for care include:

• How well managed their diabetes is
• How recently they were diagnosed
• Their readiness to change lifestyle factors that contribute to diabetes
• The speed at which their diabetes progresses
• How many other health care problems they have.

Based on current evidence, population health information, and the VDR we can estimate the service requirements. Using this information we know that 70-80% of the population will receive their diabetes care from their primary care team. An additional 15-20% of people will need additional services to manage their complex health needs, with 5% requiring care for highly complex health needs.

3.2 Services Available in Auckland and Waitemata DHB

3.2.1 Diabetes Annual Review

All general practice patients should receive an annual review of their health. The Assessment and Management of Cardiovascular Risk\(^2\) recommends people with diabetes have a diabetes and cardiovascular risk assessment annually to identify their current risk of having a cardiac event is in the next five years.

On completion of the annual check the general practice team should work with the patient to agree a care plan. This should include recommendations and referral to services that will assist the patient to look after their health. This may include referral to diabetes self-management education, retinal screening, podiatry services and Green Prescription.

A number of people who are managed by primary care will also require intermittent support. This often occurs when they are newly diagnosed, or have a change in their health status that requires additional support. The Primary Care Handbook and the Northern Region Diabetes pathway are tools available to general practice to support the provision of good care.

Figures 5 and 6 show the number of people in the two DHBs who have had their annual review as reported against the VDR. For Waitemata DHB Māori diabetes annual reviews are above the Annual Plan (AP) target of 51%. All review rates for Pacific and other people are currently tracking below target. Auckland DHB annual review rates are well below the AP target of 90%. Maori and Pacific people are more likely to have an annual review than others. Pacific has the highest coverage.

\(^2\) The Assessment and Management of Cardiovascular Risk; Evidence-based best practice guideline, December 2003
Annual review rates for both DHBs have remained static since the commencement of DCIP (refer 3.2.2 below). PHOs have developed advanced forms that allow practices to collect data in different ways, which means more people may be actively managed but their reviews are not reported through the annual review process. The DHBs and PHOs are focused on ensuring patients have access to the DCIP services not annual reviews alone. Collectively we are managing performance through the PHO Performance Programme (PPP) and are working towards equitable coverage for all ethnicities against targets from 1 July 2014. This includes monitoring of PHO diabetes registers and annual follow-up (annual reviews).

The 2013/14 target for the two DHBs was set in accordance with the coverage for 2012/13 and potential improvement in the 2013/14 year. The Auckland DHB target was set at the same level as the Health Target for More Heart and Diabetes Checks. For 2014/15 these are aligned across both DHBs however focus is moving towards common targets for good diabetes management.

**Figure 5 Waitemata DHB annual review number and percent**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of Diabetes Annual Reviews</th>
<th>Diabetes Prevalence</th>
<th>Percent Achieved</th>
<th>2013/14 Target</th>
<th>Difference From Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>566</td>
<td>949</td>
<td>60%</td>
<td>51%</td>
<td>9% ▲</td>
</tr>
<tr>
<td>Pacific</td>
<td>796</td>
<td>1,707</td>
<td>47%</td>
<td>51%</td>
<td>-4% ▼</td>
</tr>
<tr>
<td>Other</td>
<td>4,643</td>
<td>10,612</td>
<td>44%</td>
<td>51%</td>
<td>-7% ▼</td>
</tr>
<tr>
<td>Total</td>
<td>6,005</td>
<td>13,268</td>
<td>45%</td>
<td>51%</td>
<td>-6% ▼</td>
</tr>
</tbody>
</table>

**Figure 6 Auckland DHB annual review number and percent**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of Diabetes Annual Reviews</th>
<th>Diabetes Prevalence</th>
<th>Percent Achieved</th>
<th>2013/14 Target</th>
<th>Difference From Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>492</td>
<td>808</td>
<td>61%</td>
<td>90%</td>
<td>-29% ▼</td>
</tr>
<tr>
<td>Pacific</td>
<td>1,839</td>
<td>2,708</td>
<td>68%</td>
<td>90%</td>
<td>-22% ▼</td>
</tr>
<tr>
<td>Other</td>
<td>3,716</td>
<td>8,309</td>
<td>45%</td>
<td>90%</td>
<td>-45% ▼</td>
</tr>
<tr>
<td>Total</td>
<td>6,047</td>
<td>11,825</td>
<td>51%</td>
<td>90%</td>
<td>-39% ▼</td>
</tr>
</tbody>
</table>

**3.2.2 The Diabetes Care Improvement Package (DCIP)**

The DCIP service aims are to improve the health of people with diabetes through the provision of services within general practice. The service evolved from the Diabetes Get Checked Programme.

The DCIP service provided varies according to a negotiated service model with each PHO. This has allowed each PHO to implement a service model that meets the needs of their general practices and fits with the other support the PHO can provide. There are a number of core DCIP deliverables for all PHO/practice services:

- Knowing who your diabetes population are through the creation and maintenance of a patient register
- Continuing annual diabetes reviews for people with diabetes
- The utilisation of resources available through the PHO and secondary care to provide care for people with diabetes.
PHO specific service differences are detailed in the following sections.

**Auckland PHO, Alliance Health Plus and National Hauora Coalition**
The Service Agreement includes the following additional elements:
- Practice plans that state how each practice will provide care for their population each year and meet performance targets throughout the year
- Incentive for reaching each target throughout the year.

Each of these PHOs is making satisfactory progress against their plans.

**ProCare Networks Limited**
The Service Agreement includes the following additional elements:
- An incentive fee to provide additional support to people who have poor diabetes control. The activities within the incentive programme include:
  - Each eligible patient having an annual review.
  - Planned care to ensure that each person within the high needs population (Maori, Pacific and Quintile 5 patients over 15 years) with an HbA1c of <64mmol/mol maintains or improves year on year.
  - Planned care to improve the health outcomes and reduce the HbA1c for the high needs patient with an HbA1c ≥64 mmol/mol.

ProCare Networks Limited has experienced a slow uptake of the DCIP incentive programme. We are working with ProCare to ensure the programme uptake improves.

**ProCare Networks Limited and Waitemata PHO**
The Service Agreement includes the following additional elements (noting that for ProCare practices within the Waitemata district these are in addition to the elements noted above):
- Focused on patients who:
  - Are newly diagnosed with diabetes
  - Have sustained poor glycemic control
  - Need to start insulin
  - Have a high cardiovascular risk scores and require intensive support
  - Have depression.
- Practice nurse support
- Insulin starts using agreed pathways
- Dietician support
- Counselling

Waitemata PHO has integrated this service within their long term conditions services. People enrolled with one of their practices will have access to
- Services through Care Plus or the Flexible Funding Pool, or
- The DCIP package of care programme, or
- Co-payment for primary care services.

Both Waitemata PHO and ProCare Networks Limited have experienced a slow uptake of the DCIP incentive programme. We are working with ProCare to ensure the programme uptake improves. Uptake in Waitemata PHO has improved during the last 9 months.

The Planning, Funding and Outcomes Unit continues to monitor service use across all PHOs.
Ministry of Health DCIP funding 2013-2017
From 1 July 2013 the Ministry of Health made additional funding available for DCIP ($328,193 per annum for four years for ADHB and $368,244.70 per annum for four years for WDHB). The two DHBs have used the funding differently in reflection of the services that were already in place.

Auckland DHB have developed and implemented a Community Podiatry service (see section 3.2.5).

Waitemata DHB have increased service capacity for community podiatry, retinal screening, dietician, and psychology support services.

3.2.3 Diabetes Self-Management Education (DSME)
The service focuses on providing self-care and diabetes education to people with type two diabetes and family or whanau. The programme is available to people:

- Within the first two years following their diagnosis of type two diabetes.
- Who have established diabetes with poor control, HbA1c ≥ 64 mmol/mol.
- Identified as being at significant risk of another diabetes related health complication.

In Auckland DHB, Auckland PHO are contracted to provide this for all Auckland DHB residents. For Waitemata DHB, both PHOs (Procare and Waitemata PHO) are contracted to provide this for their own enrolled population and West Fono is also contracted to provide this for their enrolled population.

The providers also work together to run cultural specific courses, allowing for people from other areas to attend rather than running multiple courses for the same culture. The current capacity for each provider is:

- ProCare Networks Limited (Waitemata DHB) provides courses for 405 people (not specifically focused on a population group), 45 for Maori, and 60 for Pacific people per annum
- Waitemata PHO provides courses for 404 people (not specifically focused on a population group), 44 for Maori, and 60 for Pacific people per annum
- Auckland PHO (All Auckland DHB PHOs) provides courses for 160 people per annum
- West Fono provides courses for 240 Pacific people per annum.

There is a body of evidence that DSME is effective when patients are engaged. It is estimated that 4% of the total diabetic population would benefit from this service each year. When the need is calculated on this basis, the current contracted volumes for Waitemata should meet this need and further investment is required for ADHB. However in both DHBs, this service is underutilised. It is noted that for the current services:

- Low numbers of referrals are received from general practice.
- The providers advertise their services extensively within the sector and in local press.

The current focus of further work needs to be on increasing uptake of current available services.

Additionally, the Northern Region Diabetes Network has been working with service providers to implement quality processes to ensure self-management programmes are of a consistent quality and applicable to patient need. The group is also working to develop a tool to evaluate the effectiveness of the programme in achievement of health gain for the people who attend.
3.2.4 Retinal Screening

Screening for diabetic eye disease provides early detection and treatment plans for people with eye disease. Information from screening can also provide medical staff with information on the effect diabetes is having on the blood vessels throughout the body. Retinal screening has been provided within the two DHBs for more than a decade. The services align with the National Grading and Referral Guidance for Retinal Screening. The service provides photo screening with a quality programme for grading of photographic images of the retina. If a person is not suitable for photo screening they will be referred for slit lamp studies of the retina or referred for treatment.

The current guideline indicates that the majority of people with type one and two diabetes will be screened every two years if they do not have a diabetic eye condition. If a diabetic eye condition is detected then the individual will be screened more regularly.

Approximately 55% of the population with diabetes will need retinal screening every year. Based on this the following table shows the difference between estimated need and current contracted capacity.

<table>
<thead>
<tr>
<th></th>
<th>Required Screens at 55%</th>
<th>Current Contracted Capacity</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>14133</td>
<td>10800</td>
<td>-3333</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>15865</td>
<td>12372</td>
<td>-3493</td>
</tr>
</tbody>
</table>

Both DHBs have historically taken a very different approach to retinal screening;
- Auckland DHB – of the 10,800 contracted volumes 33% are contracted to a private provider in the community (Auckland Eye) and utilise an optometrist lead model. The remaining two thirds volumes are undertaken by the provider arm service based at Greenland Clinical Centre (GCC). This service has exceeded its maximum capacity and there is currently up to a three month wait. The community provider has some spare capacity and the Planning, Funding and Outcomes Unit are working with the two providers to optimise capacity use.
- Waitemata DHB – of the 12372 contracted volumes, 70% are contracted out to the community through the two PHOs (Waitemata PHO and Healthwest for Procare) and the remaining 30% are undertaken by the Waitemata DHB secondary services. The PHO model employs a retinal screener and the service is operated from mobile vans. The current providers are working to capacity to ensure people are screened as soon as possible against their due date. Further funding for Waitemata DHB capacity is currently being considered.

Both services have current capacity constraints in terms of demand and also forecast need requiring further investment. The Planning, Funding and Outcomes Unit will be initiating a review to determine the most appropriate service delivery options which will ideally be better aligned across the two DHBs to enable capacity to meet demand.

3.2.5 Podiatry

Community podiatry has been provided in Waitemata since 2007. Service capacity, (packages of care) was increased to 2500 in 2009 and to 3000 in 2014.

The Auckland community podiatry service started this year and has 1931 packages of care available.
The service is provided by podiatrists subcontracted to the PHOs. The PHOs have packages of care allocated according to their diabetic population. From 1 July 2014 there will be a clinical governance and audit programme for these services lead by Podiatry NZ. This will include educational resources for the podiatrists. The audit programme covers both clinical competency and facilities quality. This is the first such programme and provides improved safety and quality oversight of these services.

The service is available to people with moderate foot disease. Referrals follow a foot check completed at the patient’s general practice. Once a referral is received by the PHO they allocate the patient to one of the podiatrists for a package of care. The package of care includes a full assessment and up to three treatments. If a package of care is not fully used the remaining components can be allocated to additional patients.

Approximately 20% of the population with diabetes will need foot care for moderate diabetic foot disease at any one time. Figure 8 assesses the number of package of care that would be required to meet the needs of the diabetic population if these were to be fully publicly funded. It is noted that a proportion of patients access privately provided services. The current Waitemata DHB services are not fully utilised despite being in place over a number of years and the Auckland DHB service has only recently commenced.

**Figure 8: Auckland and Waitemata DHBs Community Podiatry Service Capacity Requirements**

(Packages of Care - a full assessment and up to three treatments)

<table>
<thead>
<tr>
<th></th>
<th>Required</th>
<th>Current Contracted Capacity</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>5139</td>
<td>1931</td>
<td>-3208</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>5689</td>
<td>3000</td>
<td>-2689</td>
</tr>
</tbody>
</table>

The primary focus is to increase service utilisation and ensure this is being accessed by those patients in need. The Planning, Funding and Outcomes Unit are also looking at options to increase service capacity to meet future need.

**3.2.6 Cardiovascular and Diabetes Risk Assessment and Management (CVDRAM)**

The CVDRAM services support the work undertaken to meet the 90% More Heart and Diabetes Check Health Targets. The majority of this work is undertaken by general practice and supported by the PHOs and the DHBs. Both DHBs have provided assessments for staff. Waitemata DHB has also provided assessment of inpatients. However, the inpatient assessment programme has not been successful.

**Eligibility and Prevalence**

The Health Target eligible population is defined as:

- Maori, Pacific and Indian men 35 to 74 years of age
- Maori, Pacific, and Indian women 45 to 74 years of age
- All other men 45 to 74 years of age
- All other women 55 to 74 years of age.

Maori, Pacific and Indian people have a higher prevalence of cardiovascular conditions. Coronary heart disease death rates for Maori under the age of 75 are 2-3 time higher than
non-Maori and up to twice as high for Pacific People\(^3\). 53% of Maori men and 33% of Maori women who die from coronary heart disease are under 65 years of age\(^4\). The early detection of cardiovascular and diabetes risk factors has the potential to improve the outcomes for Maori. For this reason the National Guidelines for the Assessment and Management of Cardiovascular risk (2003) recommend cardiovascular risk assessments begin 10 years earlier for this population.

**Intervention, Goal Setting and Follow-up**

On completion of a risk assessment the patient and general practice will know the patient’s risk of having a cardiovascular event in the next five years. Based on the result of the assessment the general practice will work with the patient to identify which risk factors can be modified to reduce this risk. The Primary Care Handbook\(^5\) provides general practice with information on the level of intervention and support recommended to reduce risk. The recommended interventions are noted in Figure 9.

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\(^3\) The Assessment and Management of Cardiovascular Risk: Evidence-based best practice guideline, December 2003


General practitioners are able to refer to the DHB funded programmes for self-management education and Green Prescription to support life style change.

**Screening and Monitoring in Action**

The CVDRAM programme includes tests to detect whether a person may have diabetes. The ability to diagnose diabetes from a single assessment is limited to people with extremely high blood glucose. A high HbA1c may indicate that the person has diabetes or is pre-diabetic. The general practitioners use current evidence based guidelines to determine the actions they and the patient will initiate in response to a high blood glucose reading.

The Clinical Directors of Waitemata PHO and Auckland PHO have provided the following insight as to how general practice manages people recently diagnosed with diabetes and/or cardiovascular disease. The screening and monitoring of people with relevant biological and laboratory tests at the time of their five year risk assessment often initiates care planning. Current activity undertaken in general practice to screen for and monitor diabetes include:

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Incorporating HbA1c in the 5 yearly CVDRA assessments. This helps identify Maori, Pacific and Indian men with signs of diabetes

Screening of Lipids (blood cholesterol) and HbA1c as routine care for most of the enrolled population 40+ or earlier with known other risk factors (ethnicity/early onset - family history)

Close monitoring of people who are already identified as being pre-diabetic as a result of routine yearly bloods. This monitoring includes bloods tests every 3-6 months and lifestyle advice

Confirmation of positive blood tests results for diabetes – (Symptomatic HBA1c ≥50mmols/mol or Asymptomatic two HBA1c ≥50mmols/mol) the patient will be seen by their general practitioner for a comprehensive clinical assessment. This will determine what type of diabetes the person has, type 1 (LADA) or type 2. The general practitioner in conjunction with the practice team will then:

- complete further blood tests [GAD,IA2 markers],
- confirm the diagnosis of diabetes
- admit to hospital if required for people with type 1 diabetes
- review or introduce diabetes and cardiovascular medications as appropriate.

The patient will also be seen by the practice nurse and an action plan with goals will be set. This may include all or some of the following depending on what is negotiated with the patient:

- Understanding what diabetes is and what the patient is concerned about
- Lifestyle factors that can impact on diabetes including eating habits and physical activity
- Medications to manage blood glucose and prevent secondary complication
- When, how and why to do blood glucose monitoring
- Referral to diabetes self-management programme
- Referral for retinal screening.

The patient may be provided services funded through either the Flexible Funding Pool or the Diabetes Care Improvement Packages.

Pre-diabetes

People who have an HbA1c of 41-49 mmols at the time of their five year CVD risk will have follow up blood tests either three or six monthly or as individually appropriate. The general practice can also refer these people to Green Prescription for physical activity advice.

Harbour Sport Trust has just been awarded a $500,000 contract for the ‘Choose Change’ programme which supports people who have been diagnosed as pre-diabetic or with Type 2 diabetes. Each participant will get a personalised plan, which will include goal setting, nutrition advice, and exercise options. They will be supported and have their progress monitored by a healthy lifestyles coordinator over a six month period. The ‘Choose Change’ project will run for 12 months from July 2014, allowing for three six-month programmes to be delivered to around 240 people. The Harbour Sport Trust is partnering with Sport Waitakere, Sport Auckland and Counties Manukau Sport to deliver the ‘Choose Change’ programme.

3.3 Long Term Condition Services for Maori

The DHBs contract two Maori Health Providers to provide Whanau Ora Long Term Condition services for Maori. The providers are Te Hononga (Auckland DHB) and Te Whanua O Waipareira (Waitemata DHB).
The goals of the service are to deliver a range of services to improve the health and wellbeing of people with long term conditions. The services focus on providing assessments and care for CVD, Diabetes, Asthma and Lung disease within the primary care setting. The services are delivered through a case management model supported by health promotion, education activities, and community support provisions. Both providers are funded for 3 registered Nurses, 1 Whanau ora navigator and 0.5 Coordinator. The caseload is set at between 25 and 55 per nurse.

Whanau Ora services for people with long term conditions have been calculated on the basis that 25% of Maori will need additional help. This calculation is based on international chronic care models where 20-25% of the people with chronic health care need care management and case management for their health.

Both Te Hononga and Waipareira services are currently experiencing vacancies which will impact their ability to meet their caseload for the year.

3.4 Pacific Health

DHB funded services for Pacific people with diabetes are focused on the two practices with high Pacific enrolments:
- Langimalie Health Centre (Auckland DHB)
- West Fono (Waitemata DHB)

The DHBs provide funding of a practice nurse to work with their population. The practice nurse provides direct care and coordinates access to the other services, including:
- Community podiatry
- Retinal screening
- Diabetes self-management education.

The two providers have a working relationship with secondary care diabetes services. Clinical staff from secondary service provides direct patient care through clinics within the practice and through on-call phone support Monday to Friday.

There has been no analysis completed on the service demand against availability as the practices nurses do not have a case load. The Planning, Funding and Outcomes Team are working with the providers to develop outcome reports to support future planning.

4. Moving Forward

Diabetes is a priority for both DHBs and has been included as our single focus priority in the District Alliance workplan. A draft workplan with a focus on diabetes is currently going through the agreed process with our PHO and MOU Alliance partners however does require the agreement of all partners before this can be confirmed. A verbal update will be provided to the Committee at the meeting.

As identified in the report, the growing numbers of people with diabetes exceeds demographic growth and with high cardiovascular risk is putting increasing pressure on existing services. In some cases, there is underutilisation of key services important in the management of diabetes.
We will be seeking a review of a number of services (including retinal screening and podiatry) to consider capacity constraints, service models, quality requirements and reporting. This is an opportunity to ensure a consistent level and types of services are put in place across both DHBs to meet the growing demand and in some cases may require potential reconfiguration to ensure:

- Value for money
- Accessibility for patients
- Appropriate capacity
- Improved reporting
- Consistency across both DHBs

Contracted service capacity has been limited by the need to live within our means and by the growth in patients needing to access these services. In addition a number of providers are seeking price reviews as they state they cannot deliver the required quality and service levels within the available funding. This will need to be a key consideration in the service reviews.

Current funding for PHOs continues in 2014/15; it will be important to ensure that this funding and resources are effectively utilised by PHOs. They will require ongoing support to collect and monitor quality data for long term conditions at a practice level, and will also require support to target those with poor performance. We continue to work closely with all the providers to ensure services are utilised appropriately and that maximisation of current investment is achieved.
4.2 Community Engagement Update for Auckland and Waitemata DHBs

Recommendation

That the report be received.

Prepared by: Simon Bowen (Director Health Outcomes ADHB/WDHB), Andrew Old (Director Strategic Unit ADHB), Wendy Bennett (Planning Manager ADHB/WDHB), Imelda King (Community Engagement Co-ordinator WDHB), Anne Curtis (Health Link North) Tracy McIntyre (Waitakere Health Link)

Glossary

Auckland DHB - Auckland District Health Board
DHB - District Health Board
NGO - Non-government organisation
Waitemata DHB - Waitemata District Health Board

1. Executive Summary

This report is an update of current community engagement activity within Auckland and Waitemata DHBs, including current information from Health Link North and Waitakere Health Link. A wide range of consumer and community engagement activity is being undertaken at both DHBs. A significant focus for both has been engagement activities to inform the primary care locality planning projects.

Changes in roles and responsibilities for community engagement are also noted.

2. Background

Auckland and Waitemata DHBs’ approach to community engagement is informed by the principles included in the Auckland and Waitemata DHB joint Consultation and Engagement Policy. The principles recognise the legislative responsibilities of DHBs as well as our commitment to prioritising engagement with consumers and the wider community in decision-making processes. These principles are also reflected in the Waitemata identified values of: Everyone Matters, Connected, and Better, Best Brilliant.

Community engagement takes place in a range of ways at both DHBs; in addition there are dedicated roles within each DHB.

At Waitemata DHB the Community Engagement Co-ordinator co-ordinates community engagement in collaboration with Health Links. This role provides advice for engaging with key stakeholders, community groups, consumers, residents and external agencies. The role is based in the Planning and Health Intelligence Team, and is therefore part of the current collaboration process with Auckland DHB.

Waitakere Health Link and Health Link North are responsible for improving health outcomes through involving the community in planning, development, delivery and review of health and disability services. These organisations provide consumer/community input into health
services through health literacy, consumer voice and developing community relationships with Waitemata District Health Board through community participation.

Within Auckland DHB the Community Engagement Manager is based in the Strategy Unit. This role is currently vacant with recruitment underway.

Auckland DHB has two Local Health Networks in place, one in Glen Innes and one in Maungakiekie and these bring social services together with residents and other agencies to collaborate on local health issues.

3. Progress/Achievements/Activity

3.1 Locality Planning

**Glen Innes**
Auckland DHB and primary health providers have been working with local people in Glen Innes to investigate how local concerns around mental health could be addressed. The outcome, from workshops in the Glen Innes community and widespread consultation, is a number of initiatives which sit under three streams of work. One stream involves wellbeing work based in primary care, the second is about linking services and peer support, while the third covers 32 wellbeing projects based in the community. These workstreams have been approved by the community. The next step is for the steering group to develop these workstreams up into a proposal which can be considered by the DHB executive.

**Maungakiekie - Tamaki**
The Maungakiekie Wellbeing and Health Group meet monthly and have developed a website to promote local services and to draw attention to local resources. The site will also encourage community members to raise issues of concern and to create a wider network of people interested in promoting better health and wellbeing.

**West Rodney**
Community engagement for Waitemata DHB is strongly focused on locality planning in west Rodney. A number of engagement strategies are in place working alongside Ngati Whatua Oranga staff and Health Link North staff including an NGO forum in Parakai planned for June. This follows and reports back on a west Rodney Locality Planning Forum held in Parakai on 17 November with 71 attendees. The target audience for these forums are non-government organisations (NGOs), stakeholders and the public. The aim is to inform locality planning in west Rodney. Attendance at local community events, i.e. local markets has provided further opportunities to engage with these communities.

A pilot for west Rodney working with Healthpoint Ltd to provide better visibility of services available in the local area utilising technology eg computer, smart phone access, is in the planning stages. Engagement with the community to identify key access words relevant to the general public and plan for a public friendly website will be incorporated in locality planning engagement.

3.2 Health Literacy

Health literacy initiatives to promote consumer responsive conversations and better health outcomes are also a significant component of this work. This includes facilitating Waitemata
DHB’s process for consumer review provided by Health Links’ consumer review groups who have reviewed a combined total of 106 documents in the past 12 months. Feedback from staff and consumers has been collated and informs on-going work. Note that a more comprehensive update on health literacy will be provided to a subsequent CPHAC meeting.

3.3 Quality
Health Links continue to input into Quality initiatives and a number of steering groups and are extensively involved in developing and contributing to newsletters and information sharing. Waitemata DHB has been working extensively with its consumers to develop the Quality Accounts.

In May 2014 a Consumer/Patient Experience Manager was appointed in the Quality team. This is a great opportunity to increase the community and patient engagement with the DHB.

3.4 Health Link Highlights
Amongst the recent highlights reported by Health Links are the following activities:

**Consumer Representative Training:**
A collaborative process with both Health Links and Waitemata DHB with input from the Health and Disability Advocacy Service was held in April 2014. The objective is to train consumers to have confidence in contributing to DHB engagement processes as representatives in advisory groups and other DHB groups. Eighteen participants attended a one day workshop. A comprehensive handbook and further training and mentoring opportunities were provided to participants. Evaluations evidenced high satisfaction with the course.

**Mapping and profiling service provision – “Babies Out West”**
Waitakere Health Link has recently reprinted the Babies Out West brochure which collates and profiles in one document the support services available to young parents. This brochure is in high demand - “Love the new ‘Babies Out West’ brochures, such an awesome resource!” Mandy Spencer, Community Waitakere Charitable Trust.

**Open Days at North and Waitakere Hospitals**
The two Health Links have facilitated successful NGO Open Days at both North Shore and Waitakere hospitals this year. The Open Days enable staff and the public to become aware of and understand the services provided by these NGOs in the community, and to meet the NGO staff involved. A potential benefit of the Open Days is the increased information available to support discharge planning.

**Health Forums:**
The forum in May 2014 focused on an Update of Maternity Services in West Auckland. Invites were distributed widely throughout the community, NGOs and key stakeholders. In October 2013 Waitakere Health Link held a Child Health Forum with 65 attendees. Dr Tim Jelleyman presented to an audience of NGOs, community and stakeholders.

Health Link North is co-organising a screening hui with Waitemata DHB and Te Ha Oranga in Wellsford on Saturday 12 July - the aim being to raise awareness and wellness for future generations.

Plans are underway for the South Kaipara Festival of Health and Wellbeing on 20 September 2014. This is being organised by Health Link North in conjunction with the Auckland North
Locality Planning Operational Group, Helensville District Health Trust, South Kaipara Men’s Centre, Te Ha Oranga and Helensville Women’s and Family Centre.

4. **Conclusion**

This report has been developed to inform the Committee of a range of community engagement activities occurring across both Waitemata DHB and Auckland DHB and identify work in progress.
5.1 Primary Care Update Quarter 3, 2013/14

Recommendation:

That the report be received.

Prepared by: Tim Wood (Funding and Development Manager Primary Care, Waitemata and Auckland DHBs) and Dr Stuart Jenkins (Clinical Director Primary Care, Waitemata and Auckland DHBs)

Glossary

A&M - Accident and Medical Centre
ACN - Alliance Clinical Network
AH+ - Alliance Health Plus
ALT - Alliance Leadership Team
ATD - Access to Diagnostics
CAMHS - Child and Adolescent Mental Health Services
CPIG - Clinical Pathway Implementation Group
CT - Computed Tomography [radiology imaging]
DAR - Diabetes Annual Review
DCIP - Diabetes Care Improvement Package
DHB - District Health Board
DVT - Deep Vein Thrombosis
ED - Emergency Department
GAIHN - Greater Auckland Integrated Health Network
IFHC - Integrated Family Health Centre
IPIF - Integrated Performance and Incentive Framework
IT - Information Technology
LEGG - Locality Establishment Governance Group
MoH - Ministry of Health
MRI - Magnetic Resonance Imaging [radiology imaging]
NETP - Nurse Entry to Practice
NHC - National Hauora Coalition
NIHI - The National Institute for Health Innovation
PARR - Patients at Risk of Readmission
PHO - Primary Health Organisation
PMS - Patient Management System
POAC - Primary Options for Acute Care
PPP - PHO Performance Programme
QIT - Quality Improvement Team
UCN - Urgent Care Network
VDR - Virtual Diabetes Register
VLCA - Very Low Cost Access
1. Summary

This report provides an update on matters relating to Auckland and Waitemata District Health Board (DHB) primary care for quarter three 2013/14. The report is presented in the following sections:

- primary care scorecard with additional commentary on the three primary care health targets
- objectives set in our annual plan and other key primary care projects
- primary care nursing
- PHO operational issues.

The immunisation and cervical screening performance and commentary will from now on be reported in a Child, Youth and Women scorecard and report.

2. Primary Care Scorecard

How to read the scorecard

The scorecard presented on the following page is a standardised performance scorecard which aligns to the overall organisational scorecard. The scorecard shows how each District Health Board (DHB) is tracking against a wide range of measures. Given the DHBs’ focus on health targets, these are presented first in the scorecard as priority measures. Where appropriate, indicators are presented with performance by ethnicity. For each measure, the green bar reflects how well we are doing against the target for the period presented.

The progress green bar is weighted for each measure based on the degree of concern of any short fall in meeting the target. For the most part, these weightings reflect those used in the overall organisational scorecard. However, this element of the scorecard is still work in progress for some of the measures. For example, this weighting is noticeable for Health Targets where the scale is very sensitive so that any variance is deemed to be significant. If performance is achieving or better than target, the bar will display as a solid green line. Where the bar is blank, this reflects very poor performance against the target or where no data is available or no target has been set.

Summary Performance Against Targets

Priority One Targets

Further detail on Auckland and Waitemata DHB’s performance against these targets is provided directly after the scorecard.

Service Delivery Targets

For PHO enrolment, Auckland DHB is at 92% and Waitemata DHB 94%. The total enrolment percentages have remained the same since the last quarter. Asian enrolment rates (71% and 76% for Auckland and Waitemata DHB respectively) have seen a slight increase of 1% for Waitemata DHB between quarter two and quarter three. However their enrolment is lower than those of other ethnicities. Māori enrolment rates have also increased slightly with Auckland DHB on 82% (up from 80%) and Waitemata DHB on 81% (up from 80%) since the last quarter.
Improving Population Health Targets

For Diabetes Annual Reviews, Auckland DHB is sitting at 67% - which is no change from the previous quarter, and Waitemata DHB is at 41% - which is a slight decrease from the previous quarter (45%).

Diabetes Management increased across all ethnicities across Auckland DHB in quarter three. Of particular note, there was a 17% increase for Māori in quarter three from the previous quarter (from 61% to 78%). Waitemata DHB also had an increase across all ethnicities for
Diabetes Management with the exception of ‘other’ which was the same as the previous quarter. Of particular note, there was a 9% increase for Pacific (from 61% to 70%).

For cervical screening, Auckland DHB is sitting at 76.9% and Waitemata DHB at 76.2% for their total population. Auckland DHB has seen a slight reduction in the last quarter – down from 77.1%. Waitemata DHB has seen a slight increase in the last quarter – up from 75.8%. Māori cervical screening rates continue to be much lower than other ethnicity groups at only 57.3% for Auckland DHB and 54.3% for Waitemata DHB.

Quarter three also saw a big improvement on the child oral health arrears rate for both DHBs. Auckland and Waitemata DHBs are currently at 6.4% and 7.8% arrears respectively (previously 8.8% for Auckland DHB and 8.6% for Waitemata DHB). The national target for arrears is 10%.

Waitemata DHB has committed to the employment of an additional three Pacific nurses to support the Enua Ola programme. This aligns with the ADHB Healthy Village Action Zones Programme which is thought to be a significant contributor to improve cervical screening rates.

**Immunisation Health Target Q3 2013/14**

- **Target**: 90 percent of eight months olds will have their primary course of immunisation on time by July 2014 (Auckland DHB)
- **Target**: 95 percent of eight months old will have their primary course of immunisations on time by July 2014 (Waitemata DHB)

Please refer to the Planning, Funding and Outcomes report, Section 2.2.2., for an update on the Immunisations health target.

**More Heart and Diabetes Checks Health Target Q3 2013/14**

- **Target**: 90 percent of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years by July 2014.

The ‘More Heart and Diabetes Checks’ results are produced by the PHO Performance Programme (PPP) and are as reported in the Ministry of Health (MoH) DHB performance tables. The quarter three denominators are 140,991 for Waitemata DHB and 152,053 for Auckland DHB. The denominator increased from quarter two by 3,462 for Waitemata DHB and decreased by 1,287 for Auckland DHB. The quarter three preliminary results are:

**Auckland DHB**
- Total coverage ↑2.9% from quarter two.
- Coverage for Māori ↑0.3% (to 80.7%) and decreased for Pacific ↓1.0% (to 84.4%). Auckland DHB leads the country for Māori coverage and is second in New Zealand for Pacific coverage.

**Waitemata DHB**
- Total coverage ↑4.4% from quarter two.
- Coverage for Māori ↑2.8% (to 74.3%) and for Pacific ↑1.8% (to 78.5%).

An additional 12,269 people are recorded as having had an assessment in quarter three than quarter two (3,270 for Auckland DHB and 8,999 for Waitemata DHB). The impact of the rolling
cohort means that people are moving in and out of the age bands, and people assessed more than five years ago are adding to the number of required assessments.

Latest estimated performance for Auckland DHB is 88% and for Waitemata DHB is 81%.

Auckland PHO has improved from 81% to 84% since December. Please note these do not include assessments stored in other systems – estimated to be at 3%. Auckland PHO have supported practices to run outreach clinics, provided funding for phlebotomy and extra nurse resource, purchased a Point of Care testing machine to collect blood results easily and used tools to identify patients who have not had a risk assessment.

Alliance Health + PHO staff has ‘buddied’ with practices to support them to achieve targets. The PHO is providing phlebotomy training and practices are paid for phlebotomy. In addition weekly target meetings are held and incentive payments for practices are paid to help achieve the target. As a result performance has improved from 84% to 85%. High risk patients are identified using Dr Info.

National Hauora Coalition has improved from 84% to 87%. This was supported by non face-to-face assessments being done, improved data collection and a strong push by clinical staff from the PHO to assist low performing large practices. Nurses are also using text to remind and are doing assessments in the home including weekends and after hours.

The result for Procare practices across Auckland and Waitemata DHBs has also improved since December (84.3% to 86.4% for Auckland DHB and 82.6% to 84.3% for Waitemata DHB). Please note these are CPI extract monthly results1. The improvements are supported by funding for phlebotomy within practices, providing further nursing support for practices, enhancing data systems, incentive payments to practices (including a payment for reaching target). Procare have profiled the eligible patients who have not had a risk assessment. The profile highlighted a large majority of European males between the ages of 45-65.

Waitemata PHO has improved from 72%-79%. Waitemata PHO is paying per risk assessment and working on improving data systems. We are working with Waitemata PHO to improve their performance.

Auckland DHB is hoping to reach the 90% target and is currently the leading DHB in the country; Waitemata DHB is unlikely to reach 90% by the target date of 30 June 2014.

All PHOs have provided a plan on how they will work with practices to ensure they meet this target. The DHBs and PHOs continue to meet to ensure that the health target remains a focus and progress is being made against the plans. All PHOs continue to report weekly to the DHBs.

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1 CPI extract results include all assessments stored in ‘The Edge” and “My practice” for Procare. These are only able to be supplied monthly.
**Better Help for Smokers to Quit – Primary Care Health Target Q3 2013/14**

Target: 90% of enrolled patients who smoke and are seen by a health practitioner in primary care are offered with advice and help to quit by July 2014.

The ‘Better Help for Smokers to Quit’ results are produced by the PHO Performance Programme (PPP) and are as reported in the MoH DHB performance tables.

The final quarter three results were:
- Auckland DHB 67.1%, ↑6.6% from the previous quarter; and
- Waitemata DHB 64.1%, ↑8.9% from the previous quarter.

All PHOs are prioritising high needs populations in their programmes to support people to quit smoking. They are all achieving a higher rate of advice and support to quit to their Māori and Pacific populations than the total population in both DHBs (see table below for actual results).
Results for each PHO are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alliance PHO</td>
<td>Auckland PHO</td>
</tr>
<tr>
<td>Māori</td>
<td>76.6%</td>
<td>72.0%</td>
</tr>
<tr>
<td>Pacific</td>
<td>85.8%</td>
<td>62.9%</td>
</tr>
<tr>
<td>Total Population</td>
<td>80.7%</td>
<td>61.0%</td>
</tr>
</tbody>
</table>

PHOs report monthly to the DHBs on their performance against this target. More frequent reporting is not possible. However, it can be seen from the results above that there has been a significant increase in the last quarter. All of the PHOs have comprehensive plans in place for increasing the result for the fourth quarter. These are some examples of activities the PHOs have been undertaking:

- PHO teams going into Practices (or running data queries) to assist them with auditing their patient notes to identify patients that may have received the advice but it has not been documented.
- Sharing of practice performance and recognising and promoting successes at cell group meetings.
- PHOs and/or practices delivering advice and support to quit via texts and phone calls.
- PHOs providing training to practices, so that GPs and Nurses are able to provide the advice when patients visit the Practice.
- Installing a one touch Patient Dashboard System (Medtech practices) to make it easier for GPs and practice nurses to record smoking status and brief cessation advice given.
- Use of alert systems within the PMS (practice management systems) to identify all smokers and the need to offer brief cessation advice.
- Running Data Quality SQL via PMS to identify patients prescribed nicotine replacement therapy (NRT) and not recorded as having been given brief cessation advice.
- IT teams actively following up data discrepancies to find the cause of data anomalies. Some of these are due to recording errors, some have been caused by incorrect data entry methods and resulting coding errors, and some point to issues within the data extraction programme.
- Direct support to practices through the PHO Smokefree Nurse, Practice Liaison Team and Practice Liaison GP, to answer any questions related to giving patients brief cessation advice and interventions.
- Practices are encouraged to have a Smokefree Champion.

The sub-target of ‘90% of pregnant women are offered advice and support to quit smoking at confirmation of pregnancy with an LMC’ is not yet being nationally reported. Waitemata DHB has set-up a DHB data reporting mechanism for this target and the result for quarter three was 99%. Auckland DHB is now working on implementing the same reporting mechanism, so that in future they will also be able to monitor their results.
3. Objectives set in our annual plan and other key primary care projects

**Diabetes annual reviews**

The diabetes annual review (DAR) targets for 2013/14 are:

- A minimum of 51% of people in Waitemata DHB with diabetes will have a DAR.
- A minimum of 90% of people in Auckland DHB with Diabetes will have a DAR.
- A minimum of 75% of people who have had a DAR will have an HbA1c of <64mmol/mol.

HbA1c is a measure of blood glucose, and provides information of the control of the blood glucose over a three month period. Fasting blood glucose will provide information on what a person’s blood glucose is at the time of the test.

DARs are measured against the MoH Virtual Diabetes Register (VDR). The VDR is an estimated population of people with diabetes calculated from health information, lab tests and pharmacy prescriptions.

The Diabetes Care Improvement Package (DCIP) provides people with diabetes and their primacy health care providers with specific resources to assist in care. Each PHO has funding to provide services to their populations and they have worked with the DHB and practices to determine the most effective way to assist people in primary care. Each PHO service differs for this reason.

**Waitemata DHB**

- Waitemata VDR population is 26,535.
- 41% of the total population have had a DAR.
- 78% of the total population have an HbA1c of <64 mmol/mol.
- The DHB has seen a 4% decrease in DAR since the previous quarter. However there has been a 1% increase in good diabetes control as measured by HbA1c over the last quarter.
- There is a 10% difference between current performance and target for DAR. However this is an under estimate of actual performance. The DHB and PHOs continue to discuss
reporting for DAR. As general practices move to the use of an ‘advanced form’ for diabetes within their patient management system, we will expect to see the number of recorded DARs increase. This may not be evident until the 2014/15 year.

- Services for the management of people with complex health needs related to diabetes continue in general practice through the Diabetes Care Improvement Packages. Both PHOs have services to assist general practice to initiate insulin. Additional education and support for people needing in-depth nutrition and self-management assistance is also available.

**Auckland DHB**

- Auckland VDR population is 23,649.
- 67% of the total population have had a DAR.
- 73% of the total population have an HbA1c of <64 mmol/mol.
- The number of annual reviews remains the same this quarter. However there has been a 2% increase in good diabetes control as measured by HbA1c over the last quarter.

We would expect to see an improvement in reported volumes once general practices move to the use of an ‘advanced form’ for diabetes within their patient management system.

- All four PHOs continue to implement their DCIP plans. The PHOs have been focused on ensuring people have their annual review. This includes meeting their PHO Performance Programme targets. The annual review includes a plan of care for the next year noting what medical and self-care activities will be worked on. This approach encourages general practice to work to improve diabetes control.

**Primary mental health**

As of July 1 the MoH provided further funding for primary mental health initiatives for one year. The new service specification outlines a stepped care model to be delivered which is regionally consistent across Waitemata DHB and Auckland DHB where possible. The service is targeted to Māori, Pacific and quintile 5 patients. Waitemata DHB and Auckland DHB have used similar service specifications, for the adult primary mental health initiatives contracts with the PHOs.

Additional funding has also been provided by the MoH to target alcohol screening and brief interventions in primary care settings. This funding supports and extends interventions that are already in place as part of existing primary mental health initiatives. In Auckland DHB; Auckland PHO, NHC, and ProCare PHOs have contracts. AH+ did not apply for this funding. In Waitemata DHB, consultation with the PHOs and the Clinical Director of the Community Alcohol and Drugs service is occurring to gather expert advice on a model of care to be implemented.

**Waitemata DHB**

- Work is ongoing with the Waitemata PHOs, to ensure the stepped care model is fully implemented, and the target population prioritised. A draft project implementation plan has been completed in partnership with Pro Care, Waitemata DHB and Auckland DHB for establishment and refinement of a collaborative stepped care model, pilot in the New Lynn Integrated Family Health Care Centre. Pilot to be evaluated and approved for roll out by June 30, 2015.
- Work to increase integration between primary, secondary and NGO services is continuing. A pilot test for the collection of base-line data for the number of consult liaison sessions delivered to primary is complete. Full testing with Child and Adolescent Mental Health Services (CAMHS) started in April 2014.

2013/14 Q3 volumes are as follows:
Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 11/06/14

Ethnicity Waitemata PHO Procare HealthWest Total
NZ European 374 109 153 636
Māori 47 130 78 255
Pacific 20 44 36 100
Asian 27 20 9 56
Other 34 29 13 76
Q3 Total 502 332 289 1,123
Q3 Expected Total 407 432 382 1,221

- HealthWest provide primary mental health interventions to youth aged 10 to 24 years as part of the Waitemata Youth Health Hub.
- Please note that ProCare had significantly over-delivered during quarter one. Procare had carried an under-spend in primary mental health options from 2011/12, into 2012/13. The cumulative effect was that going into 2013/14, ProCare packages of care were oversubscribed. Contractually they are expected to manage volumes in such a way as to make packages available throughout the full year. ProCare, on advice from their board, are managing this situation internally.

Auckland DHB
2013/14 Q3 volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland PHO</th>
<th>ProCare</th>
<th>AH+</th>
<th>NHC</th>
<th>Youthline</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>168</td>
<td>216</td>
<td>9</td>
<td>165</td>
<td>27</td>
<td>585</td>
</tr>
<tr>
<td>Māori</td>
<td>46</td>
<td>274</td>
<td>3</td>
<td>30</td>
<td>2</td>
<td>355</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>20</td>
<td>183</td>
<td>17</td>
<td>20</td>
<td>3</td>
<td>243</td>
</tr>
<tr>
<td>Asian</td>
<td>55</td>
<td>75</td>
<td>2</td>
<td>71</td>
<td>5</td>
<td>208</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>64</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td>95</td>
</tr>
<tr>
<td>Q3 Total</td>
<td>304</td>
<td>812</td>
<td>32</td>
<td>293</td>
<td>45</td>
<td>1486</td>
</tr>
<tr>
<td>Q3 Expected Total</td>
<td>105</td>
<td>385</td>
<td>89</td>
<td>86</td>
<td>38</td>
<td>703</td>
</tr>
</tbody>
</table>

Please note that this contract has now been changed to require PHOs to re-orientate services to high needs populations. This change does not include Youthline whose services are prioritised for 12 to 19 year olds.

Regional after hours network
A Network of 11 Accident and Medical (A&M) clinics open until at least 10pm, 365 days per year with reduced co-payments for under 6s, over 65s, high user health card, community services card and those living in quintile 5. The Auckland Region After Hours Network contract runs until June 30.

- Work continues on the development for the After Hours business case. The aim is to have this available for Boards to consider in July 2014.
- There has been an independent evaluation of the After Hours Network. This has been undertaken by Dr Tim Tenbensel, Health Systems, School of Population Health, Faculty of Medical and Health Sciences, The University of Auckland. It is expected the report will be available soon to inform the business case.
- The table provided in Appendix 1 provides an over view of the utilisation of the After Hours Network services through to 31 March 2014.
- The following table shows the current opening hours of each of the 11 A&M clinics and the fees charged for eligible patients.
Suburb | A&M Clinic | Opening hours | Fees 2
--- | --- | --- | ---
Pukekohe | Pukekohe Family Healthcare | Closes 10pm | $0.00 | $25.00 | $50.00 | $50.00 |
Takanini / Papakura | Takanini Care | Closes 10pm | $0.00 | $17.00 | $34.50 | $29.50 |
Otara | East Tamaki Healthcare (Bairds Road) | Closes 11pm | $0.00 | $11.00 | $17.00 | $17.00 |
Otahuhu | Whitecross Otahuhu | Closes 10pm | $0.00 | $15.00 | $28.00 | $28.00 |
Botany | East Care | 24 hours | $0.00 | $35.00 | $39.00 | $40.00 |
Henderson | Whitecross Henderson | 24 hours | $0.00 | $30.00 | $38.00 | $38.00 |
New Lynn | Whitecross New Lynn | Closes 10pm | $0.00 | $25.00 | $38.00 | $38.00 |
Remuera | Whitecross Ascot | 24 hours | $0.00 | $45.00 | $50.00 | $50.00 |
Three Kings | Three Kings A&M | Closes 10pm | $0.00 | $35.00 | $43.00 | $40.00 |
Takapuna | Shorecare | 24 hours | $0.00 | $44.00 | $49.00 | $50.00 |
Glenfield | Whitecross Henderson | Closes 10pm | $0.00 | $44.00 | $48.00 | $48.00 |

Note: The Government’s policy of free GP visits and prescriptions for children under six, including free after-hours care, will be extended to children under 13 from 1 July 2015.

Access to Diagnostics-Radiology

A regional Access to Diagnostics-Radiology steering group has been in operation since 2010/11. The group help to ensure timely and regionally consistent access for primary care, to DHB funded imaging procedures. Clinical triage criteria have been developed by a cross-regional group of primary care and secondary care clinicians and radiology specialists. These criteria support general practice decision making to improve appropriate access to diagnostic investigations. The triage criteria have been incorporated into both the Regional CareConnect e-Referrals solution and ProCare’s ProExtra form. ProExtra forms can be used by GPs for Auckland DHB and Counties Manukau DHB funded x-ray and ultrasound in community private practices. A budget is notionally allocated per practice to manage private practice referral spend. All other imaging is referred to the DHB Radiology department using CareConnect e-Referrals or faxed referrals.

Wait times
- The regional wait time targets for routine community referred radiology are 85% of x-ray and CT, and 75% of MRI and ultrasound requests provided within 6 weeks. The table shows the percentage of patients who waited less than six weeks for their imaging to be done in March. This includes a signed-off report back to their GP. The figures highlighted in red show diagnostic investigations that did not meet the target.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Target</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>85%</td>
<td>83%</td>
<td>56%</td>
<td>68%</td>
</tr>
<tr>
<td>X-Ray</td>
<td>85%</td>
<td>99%</td>
<td>86%</td>
<td>99%</td>
</tr>
<tr>
<td>MRI</td>
<td>75%</td>
<td>42%</td>
<td>83%</td>
<td>88%</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>75%</td>
<td>89%</td>
<td>71%</td>
<td>79%</td>
</tr>
</tbody>
</table>

2 The fees for 0-5 years olds and 65 plus are for all patients within those age bands. The fees presented for 6-18 year olds and 18-64 year olds are for patients who are quintile 5, and/or high user health card or community service card holders.
The three DHBs did not meet the target for CT imaging in March. Auckland DHB did not meet the target for CT in March due to equipment failures. The CT scanner in Emergency Radiology was down for four days and all non-urgent CT scans were cancelled to allow for emergency and acute scans. Waitemata fell just short of the CT target by four patients. A plan is in place to extend the outpatient scanning hours to 2030hrs three days a week to match increased demand.

Waitemata DHB did not meet the target for MRI procedures for March. An additional MR scanner is to be commissioned in April followed by upgrade of the existing scanner with doubled capacity coming fully on stream in July. It is expected that once commissioned, performance will improve considerably. Both Auckland and Counties Manukau MRI wait times have improved over the last quarter. Auckland DHB has done considerable work on auditing the wait list and improving patient throughput. It continues to outsource to a private provider until November 2014 when the new MRI scanner will be installed at Greenlane Clinical Centre.

There is a well-recognised nationwide shortage of sonographers which restricts ultrasound capacity in both public and private sectors. All three DHBs need to supplement capacity through private provided ultrasounds. Auckland DHB did not reach the target of 75% in March.

**Equity of access**

Monthly reports document the number of procedures that are performed by the DHB radiology versus the private providers. There is little difference between the ethnicity and quintile of those patients being seen in Auckland DHB radiology or private radiology (under 2% variation). Below are charts of the total radiology procedures delivered both in private and Auckland DHB, by ethnicity and quintile.
Primary Options for Acute Care (POAC)

The Primary Options for Acute Care (POAC) service provides responsive coordinated acute care in the community with an aim to reduce acute demand on hospital services and allowing patient care to be managed close to home.

Funded by the three Auckland DHBs, POAC offers a safe and effective alternative to a hospital presentation or admission. Clinical pathways and policies support consistent practice and drive greater safety and quality of care. The annual target of POAC referrals is 5,700 for Auckland DHB, 6,150 for Waitemata DHB and 11,623 for Counties Manukau DHB. 85% of POAC interventions will avoid the patient needing to go to hospital.

- The numbers of Auckland and Counties Manukau DHB POAC referrals (July 2013 – March 2014) are currently below the target (see table below).
- GP referrals have reduced and the lower volumes can be attributed to:
  - quality improvement processes
  - implementation of new and revised clinical pathways and policies
  - improved access to diagnostics across the region. This has resulted in reduced referrals to POAC for radiology requests. There is a risk however that these referrals to POAC will increase again as practices exceed their individual budget for Access to Diagnostics.
- Training and education in Auckland and Middlemore hospitals will continue and has resulted in a significant increase in POAC referrals from the hospitals.
- Waitemata DHB volumes and budget will require monitoring for the next three months to avoid over run. Risk mitigation strategies are in place.
- St John transport expanded their service to include transporting patients to the GP/medical home in quarter one. The volumes for quarter two and three have been lower than anticipated. In response to this a 0.5 FTE position has been appointed for a period of six months to provide support to St John internal process development and education and act as a clinical advisory role for the service. This will include reviewing of cases to identify missed opportunities and provide a feedback loop with the ambulance crews. The St John transport guidelines have been amended to

<table>
<thead>
<tr>
<th>Quintile of patients accessing radiology - Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quintile 1</td>
</tr>
<tr>
<td>Quintile 2</td>
</tr>
<tr>
<td>Quintile 3</td>
</tr>
<tr>
<td>Quintile 4</td>
</tr>
<tr>
<td>Quintile 5</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>
loosen the exclusion criteria and increase potential opportunities for managing patients in a primary care location.

- Regional Renal Colic pathway has been implemented within POAC service providing access to CT investigations. Key measurements have been determined and the pathway will be regularly audited and reviewed as required.
- The average cost per referral was lower across the whole region compared with the same time last year. This can be attributed to changes in clinical policies and revised provider agreements negotiated.
- The number of POAC referrals from the Auckland regional hospitals to support discharge continues to steadily grow.

### Year to date (July 2013 – March 2014) referrals for Metro Auckland DHBs

<table>
<thead>
<tr>
<th>POAC referrals</th>
<th>Auckland</th>
<th>Waitemata</th>
<th>Counties</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target number of POAC referrals</td>
<td>4531</td>
<td>4890</td>
<td>9240</td>
<td>18,661</td>
</tr>
<tr>
<td>Actual number of POAC referrals</td>
<td>3138</td>
<td>5858</td>
<td>5763</td>
<td>14,759</td>
</tr>
<tr>
<td>Difference between target and actual</td>
<td>-1393</td>
<td>968</td>
<td>-3477</td>
<td>-3902</td>
</tr>
<tr>
<td>Avg cost per referral (budget $200.00)</td>
<td>$182.32</td>
<td>$169.03</td>
<td>$189.46</td>
<td></td>
</tr>
</tbody>
</table>

### e-Referrals

- Increase uptake of e-Referrals by general practitioners and implement referral templates for remaining procedures

  - Important progress has recently taken place in the regional eReferral project. This includes the implementation of the electronic triage functionality in Concerto, and the extension of the use of eReferrals to the services of allied health and older persons health.
  - In Waitemata, the use of electronic triage for managing referrals has started with paediatrics and rheumatology, with cardiology to follow soon. Other services (such as skin cancer) are also expected to begin soon. The advantages for all parties (patients, referrers, and secondary care providers) include safer and faster management of referrals, and the ability to communicate quickly to GPs using electronic messaging.
  - The messaging can be used to seek further information about a referral, or provide advice which might obviate the need for a hospital appointment. Furthermore, triage by the specialist can take place in any geographical location (including overseas, as has happened in the case of rheumatology). These new developments add value for referring GPs and are expected to drive further increases in the uptake of eReferrals.
  - Waitemata DHB has the highest uptake across the Auckland region with over 5000 referrals/month and over 60% of referrals being sent electronically. The largest number of referrals by far is to radiology, where referrals submitted using the decision support criteria built into the forms are not triaged but added directly to the booking list (faxed referrals continue to be triaged). The regional project is currently focussed on planning for inter and intra-hospital eReferrals (phases 2.3 and 2.4). The Concerto vendor Orion has a product which is being evaluated for suitability, and a decision is expected soon, with business cases to follow.
  - The Waitemata DHB executive has asked for the acceleration of e-referrals to become a major priority for the DHB.
**Localities**

Earlier in 2013 the Locality Establishment Governance Group (LEGG) approved the boundaries of localities as those of local board areas. Tāmaki, West Rodney and West Auckland were identified by the LEGG as the three focus areas across Auckland and Waitemata DHBs.

### Tāmaki
- Mental health has been selected as the priority for the Tāmaki locality.
- A second workshop was held in April where the community and health professionals came together to create a range of projects to address the identified mental health needs of the Tamaki community.
- The workshops produced over 750 ideas that have been subsequently grouped into 32 possible projects. The projects have been grouped into three high level work streams:
  - Building Mental Health capability in primary care
  - Effective navigation between primary care and the community through care navigators and peer support
  - A physical, virtual and mobile community wellness hub
- Project charters have been drafted for three possible projects and have been provided to the Steering Group and the project sponsors for comment prior to submission to Auckland DHB Senior Management for approval for funding.
- All three projects are to develop business cases at this stage. More detail is provided in the Project Charters section below. In addition the Tamaki project is seeking support from an ISG to help develop the projects. An application for this support has also been drafted.

### West Rodney
- Focus during quarter three has been on scoping and initiating the first two West Rodney workstreams: ‘Improving West Rodney child oral health’ and ‘Improving access to services’.
- These workstreams were identified as a result of our engagement with West Rodney health providers, NGOs and communities to understand what health services could be improved in the area. These areas were also supported by the results from the West Rodney locality profile which was finalised in December 2013 and describes the health needs, service use, and population characteristics of the West Rodney area. A copy of the report can be found at [www.waitematadhb.govt.nz/PlanningConsulting.aspx](http://www.waitematadhb.govt.nz/PlanningConsulting.aspx).
- We continue to engage and keep the community informed of progress via email updates, attending local community meetings, and meeting directly with the six West Rodney general practices. Updates are also posted on our West Rodney localities website which has been created on health point [www.healthpoint.co.nz/specialists/other/auckland-north-localities/](http://www.healthpoint.co.nz/specialists/other/auckland-north-localities/). This is supported by a formal communications and engagement strategy that was developed in quarter three. The strategy was developed collaboratively with the DHB, Health Link North and Te Rūnanga o Ngāti Whātua and includes ongoing engagement with West Rodney Māori communities.
- Planning has begun for a follow-up West Rodney locality forum in June and a South Kaipara Health and Wellbeing Festival (led by Health Link North) in September. These forums will provide further opportunities to engage with West Rodney communities around the progress being made.
- Engagement with wider sectors such as the local Rodney Board and Auckland Council has also been initiated. Representatives of the Auckland Council special housing office presented to our localities operational groups on the long and short term growth within our locality areas which is helping to inform our locality planning.
West Auckland

- The focus continues to be the two clinical workstreams: diabetes and child health. The secondary care specialists involved in the workstreams are providing governance and leadership for the integration work. LEGG has requested that the clinical workstreams are put forward to the Metro Clinical Governance Forum once established. The first meeting is expected in May.

- The West Auckland Diabetes working group continue to support three priorities with a focus in New Lynn initially;
  1. **The implementation of the Quality Improvement Team (QIT)**. Recruitment for a Registered Nurse is in progress with the position advertised for a third round again in May. Once in post, the nurse will be on working with practices across West Auckland to improve diabetes care with a focus on improving care for Māori and Pacific populations.

  2. **The development of an integrated diabetes model of care**. Four clinics and lunchtime educational sessions have been held in Totara Health, New Lynn since the pilot began in October 2013. Practice GPs and nurses are invited to attend the consultation with the specialist to support upskilling. These have not been well attended so far by clinicians within the Integrated Family Health Centre (IFHC). Therefore alternate options are being considered for patients within the wider cluster such as virtual clinics or chart reviews, the use of care plans and shared care tool and nurse specialist clinics. There are now Diabetes Nurse Specialists offering clinics within Whānau House, Henderson and Totara Health, New Lynn. The Whānau House service is for Māori patients only and work is underway to support wider integration with primary care and other service providers.

  3. **Facilitation of network development to support improved diabetes care**. Without a Clinical Director in post there has been little interaction with the surrounding GP practices although they are invited to the lunchtime educational sessions. Some of the DHB services operating out of Totara Health Services are continuing to use the clusters as their referral mechanism. These linkages will hopefully be strengthened through the QIT workplan. There has also been some work by an independent facilitator with a subset of New Lynn cluster practices to look at a number of diabetes performance initiatives which is to be progressed next year. This will work in parallel to the QIT.

- The child health working group developed two project scopes to focus on Asthma at Whānau House and Cellulitis at Totara Health. These were two of the highest causes of child admissions to the emergency departments in 2012. The scopes were focused on the implementation of best practice guidelines and coincided with the Greater Auckland Integrated Health Network (GAIHN) work in these areas. The project manager for this work has since left the organisation and the project scopes are being reviewed.

Greater Auckland Integrated Health Network

Greater Auckland Integrated Health Network (GAIHN) was established in 2010. It is a partnership between the Auckland, Waitemata, and Counties Manukau DHBs, and ProCare, Auckland, East Health and Total Healthcare PHOs. The purpose of GAIHN is to strengthen integration between primary and secondary care, and the regional capacity of primary care to reduce avoidable hospital admissions. The work programme has four work streams: (1) Identification and management of high risk individuals, (2) Better response to acute events in the community, (3) Enablers of better individual care, and (4) Child health across the work streams. It has been agreed with all parties across the Greater Auckland Integrated Health Network that the work programme will transfer accountabilities to the two new Alliances.
Work Stream 1: Better management of high risk individuals

a) Develop a predictive risk algorithm (to identify patients with a high risk of admission to hospital).
   - Patients at Risk of Readmission (PARR) tool based on secondary data: DHBs continuing to provide lists of patients, with risk score, to engaged PHOs.
   - Predictive risk tool based on combined primary and secondary care data: Regional Privacy Advisory Group permission was granted to proceed with data collection and analysis. DHB and PHO data for 110,000 patients, across four years was selected, anonymised, and provided to Sapere for analysis.
   - Regional Data Sharing Framework: GAIHN Alliance Leadership Team agreed to proceed with this initiative. This will support implementation of the combined predictive risk tool, as part of a broader infrastructure that includes several defined uses of data sharing. A proposal for Phase 2 (design) has been sought.

b) Enhanced integrated care for patients at high risk of admission
   - Pilot projects to enhance integrated care for patients at high risk of admission are in development and early implementation stages at Counties Manukau Health and Waitemata DHB.
   - Development of a high risk individual regional pathway: A pathway has been developed through the GAIHN pathway work stream. Discussions with pilot practices highlighted the need for changes in resourcing and the model of care to implement the pathway. It has been referred to Clinical Pathway Implementation Group (CPIG) to consider resource implications.

c) Evaluation
   - Implementation of The National Institute for Health Innovation’s (NIHI’s) evaluation methodology has not commenced.
   - Professor Rhema Vaithainathan (who developed the PARR predictive risk algorithm) is working with Procare to evaluate the impact of the tool on avoidable admissions using a case-control methodology.

Work Stream 2: Better response to acute events in the community

a) Urgent Care Network
   - The Urgent Care Network was established as an extension of the After Hours Network to include in-house care, St John and ACC. The network has developed a 12-month work programme and a three year strategic plan. Key areas of focus include after hours, St John service delivery plan, metrics, primary care model of care, communications, telephone triage and governance. The first meeting of the year was held in March and focused on updates of the key actions in the Urgent Care Plan.

b) St John
   - The extension to the St John transport initiative to include the medical home (own GP), and to transport low acuity patients to an A&M facility as an alternative to a hospital emergency department (ED) has continued. On average 50 – 60 patients are transported each week to an A&M reducing low acuity attendances to ED.
   - A review of the St John initiative (carried out by the University of Auckland) highlighted the need to improve communication and support for front line ambulance officers in order to improve uptake. To address this, GAIHN contributed funding to a new role providing education and support for St John frontline staff, in relation to transport options. A position description and key deliverables were agreed.
   - Continued support for the development of a referral pathway to District Nursing services.
   - Clinical guidelines have been reviewed and signed off by the Alliance Clinical Network (ACN), Urgent Care Network (UCN) and awaiting sign-off by POAC Clinical Governance Group.
c) Metrics
- A metrics framework has been reviewed and has initially been applied to the Mangere locality to test its utility. Population level data for use of After Hours urgent care facilities in Mangere was presented to the Locality Leadership Group and clinical leads. The locality has expressed a keen interest to see the data at a practice level, and this is being explored with the PHO. The report and data presentation to be completed by end of June.

d) Model of Care
- Urgent Care in Primary Care: Implementation of the UK’s Primary Care Foundation tool has been delayed by the limited availability of practice staff. Data collection has however taken place and the tool will be completed during quarter four.
- Home Visiting in Primary Care: A literature review was completed in quarter three and a ‘strawman’ presented to the ACN and the UCN. A survey for primary care to understand current practice regarding home visits for urgent needs to be carried out in quarter four. This will inform on-going developments.

e) IV service for aged residential care residents in the Auckland district
- Following a review of the IV service a new service provider has been identified. This will improve flexibility of the service thereby increasing uptake. The service has now been extended across the region and will be managed and governed by POAC.
- The Community Acquired Pneumonia pathway has been reviewed, and as a result a new clinical pathway group has been established. The Community Acquired Pneumonia in Aged Residential Care pathway should be completed by the end of June.

Work Stream 3: Enablers of better care
Pathways
a) Development
- 37 pathways have been completed and uploaded to the Healthpoint website (www.healthpointpathways.co.nz/northern/). An additional 12 pathways are in development with six due for sign off at ACN in May.

b) Implementation
- Implementation has focused on renal disease and atrial fibrillation pathways. Clinical Pathway Implementation Group (CPIG) has also commenced resource planning for the high risk individual pathway, with specific focus on options for configuring care coordinator role.

c) Evaluation
- Completed two-yearly review of dyspepsia and iron deficiency pathways. The Deep Vein Thrombosis (DVT) pathway is currently under review.

d) Clinical Pathway Enabler Tool
- Preparation for the Proof of Concept, including detailed planning, training, preparation of communications and education packages, and confirmed practices. Note that the start date has been delayed due to delayed release of DHB funding.

4. Primary Care Nursing

Auckland DHB and Waitemata DHB both run a Nurse Entry to Practice (NETP) programme for nurses wanting to begin their career in a primary health setting. The programme is approved by the Nursing Council of New Zealand and is focused on helping new graduate to achieve competence as soon as possible.
Waitemata DHB

- 12 primary health care new graduates started in the NETP programme in February 2014 in a variety of primary care settings. Three of these are funded by the MOH very low cost access (VLCA) funding to support new graduate nurses in VLCA practices. One is funded with MOH aged residential care funding. The four new graduate nurses who started in September 2013 continue in their general practice and aged residential care settings and are undertaking an AUT post graduate paper. All the new graduates are supported by the Waitemata DHB Primary Health Care Nurse Educators.

Auckland DHB

- Four new graduate nurses started in February 2014 with three supported by the MOH VLCA funding. One graduate in the September 2013 intake continues in a general practice setting and is undertaking a University of Auckland post graduate paper. All these graduates are supported by the Auckland DHB NETP Programme.

Combined Auckland and Waitemata DHB Primary Health Care Nursing Reference Group

- This group is now well established and includes nursing leaders across the Primary Health Care sector including representation from PHOs, NGOs, School Nursing, District Nursing, Public Health Nursing, University Schools of Nursing and Plunket. The group is currently working on developing a Primary Health Care Nursing strategy and is chaired by the Primary Health Care Nursing Director. This group is meeting with Counties Manukau DHB Primary Health Care nursing reference group next week to begin some regional sharing of successful strategies and work plans.

5. Primary care operational issues

PHO Performance Programme

The PHO Performance Programme (PPP) has been designed by primary care representatives, DHBs and the Ministry of Health to improve the health of enrolled populations and reduce inequalities in health outcomes through supporting clinical governance and rewarding quality improvement within PHOs. Improvements in performance against the indicators result in performance payments to PHOs.

PPP targets are based on the previous performance of the PHO. A number of the PPP indicator targets are negotiated between the PHO and the DHB. The remaining PPP indicators are set on a trajectory towards the Programme goal. Targets are set for the high needs population and the total population.

The Auckland Metro DHBs have taken a joint approach to negotiating and setting the 2014 PPP targets across the PHOs. Historically for some PPP indicators the high needs targets have been set lower than the total population. The process aimed to align the high needs target and the total population target and therefore eliminate the gap.

The longer term goal is for all PHO related targets to be the same for each PHO. This means that irrespective of which PHO a person is enrolled with, the same target will be applied. The DHBs and PHOs will work together in aligning the targets over the coming years.

The above two initiatives aim to increase the health gain of our high needs population and ensure a consistent population health outcome.

The purpose of the PPP report is to provide information on how a PHO performs against the nationally consistent indicators.
This performance programme is soon ending. This will be replaced by the Integrated Performance and Incentive Framework (IPIF).

The graphs below show performance at quarter three 2013/14, compared to target and historical performance (quarter three 2012/13).

The graph below shows ‘Cervical Screening Coverage’ across Auckland and Waitemata DHB PHOs. All PHOs met this target in quarter three but the National Hauora Coalition (NHC) and Waitemata PHOs’ high needs populations were slightly under target.
The graph below shows ‘Breast Screening Coverage’ across the six Auckland and Waitemata DHB PHOs for high needs populations. All PHOs met this target in quarter three.

![Breast Screening Coverage - High Needs Population](image)

The graph below shows ‘Ischaemic CVD Detection’ across Auckland and Waitemata DHB PHOs. All PHOs met this target in quarter three and most PHOs are significantly exceeding the target for high needs populations.

![Ischaemic CVD Detection](image)
The graph below shows ‘Diabetes Detection’ target for Auckland and Waitemata DHB PHOs. All are now meeting or exceeding the target of 90%, but performance for Waitemata PHO has declined significantly since last year.

The graph below shows ‘Diabetes follow-up after Detection’ across Auckland and Waitemata DHB PHOs. Procare is not meeting three out of their four targets for this indicator.
The graph below shows that with the exception of NHC, all PHOs met the ‘Smoking Status Ever Recorded’ target for quarter three.

The graph below shows ‘Influenza Vaccination Coverage’ across Auckland and Waitemata DHB PHOs. Targets are only set for this indicator for July-December, so quarter three performance is not shown against a target.
The graph below shows ‘Immunisation Coverage for 2 year olds’. Procare Auckland, NHC (high needs) and Waitemata PHO (total population) are not meeting the target in quarter three, although all PHO’s performance has increased on last year.

**Immunisation Coverage - 2 year olds**

<table>
<thead>
<tr>
<th></th>
<th>Auckland PHO</th>
<th>Procare NHC</th>
<th>Alliance Health+</th>
<th>Waitemata PHO</th>
<th>ADHB ProCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance 2014</td>
<td>93%</td>
<td>93%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>Target</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
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<tr>
<td>Performance 2013</td>
<td>82%</td>
<td>87%</td>
<td>92%</td>
<td>89%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**PHO enrolment data**

The graphs below show the number of people enrolled with each PHO, by ethnic group, for Auckland and Waitemata DHB. Using 2013 population projections, it is estimated that 80% of Māori living in both the Auckland and Waitemata DHB areas are registered with a PHO. Non-Māori enrolment rates are 94% and 95% for Auckland and Waitemata DHBs respectively.

Some of the under-enrolment will be due to data quality issues with misclassification of Māori as other ethnic groups – most commonly as NZ European. We are not able to accurately quantify the extent of this misclassification at the moment. Auckland and Waitemata DHBs have recently received confirmation that their proposal to implement the primary care ethnicity data audit tool has been accepted by the MoH. This tool will assist general practices to improve the quality of their ethnicity data through an audit process. The audit process will identify where improvements to their systems, protocols and processes for collecting, inputting and outputting ethnicity data can be made. If these changes are implemented, the quality of ethnicity data in primary care will improve over time. Please note that the audit process will not provide quantification of the extent of misclassification currently.
### Appendix 1: After Hours Network Report

#### Summary Year to Date (Period ending March 2014)

<table>
<thead>
<tr>
<th>Medical ED Afterhours Hub</th>
<th>Medical AM Afterhours Hub</th>
<th>Summary Year to Date</th>
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5.2 Planning, Funding and Outcomes Update

Recommendation:
That the report be received.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Ruth Bijl (Funding and Development Manager Child, Youth and Women’s Health), Kate Sladden (Funding and Development Manager Health of Older People), Lita Foliaki (Pacific Planning and Funding Manager), Tim Wood (Funding and Development Manager Primary Care) and Samantha Bennett (Manager Asian, Migrant and Refugee Health)
Endorsed by: Dr Debbie Holdsworth (Director Funding), Simon Bowen (Director Health Outcomes),

Glossary

ARDS - Auckland Regional Dental Service
ARRC - Age Related Residential Care
B4SC - B4 School Check
CALD - Culturally and Linguistically Diverse
DHB - District Health Board
DML - Diagnostic Medical Laboratories
DSS - Disability Support Service
ESBHS - Enhanced School Based Health Services
GNS - Gerontology Nurse Specialist
GP - General practitioner
HBSS - Home Based Support Services
HPV - Human Papilloma Virus
IMS - Information Management Services
LMC - Lead Maternity Carer
LTS-CHC - Long-Term Supports for Chronic Health Conditions
NCSP - National Cervical Screening Programme
NSU - National Screening Unit
NRA - Northern Regional Alliance
PFC - Paid Family Carer
PHO - Primary Health Organisation
TAG - Technical Advisory Group
VHT - Vision and hearing test

1. Summary

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

1. Planning Update
2. Women, Children and Youth Update
   a. Development of Women, Children and Youth Scorecard
   b. Immunisation
   c. Cervical Screening
   d. Maternity - Women’s Health Collaboration
   e. Maternity - Early Engagement Survey
   f. Youth - Auckland Youth Health Alliance
2. Progress Updates

2.1 Planning

The final drafts of both the Waitemata and Auckland DHB Annual Plans 2014/15 were submitted to the National Health Board on 26 May 2014 as required. Final versions had been approved at respective DHB Board meetings in May. Updated versions of Auckland DHB’s Financial Performance and introductory sections are still to be provided. Further updates of the Plans will be completed in line with any further feedback from the National Health Board. Initial work has begun on both the Auckland and Waitemata Annual Reports 2013/14.

2.2 Women, Children and Youth Update

2.2.1 Development of Women, Children and Youth Scorecard

In 2012, CPHAC signed off the Child Health Improvement Plan 2012 – 2017. One of the commitments made in the Plan was to report at least annually to the Board against a range of child health indicators. In line with other reporting to the Board we propose a scorecard which covers not only Child Health indicators but also key indicators for Women and Youth.

The purpose of the scorecard will be several-fold including to:

- Inform progress against core child health indicators, including Ministry of Health Targets, Maori Health Plan indicators, Well Child Tamariki Ora Framework indicators, B4 School Check indicators and others identified as important for both DHBs,
- Monitor improvement in equity of access to services and health outcomes,
- Monitor critical processes required to improve child health outcomes.

The scorecard being developed includes a range of core indicators reported quarterly with some indicators added for the purpose of annual reporting where numbers are too small for the purpose of meaningful quarterly reporting. We intend to report the core indicators to alternate CPHAC meetings along with a brief commentary. For this month we present more detailed comment on Immunisation and on Cervical Screening. This update also covers some other areas where significant work is underway for Women, Children and Youth.

2.2.2 Immunisation

Performance against the National Health Target
Performance against the national health target for immunisation is being exceeded by both DHBs though results declined in Auckland DHB over the quarter. The target is 90% of eight months olds will have their primary course of immunisation on time by July 2014. The quarter two results were:

- **Auckland DHB 93% Total; Maori 86%; Pacific 92%**
  - This is a decrease of 1% Total; 5% Maori; 1% Pacific from the previous quarter
  - Practice merges and introduction of the influenza vaccine on the National Immunisation Register may account for some delay in timeliness of immunisations.
- **Waitemata DHB 93% Total; Maori 89%; Pacific 95%**
  - This is an increase of 1% Total; 2% Maori; 1% Pacific from the previous quarter.

**Current activity**

We are working with Waitemata and Auckland DHB PHOs and practices with overdue vaccination episodes to improve timeliness. In addition we are:

- Working with PHOs to provide targeted support to a merged Auckland practice with low coverage rates and high Maori population to encourage newborn enrolment, precalls and recalls and identify infants overdue for immunisation.
- Promoting Immunisation Week 2014 including offering immunisations in Starship outpatients which was visited by Assoc. Minister of Health Jo Goodhew.
- Introducing the Immunisation Status on Starship Paediatric Electronic Discharge Summary.
- Adding influenza vaccine on the National Immunisation Register for adults.
- Working with Auckland Regional Public Health and Counties Manukau DHB on a Regional Focused Control Response to the measles outbreak.

Other planned activity includes:

- Working with primary care partners and the Maori health team to develop a multi-provider case review group to identify opportunities for collaboration and service improvements for Maori infants in West Auckland.
- Extending opportunistic immunisations through the in-patient services of both Starship and Waitakere paediatric hospitals.
- Developing early indicators of change in practice performance to support systematic early interventions.
- Introducing the Immunisation Schedule change, including the rotavirus vaccine from 1 July 2014.

**Measles**

As of 13 May, 109 cases of measles were confirmed in Auckland during 2014. Twelve of these acquired measles while travelling overseas, the others are mostly contacts. Nearly half of the cases are linked to Westlake Boys High School (52) though this series appears to have ended. Measles is spreading in the community. The best protection remains immunisation. The last time Auckland had a measles outbreak, in 2011-12, there were 500 cases with 82 requiring hospitalisation. So far during this outbreak there have been 24 hospitalisations (9 ADHB, 7 Waitemata DHB, 8 CMDHB).

There is continued surveillance for measles, and ongoing efforts by local public health services, hospitals and primary health care practices in tracing cases and contacts. The DHBs are promoting resources to remind health professionals, patients and travellers of the...
importance of being immunised before overseas travel and to be alert for measles symptoms, especially on return from overseas.

2.2.3 Cervical screening
The most recent cervical screening coverage results available from the National Cervical Screening Programme (NCSP) are for December 2013. Three year coverage for Auckland and Waitemata DHB is stable; Auckland DHB 76.9% and Waitemata DHB 76.2% (national target 80%). Ethnic-specific coverage remains much lower than overall coverage, although it is noted that there is a small improvement in the rate for Māori women, which may be attributable to the Waitemata DHB cervical ethnicity project.

The National Screening Unit (NSU) has confirmed regional coordination service funding for a further two years. Free smears for the whole metro Auckland region have been consolidated and increased by the NSU to 8500 per annum for 2 years; these will be allocated to the metropolitan Auckland DHBs through the regional coordination service. Free smears will continue to be targeted to high risk priority women (never screened or not screened for five or more years).

Further detail is provided below on four main activities:

- Review of the Auckland Regional Cervical Screening Coordination Service
- Pilot Data Matching project
- Best Practice Manual (“How to Guide”)
- Pacific review of high coverage rates for Pacific women in the Auckland central region

Some new information on primary HPV screening and self-testing is also provided.

Review of the Auckland Regional Cervical Screening Coordination Service
An independent review of the coordination service has been undertaken. The aim of the review was to assist in identifying changes needed to improve the service specifically in relation to the key goals of increasing coverage and equity. The report recommends that the metro Auckland DHBs continue to support the cervical screening coordination through one consolidated regional service. Recommendations regarding structures and governance will be implemented. Other recommendations regarding the optimal location and FTE allocation of the coordination service need further consideration.

Pilot Data-Matching Project
A proposal for regional data matching between the seven Auckland PHOs and DHB Shared Services has been outlined in previous CPHAC updates. Data-matching is considered to be a critical platform for a step-change in primary care activity to support the achievement of the national target. The planned data-match is between a large PHO (all eligible women aged 20-69 years old based on practice registers) and the National Cervical Screening Programme (NCSP)-Register. This match process provides PHO and practice level accurate and complete data on all women who have:

- Never had a smear (and are therefore not on the register).
- Are overdue for a smear.

These lists are then further prioritised on length of time overdue and clinical risk (based on smear history) to assist practices in inviting or recalling women (in association with free smears). Previous PHO data-matching has clearly demonstrated that these steps are necessary to generate practice action.
The data-match has been successfully trialled. Appropriate practice level communications are now being developed to be provided to practices along with their own data. The project has been presented to the Privacy and Security Governance Group at Waitemata DHB, and will be presented shortly to the regional Privacy group. The group was appreciative of the nature of the project and the protections in place to manage data of this nature, and suggested some additional measures for the transfer of information from the PHO to the practice, which are currently being implemented.

Through learnings from previous PHO data-matches it is clear that the communications element is critical for practice understanding and action. To address this, a specific sub-project is included to look more in-depth at what works at the practice level in terms of communication and to strengthen the feedback loop with the regional register team to manage any queries.

**Best Practice Manual (“How To Guide”)**
The Cervical Screening “How To Guide” has been produced by the regional coordination service, and is now available in hard copy and online. The model is based on the successful ADHB immunisation operational guide that supported practice level process improvement towards achieving the immunisation target. The purpose of the Cervical Screening “How To Guide” is to support cervical screening best practice at a general practice level, to improve coverage with a particular focus on priority group women. The Guide was developed in consultation with PHO-nominated smear-takers across the Auckland region and has been reviewed and endorsed by the NCSP Clinical Advisor. The resource does not replicate existing guidance; it focuses on how to implement the policies, standards and guidelines provided by the NCSP. It is intended to provide a common point of reference for health practitioners and to support leadership through identification of strategies for improvement which complement current practice. It includes a practice self-audit process to determine areas for improved systems and processes.

The “How To Guide” is now ready to be implemented in primary care. A clinically trained (practice nurse with expertise in cervical screening) coordinator will work with PHOs to communicate and implement the resource across primary care. A small number of practices will be identified to receive operational support to improve their systems and processes. This systematic improvement is expected to provide a better foundation for identifying and offering cervical screening to women.

**Cervical Screening Pacific Review**
A project has been commissioned to understand the high cervical screening coverage rates for Pacific women in Auckland DHB (86% Auckland vs 65.8% in Waitemata DHB and 64% Counties Manukau DHB). The Auckland DHB Pacific rates have been sustained at this level for the last two years. This project is now underway.

The purpose of the review is to provide a comprehensive, independent, investigation into the historical and current data, and initiatives undertaken in the Auckland DHB area to improve Pacific cervical screening rates. The Project will make recommendations for improving cervical screening coverage for Pacific women living in Waitemata and Counties Manukau DHB areas.
Primary HPV Screening and Self-Testing

Human Papilloma Virus (HPV) is the causal factor in virtually all cases of cervical cancers, and a range of other genital tract, rectal and oro-pharangeal cancers. These cancers are preventable through HPV vaccination programmes. HPV can be detected in laboratory samples.

There is now substantial evidence that testing to detect HPV on samples of cervical cells is a far superior test than the currently used conventional smear to predict pre-cancerous cervical changes (Cervical Intraepithelial Neoplasia CIN2/CIN3) that can be treated to prevent cervical cancer. There is also evidence that using HPV testing in the setting of a cervical screening programme can safely be done starting at a later age (25 or 30 years), with a longer interval between testing (5 years). The potential to change to a primary HPV programme therefore offers the possibility of a better test (detecting more pre-cancerous changes and detecting these earlier, therefore preventing more cancers) with less burden on women. There are current studies underway, including in Australia, to examine the costs and cost-effectiveness of this potential programme change. There are already several countries which have moved to primary HPV cervical cancer screening, and many countries which are moving that way in the near future, including Australia.

The Australian study examining primary HPV screening, called the COMPASS study, includes a small New Zealand arm (approximately 500 women in the metro Auckland region). This study arm is designed as a service evaluation project, to assess how the laboratory manages the testing, what the associated costs are, and an assessment of understanding of the changes for practitioners and women involved. The study is being run by Diagnostic Medical Laboratories (DML) and is endorsed by the NSU. The study has received ethical approval is currently being examined by the DHB local Research Review offices.

The current test for HPV uses the standard collection method as used for a pap smear. In New Zealand cervical cells are collected for a pap smear in a liquid medium (called Liquid Based Cytology), and HPV testing can also be performed on the same sample if it is required. Instead of the sample being analysed by cytology (looking at the cells under a microscope), in the setting of primary HPV screening the sample would be tested for the presence of HPV (using one of the HPV tests approved by the NSU) and cytology would not be performed.

Because the same mechanism for collecting the sample would be used for women (even though the test performed at the laboratory is different) there is the potential that the inequalities in cervical screening coverage would persist for any new programme using primary HPV testing. In order to address this there has been considerable activity to develop a

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1 There are a large number of subtypes of HPV. There are 14 subtypes which are known to cause cancer (called oncogenic or ‘high risk’ subtypes). For cervical cancer the commonest linked subtypes are 16 and 18, and these subtypes are covered by HPV vaccination. Other HPV subtypes cause genital warts and warts elsewhere on the body.

2 The strength of this evidence comes from one extremely large cross-sectional study in the United States and four randomised controlled trials in Europe. There have now been several rounds of testing using HPV as a primary screening test in these trials, and over a million woman-years of follow up in terms of safety and efficacy.

3 This is because approximately 80% of people ‘carry’ HPV by the time they are in their 30s (linked to sexual behaviour), however approximately 90% of HPV infections are cleared by the immune system very rapidly. The HPV infections that cause cell changes that ultimately lead to cancer are those infections that are persistent and are not cleared by the immune system.

4 The current NCSP Guidelines recommend HPV testing in certain settings to help distinguish difficult cases and also as a ‘test of cure’ after having colposcopic treatment for pre-cancerous changes.
self-testing kit. This kit would be a standard swab for women to perform a vaginal self-test (the cells do not have to be cervical cells). There are two possible applications for this test – it is currently being examined for women who present to a health practitioner but who do not want to have a smear test examination. However there is the important potential second use for the self-test kit to be used for unscreened or under-screened women in a ‘mail out’ setting similar to bowel screening. The current evidence suggests that the HPV test on self-test kits performs at least as well as a pap smear and cytology, although not quite as well as practitioner directed cervical HPV testing. This makes it very promising as a way of improving cervical screening coverage and reducing inequalities in the near future.

There are currently no commercially available test kits approved by the NSU for use in New Zealand. However there is a trial which is nearly completed in Australia (called the iPAP trial, as well as other international studies), and if the results are favourable then the NSU will consider piloting it in New Zealand. The metro Auckland region would be a good location to examine the impact that self-testing could have on improving coverage. Metro Auckland Cervical Screening Governance Group is involved in on-going discussions on primary HPV testing and self-testing, as well as following the small DML primary HPV testing study underway this year.

Overall, the focus and coordination of activities associated with cervical screening is gaining momentum. Clearly, we expect this to translate to increased coverage rates for Maori, Pacific and Asian women in particular.

2.2.4 Maternity - Women’s Health Collaboration
In the March 2014 CPHAC meeting we provided a first report to CPHAC on the Women’s Health Collaboration between Auckland and Waitemata DHBs. The Collaboration focuses on maternity services across both DHBs and takes a ten year planning horizon in relation to the configuration of maternity services across both districts.

The March CPHAC questioned the project design in relation to the engagement and participation on the governance group of Maori, Pacific, Asian and Consumers. In response, the Health Gains Managers Maori, Pacific and Asian have become members of the Governance Group. To select consumer representatives, we went through a nomination process and now have two consumer representatives, Isis MacKay (ADHB) and Jesse Solomon (WDHB). They will attend the group for the first time on 4 June 2014. Both have participated as consumer representatives on the DHBs’ Women’s Health Clinical Governance Groups and are mothers of young children.

The work commissioned from Health Partners is underway. They have identified a number of areas where we need to obtain further information from women and from service providers as there are currently no adequate New Zealand data or research in these areas.

2.2.5 Maternity - Early Engagement Survey
A survey of postnatal women, Lead Maternity Carers (LMCs) and General Practitioners (GPs) regarding early engagement in first trimester care has been undertaken by Dr Karen Bartholomew (now on parental leave). The results of this work have been collated into a report by Dr Bartholomew and Dr Patricia Bolton. A total of 302 women, 68 LMCs and 29 GPs participated in the survey.

Early results suggest that two thirds of women knew that first trimester care was important, and 79 percent of women visited an LMC in the first trimester. Comparison of early (≤12
weeks) and late (≥13 weeks) booking women revealed that women needing more support to book early included those aged 20-24 years, Maori and Pacific women and women with secondary school education as their highest education level. To support early pregnancy care, women said they needed to be provided with more information on the importance of early pregnancy care from GPs and other sources, and better support to find a LMC. To enable first trimester care providers suggested that women need to be provided with information and improved resources on the importance of early pregnancy care, early pregnancy care must be free, the LMC schedule should be changed to incentivise early pregnancy care, collegial relationships needed to be improved between LMCs and GPs, GPs and practice nurses should be provided with education and resources to improve the referral process to LMCs and LMC and primary care could become more integrated.

A number of recommendations to support early engagement in pregnancy care are currently being considered.

2.2.6 Youth - Auckland Youth Health Alliance

All Auckland PHOs signed up to the Auckland DHB Youth Health Alliance in August 2013. Procare hosts the agreement. Appointments have now been made to key roles including:

- Enhanced School Based Health Services (ESBHS) Nurse Educator - Catherine Lambe
- General Practitioner Leader for ESBHS - Dr Fionna Bell
- Clinical psychologist - visiting psychologist ESBHS – Dr Casey Mendiola.

GPs have now been appointed to all nine mainstream ESBHS schools. As well as undertaking regular weekly clinics, GPs support the nurses in schools to work under standing orders to dispense agreed medicine to students. Common conditions such as skin infections are managed in the school setting. Confidentiality and access are keys to successful youth health services. Comments from Otahuhu College students regarding why they used the ESBHS emphasise this:

“because you are able to trust the health centre rather than your family doctor”.
“you know you can trust them” “because it is close”
“because my parents can’t take time off work to take me”
“no transport” “no money” “it’s free”
“it’s easy because it is at school” “they’re friendly”
“mum’s too busy” “not scary”. (Otahuhu College Annual Report 2013)

2.2.7 Children - Before School Check Programme

The B4 School Check (B4SC) is a comprehensive health and development assessment for four year olds. It is comprised of a nurse check and a vision and hearing test (VHT).

The Waitemata B4SC nurse component is delivered by Plunket and the VHT is delivered by the provider arm. The Waitemata programme is currently on track to achieve the 90% target. In early May 2014, coverage was 76% total eligible and 76% high deprivation, to be on track coverage should be at least 75%. The coverage for Maori (69%) and Pacific (63%) is lower than other (79%).

The Plunket and Vision and Hearing teams have worked together to adapt the programme to meet the needs of families. Changes to the programme have included increasing the number of joint VHT and nurse clinics, introducing home visiting by a VHT as well as the ongoing home
visiting provided by Plunket for the nurse component and providing additional school holidays clinics. To increase the Maori and Pacific coverage Plunket and VHT are identifying the children through the B4SC database and working with the families to provide a check at the venue that works best for them – either home or clinic. Te Ha o Te Oranga have entered into a subcontracting relationship to provide B4SC to children in their community. Plunket are also working with West Fono to develop a subcontracting relationship.

A B4SC quality plan has been developed in Waitemata which has a strong focus on improving equity. The quality plan will be extended across both Auckland and Waitemata and will allow us to track and monitor coverage and service delivery.

The coverage for the Auckland programme is below target at 64% total eligible population and 61% high deprivation population. The coverage for Maori (52%) and Pacific (51%) is also considerably lower than other (70%). The nurse component of the Auckland programme is currently delivered by a PHO Alliance. This agreement ends on 30 June 2014 and from 1 July 2014 Plunket will be the lead provider for the Auckland B4SC programme. The change in service provider will allow regional consistency as Plunket is also the provider of the B4SC Programme in Waitemata and Counties Manukau DHBs. A comprehensive transition plan has been developed to ensure the transition goes as smoothly as possible and that there is no decrease in service delivery. Providers are working very cooperatively to ensure a smooth transition. Under the new service delivery model Plunket will work with Well Child Tamariki Ora providers to identify opportunities for subcontracting. Plunket will also provide B4SC clinics within local communities and home visiting for families.

2.2.8 Rheumatic Fever Register
The Auckland Regional Rheumatic Fever Register is being re scoped as the current platform (MS Access is no longer supported). A paper providing options for consideration and a recommendation for implementation is being drafted by the Information Management Service with completion expected in June 2014. Estimates from a number of vendors are being sought.

The options paper will be supplied to the project sponsor (Dr Richard Aickin) with a request that this is presented to the regional CIO group if contributions to the capital cost are required.

Clinical utility will be increased with the addition of a patient management component for recording and reporting of secondary prophylaxis administration (compliance reporting to the MoH required as part of the Rheumatic Fever Prevention Plan).

2.2.9 Dental Van Issue
A situation has arisen in Canterbury affecting mobile dental vans which now affects the Auckland Regional Dental Service (ARDS) mobile dental vans. On 14th May 2014 the Ministry of Health advised DHBs that Canterbury DHB (CDHB) had identified that one of their Level 2 mobile dental vans was found to have a concentration of airborne formaldehyde. Canterbury DHB engaged an independent occupational health specialist Dr Andrew Hillier who advised CDHB on the health effects of formaldehyde exposure:

“Airborne formaldehyde is common in low concentrations, particularly where certain materials such as MDF, particle board and plywood have been used in construction (the ceiling tiles). At the kind of concentrations found in one of Canterbury’s mobile dental clinics, the risk to the general public with a short appointment is negligible. For people who worked there over a
period of time, the risk is very low, although some may have experienced acute symptoms such as itchy eyes, a headache or sore throat, which will have quickly diminished once they left that environment. In some cases it may make worse pre-existing conditions such as asthma or bronchitis.”

Canterbury DHB subsequently identified formaldehyde issues with its Level 1 mobile dental vans which are the same specification as the ARDS fleets. The fleet has 18 mobile vans across the region (seven at WDHB, six at ADHB and five at CMDHB).

As a precautionary measure the fleet of mobile vans was temporarily taken out of service as of Monday 19th May 2014. WDHB Occupational Health engaged Paragon Health Services to test the fleet of mobile vans. This testing was completed and formaldehyde levels were found to be well below the accepted workplace levels. As of Tuesday 3 June 2014 the mobile vans returned to service. Testing has also been completed in a sample of the larger transportable units, although these were manufactured by a different company using different materials. These units have continued in service. These readings were also found to be well below the accepted workplace levels.

As Canterbury DHB has identified high levels in their mobile fleet, their units remain out of service. Southland, Mid Central and Northland are at varying stages of either testing or awaiting results. Hawkes Bay are completing testing while units are in service.

2.3 Health of Older People

2.3.1 Home Based Support Services (HBSS)

Auckland DHB

The ADHB HBSS model has had an increase in the proportion of clients classified as ‘complex’, from 27% in January 2013 to 37% in January 2014. There has also been a shift up the eight complex categories from what was originally modelled using client data in 2012. Both these shifts have funding implications.

There is no convincing reason for the shift in complexity of the client population to the extent that it has occurred, over such a short time period. At the same time there has been no indication from providers that the level of service they are being required to provide has taken a sudden or marked step increase.

However, some systems and processes have changed over the last year with an increased proportion of patients now being assessed (using the interRAI Home Care assessment) in hospital prior to their discharge rather than in their homes. The increase in hospital based assessments began in mid-2012 and potentially could be inflating a patient’s acuity.

A recent analysis of Auckland DHB interRAI data has shown that patients assessed in hospital have a significantly higher complexity rating than those assessed post discharge. An audit of all HBSS clients assessed in hospital started in May 2014. The audit will determine if there has been a reduction in a client’s complexity/acuity since they returned home.

Current priorities for HBSS are:
- Finalising bulk funding payments with providers for 2013/14 in order to remain within budget
in conjunction with the University of Auckland (who developed the original cost model) realigning the cost model for 2014/15
working with Gerontology Services to ensure consistency in triaging (non-complex vs complex) and assessment processes
working with the four community providers and Gerontology Services to establish a mechanism for timely review of a client’s complexity rating.

The existing five year contract with the community HBSS providers expires on the 30 June 2014. The Audit and Finance Committee has recommended to the Board that the contract is extended for one year to 30 June 2015 and that the option of having a joint procurement process with Waitemata DHB is investigated.

Waitemata DHB
The HBSS Wait List Assessment Project commenced on 31 March 2014. Four experienced Needs Assessors have been seconded to complete assessments of people on the NASC waiting list for HBSS. All individuals on the waiting list were screened as low risk when their referrals were received but due to the high inflow of more complex patients the low risk waiting list became too long. Despite the DHB making no change to the eligibility criteria for HBSS the Needs Assessors are finding a significant number of people on the waiting list do not require any HBSS at the time of assessment. When the needs assessment is completed both the individual and their GP are sent a letter to confirm the results; these are also discussed with the person at the time of the assessment.

2.3.2 Paid Family Carer Policy
In May 2013, as part of the Budget Legislation, Parliament enacted the New Zealand Public Health and Disability Amendment Act 2013, which inserted a new Part 4A in the Act called family care policies. This amendment Act was a response to Court decisions in Atkinsons and Others v Ministry of Health that the Ministry of Health’s blanket policy of not paying certain family members to provide disability support for their disabled family members amounted to unjustified discrimination, on the ground of family status, under the Human Rights Act 1993.

In May 2013 the Director-General of Health advised all DHBs that Part 4A in the Act requires any DHBs that are paying, or intending to pay, family carers to have an explicit and lawful Paid Family Carer (PFC) policy in place by 21 May 2014.

In December 2013 Cabinet decided that no payments should be made to spouses (including civil union partners and de facto partners) or parents of children under 18 years.

The Ministry of Health provided DHBs with a guidance document for developing PFC policies in April 2014. It recommended that PFC policies only enable DHBs to permit some family members to be paid, in exceptional circumstances, for providing home-based support services (HBSS) to disabled family members.

It was agreed that the three metro Auckland DHBs would develop a policy to be used across the region. The management arrangement decided upon was to pay family carers via contracted HBSS providers rather through a host agency or paying directly. This approach mitigates a number of risks and can be implemented quickly. It means that two independent bodies (DHB as funder and provider organisation as employer) have clearly defined responsibilities and already established processes for monitoring to ensure a family carer does not abuse or financially exploit the family member they are caring for. The DHB contract makes the HBSS provider responsible for ensuring statutory employee rights are not breached.
and working as a HBSS employee means family carers have more access to peer support from other non-family carers to ensure they are not exploited by the family member they are caring for.

The metro Auckland DHBs’ PFC policy has been approved by the Ministry of Health and signed off by the three DHBs.

2.3.3 Dementia Care Pathway

**Auckland DHB**

The following four workstreams have been established for the Dementia Care Pathway:

1. Carer Workstream (support for carers)
2. Integration Workstream (integration between services and agencies, diagnostic processes)
3. Support Suite Workstream (support services e.g. respite care, day programmes, home based support)
4. Foundation Workstream (workforce competency and understanding roles and accountabilities)

Actions over the last quarter include:

- Shared Care Record pilot commenced. The Shared Care Record is a key mechanism for communication and information sharing between the care team. A small pilot has started involving specialists, GPs, and Alzheimer’s Auckland. The pilot will test processes and user acceptability prior to wider rollout.
- Carer assessment and action plan developed. As carers carry a large burden in caring for a person with dementia, the focus of this work has been on early identification of carer strain and implementation of interventions that provide support to enable carers to continue their role for longer.
- The Waitemtata DHB Cognitive Impairment Clinical Pathway has been presented to the ADHB stakeholders and there is agreement to adopt this pathway for use in primary care once it has been evaluated.

**Waitemata DHB**

The Waitemata DHB Cognitive Impairment Clinical Pathway is tracking to plan. The third of four action research meetings was held with Geriatricians, Specialist Nurses, General Practitioners, Practice Nurses, PHO Clinical Leaders, and Alzheimer’s Auckland to discuss what is working / what is not / what will we change and test for the next six to eight week period of the Pilot. There continues to be high attendance at these interactive forums. The GPs have recruited 50 of the required 60 patient and carer pairs and they were all at varying stages on the pathway from diagnosis through to a management plan being in place.

The Regional Clinical Pathways Navigator has been approved to proceed to proof of concept testing and the Cognitive Impairment Clinical Pathway will be one of the Pathways piloted on the Navigator. A lot of work has gone into translating the static Cognitive Impairment Pathway algorithm into a dynamic pathway on the Regional Navigator.

2.3.4 Aged Related Residential Care (ARRC)

All ADHB and Waitemata DHB facilities are now engaged with interRAI (comprehensive clinical assessment) training.
Auckland DHB

The ARRC cluster group model continues to make progress. There is a bimonthly Steering Group meeting with the cluster groups meeting in the alternate months. The focus has been on achieving the First Do No Harm targets to reduce pressure injuries and falls by 20%. Approximately 30% of facilities are providing data on falls and pressure injuries and they are now transitioning from sending the data via Excel to entering it themselves via the www.qualitycare4olderpeople.org.nz website. Work is also underway to determine what other topic areas would be most beneficial for facilities and could be become a focus for the cluster group model.

A study day held for aged residential health care assistants had 115 attendees from 33 facilities. Topics covered were: stroke management; infection control; patient handling; heart failure management; and managing residents with COPD.

The specialist team had 303 consultations with aged residential care over the last quarter. Key reasons for these consults included: wound care, orthopaedic interim care case management, complex residents, complex discharges from Auckland City Hospital, care planning guidance, advice on falls, pressure injury, behaviours of concern, change in level of care, interRAI, support for facility (manager/clinical manager), meetings with families.

Waitemata DHB

The 60 ARRC facilities have the opportunity to meet in two forums (the quality forum for managers and owners) and the Residential Aged Care Integration Programme (RACIP) work group.

The RACIP work group meets bi-monthly, its members are: managers and clinicians from ARRC facilities, Gerontology Nurse Specialists (GNS), Funding and Planning Quality Nurse Leader and experts in the field e.g. Hospice, Dementia Nurse Specialist. The purpose of this group is networking, informing practice and developing clinical guidelines.

2.3.5 Residential Aged Care Integration Programme (RACIP) projects

- Development of a booklet for family members of people with advanced and end-stage dementia living in ARRC. This resource will support families to understand end stage dementia, advance care plans and appropriate and inappropriate intervention.

- Development of two resources: one for end stage lung disease and one for end stage heart disease. These new resources will support staff in ARRC to help families understand disease trajectory and what end stage disease looks like. They will encourage appropriate symptom management, advance care planning and avoidance of preventable admission.

- Project Toru is the vision of Di MacGregor Maori GNS. It is a partnership between Seadrome residential care facility, Kelston Girls College and Waitemata DHB. It brings Maori Kaumatua in a dementia unit and year 13 Maori focused students into regular contact with each other using a Maori model based on traditional Kaumatua Mokapuna interaction. Objectives include use of Maoritanga for all (young-old interactions) teina tuakana kawa, NCEA credits for student time with clients, encouraging the students into health related careers and potential employment opportunities.

- ARRC cluster groups have been formed in response to the targets set by First Do No Harm to reduce Pressure Injuries and Falls by 20%. Facilities are encouraged to group
together to support each other with quality improvements and data collection. There are four cluster groups up and running with 20 represented facilities.

### 2.4 Pacific Health Gain

**Implementation of the Pacific Health Action Plan (PHAP) 2013 – 2016**

The Pacific Health Action Plan was officially launched on 27 May 27 at the Samoan Congregational Christian church in Sandringham. This event was well attended by over 300 members of the Pacific Community and staff members from both DHBs. The theme of the launch was consultation, collaboration and commitment. It was very encouraging to see public commitment to the Plan from right across the Pacific Community and the positive feedback to seeing their words in print.

As presented previously to the Committee, the plan has six priorities and an update on the progress of implementation of the priorities is as follows:

In relation to the first priority *that children are safe and well and that families are free of violence* the initial work is to establish connection to and participation in existing forums addressing family violence. The following are underway:

- Participation in the ADHB Family Violence Steering Group
- Participation in the Auckland Family Violence Project Board along with Police, Justice, Corrections and Ministry of Social Development (MSD)
- Meetings with the *Proud Pasifika* Campaign (MSD’s Pacific antiviolence campaign) project managers
- Participation in the Auckland Pacific Public Service Network
- Submission made by MSD West Auckland office for $50,000.00 for a violence free programme to be delivered through the Enua Ola network in West Auckland (decision to be made shortly)
- Draft project plan to be consulted upon with key people in the churches / communities has been completed.

The second priority of the Plan is that *Pacific people are smoke free*. The following are underway:

- Smokers have been encouraged by Enua Ola and HVAZ co-ordinators to participate in the smoke free group competition managed by the School of Population Health, starting on 1st June and a number of groups have decided to participate
- A survey of HVAZ and Enua Ola churches will be undertaken to establish the number of churches that are totally smoke free, the number that have smoke free church halls but not church grounds and the number of churches where there no prohibition on smoking at all
- Once this is established work will be done to establish some targets that the churches will work towards in the 2014/15 financial year.

The third priority is that *Pacific people eat healthy and stay active*. The weekly physical activities are continuing in churches and communities, nutrition training is being provided by Pacific Heart Beat of the National Heart Foundation of NZ, first aid training is provided by St. John’s. The Aiga Challenge which is the annual 8 week weight loss competition will be held in August and because this is the second year it is being held, data will show whether the weight loss from last year’s competition is sustained. The competition, as well as helping participants, also provides quantitative data about the programme.
The fourth priority is that **we seek help early**. Although data confirms that Pacific people are enrolled in PHOs in very high numbers and that there is good coverage in some areas such as immunisation and breast screening, hospital ASH rates show that there is still high hospital admissions for conditions that are primary care preventable. Currently contracts held by Alliance Health + that provided support for pregnant mothers and mothers and children in their first year of life are being reviewed. New contracts effective from 1 July 2014 will attempt to better connect these services and ADHB’s maternity and child services, not just to provide a service but to better understand the families’ needs and the barriers that they continue to experience so that we are better placed to address them.

Waitemata DHB Board approved $200,000.00 for the employment of up to three Parish nurses to enhance the work of the Enua Ola programme. This aligns with the ADHB Healthy Village Action Zones (HVAZ) programme and is thought to be a significant contributor to the improved outcomes for ADHB including cervical screening identified in the Cervical Screening Pacific Review section of this report.

The fifth priority is that **Pacific people use hospital services when needed**. The General Manager for Pacific Hospital Services is responsible for this priority and reports progress to the Hospital Advisory Committees.

The sixth priority is that **Pacific families live in warm healthy houses that are not overcrowded**. Some Pacific providers such as the Fono Henderson are currently contracted by Waitemata DHB to provide social work support for their enrolled patients with both high clinical and social support needs. People in poor housing are a priority for this service. When social workers are involved in an advocacy role for clients, their housing needs are better responded to by Housing NZ and the private sector. It is acknowledged that this does not resolve the fundamental issue of the shortage of affordable good quality housing especially for low income people in Auckland.

### 2.4 Asian, Migrant and Refugee Health Gain

Asian, migrant and refugee health gain efforts include leading and advising on the development of strategies and plans to improve the health and independence of Asians, migrants and refugee populations across Auckland and Waitemata. Two key governance and strategic groups are the Asian & Middle Eastern, Latin American and African (MELAA) Health Governance Group (ADHB -WDHB), and Auckland Regional Asian & MELAA Primary Care Working Group. These guide health gain planning, implementation and monitoring across the priority areas/workstreams, targeted projects and in primary care.

Respective action plans are in the process of development for 2014-15. With respect to targeted primary care services to refugee groups, the Primary Care Wrap Around Services contract is in the process of revision for 2014-15 in collaboration with participating PHOs. The intent is to include a flexible funding pool component in the contract to support episodic care to enrolled eligible refugee patients in general practice as well as continue to fund extended consultations (up to four times/year). Counties Manukau DHB also intend to adopt the Auckland and Waitemata contract service specifications to streamline and regionalise the PHOs approach to targeted refugee services in general practices.
Adopting a regional approach to capacity building across shared Asian, migrant and refugee partners has included the planning and delivery of three refugee health forums in 2014 to primary health professionals. The topics focus on child health, family violence and preventive behaviours. At a community level, on-going capacity building is delivered to targeted ethnic groups on health screening, as well as engagement with stakeholders on better understanding issues and barriers to health service access across the priority areas/workstreams within ethnic subgroups.
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 30/04/14</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>
</tbody>
</table>