Community and Public Health Advisory Committees Meeting

Wednesday, 05\textsuperscript{th} February 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.
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 27/11/13 ................................................................. 1

3 DECISION ITEMS

2.05pm 3.1 Healthy Eating and Physical Activity in the Auckland Region ............................................................. 13

2.25pm 3.2 Auckland Regional Public Health Service Submission on the Unitary Plan ........................................... 32

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5 STANDARD MONTHLY REPORTS

3.10pm 5.1 Planning and Funding Update ........................................................................................................ 49

3.20pm 6 GENERAL BUSINESS
<table>
<thead>
<tr>
<th>Committee Member</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                                                                                                         | 11/11/13     |
| Max Abbott       | Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology  
                      Patron – Raeburn House  
                      Board Member – Health Workforce New Zealand  
                      Board Member, AUT Millennium Ownership Trust  
                      Chair – Social Services Online Trust  
                      Board Member – The Rotary National Science and Technology Trust                                                                                                           | 28/09/11     |
| Jo Agnew         | Professional Teaching Fellow – University of Auckland  
                      Casual Staff Nurse – Auckland District Health Board                                                                                                                                                                            | 12/10/11     |
| Peter Aitken     | Pharmacist  
                      Shareholder/Director, Consultant - Pharmacy Care Systems Ltd  
                      Shareholder/Director – Pharmacy New Lynn Medical Centre                                                                                                                                                                           | 15/05/13     |
| Judith Bassett   | Nil                                                                                                                                                                                                                                | 09/12/10     |
| Pat Booth        | Consulting Editor – Fairfax Suburban Papers in Auckland                                                                                                                                                                               | 24/06/09     |
| 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  
                      Managing Director – Lee Mathias Ltd  
                      Shareholder/Director – Pictor Ltd  
                      Director – John Seabrook Holdings Ltd  
                      Governance Advisor – AuPairlink Ltd  
                      Chair – Health Promotion Agency Board  
                      Chair – iAC IP Ltd  
                      Governance Advisor – Health Vision Ltd                                                                                                                                                                                           | 02/12/13     |
| 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     |
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<tr>
<th>Name</th>
<th>Role and Additional Information</th>
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<tr>
<td>Allison Roe</td>
<td>Member – Devonport-Takapuna Local Board, Auckland Council</td>
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<td>Shareholder – Optimisewellbeing.com</td>
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<td>Founder – Takapuna 2020 Community Group</td>
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<td>Board member – North Shore Hospital Foundation</td>
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<td>Gwen Tepania-Palmer</td>
<td>Chairperson – Ngatihine Health Trust, Bay of Islands</td>
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<td>Life Member-National Council Maori Nurses</td>
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<td>Committee Member – Lottery Northland Community Committee</td>
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<td>Co-opted Members</td>
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<tr>
<td>Dr Tim Jelleyman</td>
<td>Head of Division (Medical) - Child Women and Family Services, WDHB</td>
<td>13/03/13</td>
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<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>Eru Lyndon</td>
<td>Honorary Research Fellow – Auckland University</td>
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<td>Member – AUT Business School Industry Advisory Committee</td>
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<td>Director – Tamaki Development Company</td>
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# Auckland and Waitemata District Health Boards

## Community and Public Health Committees

### Member Attendance Schedule 2013

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**Co-opted members**

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*absent

^ leave of absence

* attended part of the meeting only

# absent on Board business

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Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting /14
2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 27th November 2013

Note: There is nothing in the public excluded minutes for this meeting which could not be disclosed in open meeting and it is therefore recommended that approval of the public excluded minutes be included in this resolution.

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 27th November 2013 (including the public excluded minutes for that meeting) be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 27 November 2013

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.01p.m.

COMMITTEE MEMBERS PRESENT:

Lee Mathias (Committee Chair) (ADHB Deputy Chair)
Warren Flaunty (Deputy Committee Chair) (WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair) (present until 3.10p.m.)
Max Abbott (WDHB Deputy Chair)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Susan Buckland (ADHB Board member)
Chris Chambers (ADHB Board member)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Allison Roe (WDHB Board member) (present until 4.16p.m.)
Gwen Tepania-Palmer (WDHB Board member) (present from 2.22p.m.)
Tim Jelleyman (Co-opted member)

ALSO PRESENT:

Andrew Brant (WDHB, Acting Chief Executive)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Ruth Bijl (ADHB and WDHB, Funding & Development Manager, Women’s, Child and Youth Health)
Tim Wood (ADHB and WDHB, Funding & Development Manager, Primary Care)
Andrew Old (ADHB, Medical Advisor, Public Health Medicine)
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
Jude Sprott, ProCare
Lorelle George, Comprehensive Care/Waitemata PHO
Gaylene Sharman, HealthWest

APOLOGIES:

Apologies were received and accepted from Rob Cooper (leave of absence), Sandra Coney and Ailsa Claire. There were subsequent apologies for early departure from Lester Levy and Allison Roe.
PRESENTATION: Co-design to Improve Participation and Bleed reporting in Haemophilia

Ian d’Young (Physiotherapy Practitioner, National Clinical Lead, Haemophilia Physiotherapy, Auckland DHB) provided this power point presentation. A copy of the presentation is available on request from the WDHB Board Secretary.

Some of the matters highlighted during the presentation were:

- The reduction in cost of treatment as a result of initiatives by the Auckland DHB Haemophilia Service – treating 108 patients at a cost of $7.1M in 2011/12, compared to 100 patients at a cost of $10.2M in 2009/10. This is at a time when costs are escalating nationally, with $30M per annum being spent on 250 patients.
- The work carried out through focus groups to establish why patients don’t seek treatment for bleeds promptly (50% of bleeds not reported and of that 50%, 70% reported late). Factors identified included distance to travel; long waits in provincial EDs; difficulties seeing GPs; a perceived blame culture; a history of treatment in past periods hurting; and other value and technology factors.
- The high cost of delayed reporting.
- The goal of having all bleeds reported within 48 hours of onset.
- The patient centred solution and co-design approach adopted. This involved partnership with both patients and clinicians.
- As a result of the programme, a dramatic reduction (by 63%) achieved in the number of bleeding episodes reported outside 48 hours, combined with a major increase in the number of bleeds reported.
- Factor usage dropped from 2,080,000 IU in March–July 2012 to 1,758,500 IU in March –July 2013.
- A report on the project is expected to be published shortly in the International Journal of Haemophilia.

2.22p.m – Gwen Tepania-Palmer present.

Matters covered in discussion and response to questions included:

- The partnership with patients and clinicians had included paediatrician, haematologist, social worker, Haemophilia Foundation and Blood Service involvement. They had identified a number of patients willing to be involved in the development of communications and as patient champions.
- The project scope had been moderate and severe adult patients, not child patients. Most parents do rush their children to hospital if there is a bleed.
- The approach had been rolled out to all Auckland region patients. There had been resistance encountered elsewhere nationally, but they were getting the message out there. Recently Ian d’Young had been in Australia talking about this project and he expected that other parts of New Zealand would start to take up the approach.
- The Board Chair noted that the management of blood products is being shifted to Pharmac and as part of that process there will be much greater expectations on clinicians for the management of blood costs.
- Debbie Holdsworth will arrange for information on the project to be shared with Funding Managers nationally.
- The Committee endorsed the project as a good example of innovation and good inter-disciplinary practice; symbolic of what they would like to see across the two organisations.
• In answer to a question, Ian d’Young advised that he did see lessons from the project for other services in areas of managing chronic illness and supporting patients better. Personally he had found he was now doing much more of his work by internet and telephone and also working a lot more closely with other services such as social workers. Another successful element in the project had been reducing variation in how things are done and setting up agreed procedures.

• Andrew Old advised that the messages from the presentation could be shared through the clinical networks in the hospitals, Quality Grand Rounds etc.

• The Board Chair emphasised the need to accelerate the adoption of this type of approach in other areas. In discussion Type 1 Diabetes was seen as an excellent area for that.

In conclusion, the Committee Chair congratulated Ian d’Young on the project. She noted that Debbie Holdsworth would be conveying information on this to Funding Managers nationally and the need for information on this successful approach to be transferred to other discussions, nationally and locally.

KARAKIA Jo Agnew led the Committee in the English version of the karakia.

WELCOME The Committee Chair welcomed those present

DISCLOSURE OF INTERESTS

Lee Mathias advised that two interests under her name no longer applied and could be deleted from the Interests Register: Director - Midwifery and Maternity Providers Organisation Ltd and Council Member – NZ Council of Midwives

There were no declarations of interest with regard to the agenda for this meeting.

1. AGENDA ORDER AND TIMING

Items were taken in the following order: 2.1, 3.3, 4.1, 3.1, 3.2, 4.2, 5.1, 5.2, 6 and 7

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 16 October 2013 (agenda pages 1-9)

Resolution (Moved Judith Bassett/Seconded Gwen Tepania-Palmer)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 16 October 2013 be approved.

Carried

Matters Arising:

Cervical Screening – letter women receive following a normal smear – Allison Roe advised that the letter she had received from her doctor differed from the standard letter that had been circulated to Committee members for information. She will provide a copy of the letter to Debbie Holdsworth who will look into.
Fluoridation – Allison Roe needs some additional information and has been referred to Chief Dental Officer, Robyn Haisman, who will respond to Allison. The response will be copied to Board members when it is received.

In answer to a question, it was noted that as a Board member of a Crown Entity, there is an expectation for members to follow national policy. The expectation is noted in the letter of appointment members receive at the start of a term in office. However this does not preclude a member discussing with a Board their views on the need for a change in national policy, and if supported by the Board, there could be advocacy of that to the Minister.

3 DECISION ITEMS

3.1 Child and Youth Mental Health Services Update – the approach to designing common systems and processes across both the Auckland and Waitemata DHBs (agenda pages 10-19)

Helen Wood (General Manager, Mental Health and Addictions, ADHB and WDHB), Mike Butcher (Clinical Director, Child and Youth Mental Health Services, ADHB) and Selena Griffith (Mental Health and Addictions Project Coordinator, ADHB and WDHB) presented this item.

Helen Wood introduced the report, which had been developed in response to the request from CPHAC for further information on the potential for aligning some systems and processes after both DHBs presented their child and youth plans. She described the three key areas identified for this and progress to date, as detailed in the report under Sections 2 and 3. In conclusion she noted that both services are sharing opportunities and also working on how to streamline processes and getting people assisted by our services quicker. Mental health collaboration in Primary Care will be covered elsewhere through the localities work.

The Committee Chair thanked those presenting the report and said that she saw this as representing another leap forward in working together across the two Boards. She suggested that a further report on progress be brought back to CPHAC in three months time. CPHAC recognised collaboration in this area as a key area and was serious about getting it right.

Pat Booth noted the impact that difficulties in retaining sponsorship are affecting organisations providing social services. Barnados in West Auckland had reduced staff numbers from 21 to five.

It was noted that questions relating to the high rate of mental health issues for younger people could be considered under the following agenda item.

The report was received.

3.2 Auckland DHB Child and Youth Mental Health and Addiction Direction 2013 -2023 (agenda pages 20-120)

Helen Wood (General Manager Mental Health and Addictions, ADHB and WDHB), Hillary Carlile (Planning and Funding Manager, Mental Health and Addictions, ADHB), Paul Ingle (Project Manager Wise Group and Chair of the Working Group and Sponsor of the Workstream), and Michelle Atkinson and Kirsty Fong (who both provided youth consumer expertise in developing the Direction) all participated in presenting the report.
Helen Wood described the prevalence of mental health and addiction issues in young people from about age 10 or 11 to 18 or 19, which is higher than for any other age group.

Michelle Atkinson and Kirsty Fong provided a youth perspective including:

- Issues such as abuse and trauma, high levels of cannabis use, involvement in hazardous activities and high suicide rates. Suicide rates are particularly high amongst minority groups and those with a same sex orientation.
- Unmet needs and the need to change to meet those needs. Services need to be easy to access.
- The role of the Youth Reference Group in this project.
- Young people are very diverse. People should talk less about young people and more to young people.

Paul Ingle described the process followed in developing the Direction. This involved working from a multi-agency perspective, including Ministry of Social Development, Education, a range of other agencies/expertise and getting the perspective of people using or not using Mental Health and Addiction Services. The working group process had continued for most of the year and they had spoken to many people. There was a significant desire for change. A big part of the exercise had been mapping who was doing what. Different agencies have different definitions of distress etc and a significant component of the plan is the need to coordinate much better. A lot of good information and advice had been received and there was also a need to look at what is happening abroad.

Helen Wood outlined the six key actions at the end of the report:

- Strengthening the voice of children, young people and their family/whanau who use our services or may need to use them.
- Intervening earlier in life course and early when there is a need. Getting the right support and training early to those who need it, before complex problems develop. Better integrated approaches will help achieve this.
- Addressing inequalities – listening to the Maori and Pacific voice to hear what type of services are needed.
- Fostering innovation - there are also strong opportunities to achieve progress through the localities approach.
- Workforce development – including getting the right mix of clinical staff, getting the voice of lived experience accepted as a valuable voice, and developing a whole peer support network.
- Working better together – there are a lot of different agencies involved and a lot of opportunities to work together better. There is a need to understand each other better and make better use of each other’s resources.

In conclusion, Helen Wood said that the Service was keen to get moving on this and get action.

The Committee Chair thanked those involved for an excellent report. She also noted the importance of keeping track of progress of the National Depression Review and of e-initiatives in this area.

Hillary Carlile thanked Kirsty Fong and Michelle Atkinson for being on the Working Group and making a great contribution.
It was noted that issues raised by Chris Chambers about definitions would be discussed separately between him and Helen Wood.

Those involved were thanked for developing and presenting the report.

Resolution (Moved Susan Buckland/Seconded Jo Agnew)

a) That the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees receive and endorse this Auckland DHB Child and Youth Mental Health and Addictions Direction 2013-2023.

b) That the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees recommend to the Auckland DHB Board:

That the Auckland DHB Child and Youth Mental Health and Addictions Direction 2013-2023 be adopted and implemented.

Carried

3.3 2014/15 Annual Plan Approach (agenda pages 121-126)

Simon Bowen (Director-Health Outcomes) and Wendy Bennett (Planning and Health Intelligence Manager) presented this item. Simon Bowen introduced the report, noting the changed legislative requirements for statements of Intent, which will become high level strategic documents, with a four year focus. He also noted the commitment to having the two DHBs’ Annual Plans as identical in format and layout as possible, with the majority of content consistent. Members interested would be welcome to attend either the Waitemata DHB Planning Day on 16 January 2014 or the Auckland DHB Planning Day on 21 January 2014 (these days not to be confused with the Strategic Planning days organised for Board members by the Board Chair). Invitations will be sent to Board members.

In answer to questions, the meeting was advised that the aim of achieving consistent annual plans should be assisted by the combined Planning and Funding team being the lead for the two organisations on this and by Wendy Bennett being the co-ordinator on behalf of both DHBs. It was also confirmed that the Boards’ partners, including Maori partners, would be fully consulted in developing the Annual Plans.

Resolution (Moved Lee Mathias/Seconded Warren Flaunty)

That it be recommended to the Auckland and Waitemata DHB Boards:
That the Board:

a) Approve the approach to annual planning for 2014/15, including the longer term direction and timetable.

b) Note the national planning guidance, including updates and changes.

Carried
4. INFORMATION ITEMS

4.1 A Model of Care for Adult Palliative Care Services in the Waitemata District (agenda pages 127-132)

Tim Wood (Funding and Development Manager, Primary Healthcare, ADHB and WDHB), Dr John Robertson (Independent Chair, Waitemata District Palliative Care Governance Group) and Sarmila Gray (Project Manager, Planning and Funding, WDHB) were present for this item.

Tim Wood introduced the report.

John Robertson outlined key issues including:

- The DHB has no model of care in place for palliative care that is consistently and equitably provided in the District.
- The use of resources and relationships between providers is not as effective as one might expect if a comprehensive approach was put in place.
- This is an area where public and private arms need to have an effective relationship.
- Changes in the population’s age profile are increasing the demand for palliative care and this has many implications.
- There is a need for a comprehensive model across the district encouraging cooperation and maximising use of scarce resources.

John Robertson then described the key features of the Proposed Model of Care as outlined in Section 5 of the agenda report. He noted that the model of care needs a funding model to support it. The funding of palliative care needs overhauling. The funding model will need to be presented to stakeholders, explained to them and embraced by them.

Matters covered in discussion and response to questions included:

- With regard to what is envisaged by a ‘locality’ in the context of the model of care, Tim Wood advised the intention is to define geographic localities and look at whether there is a hub for each and if so whether or not this is the hospice in that locality.
- There was discussion of the concept of general practitioner leadership as the home for palliative care. Tim Wood advised that this was based on the advice of the clinical group for the project. The Committee Chair noted there may need to be further discussion about definition.
- Focus groups of patients and their families had provided input into the model of care.
- The next stage of the project was development of the Implementation Plan and funding models.
- The issue of general practitioner capacity to meet the extensive role envisaged in the model of care was raised and it was noted that there are also a number of other areas where GPs are being expected to play a greater role. It had been accepted that there would be issues about capacity, but this was seen to be the best model for the district. The issue of capacity would need to be looked at in developing the Implementation Plan, which would be a challenge. John Robertson advised that the Clinical Group accepted that engagement and consultation with GPs would be extremely important.
• With regard to leading development of the Implementation Plan, a joint approach would be taken. The Funder would facilitate the process, but with a strong commitment already made from a number of clinicians to be actively involved.
• It would be important to see what emerged for Waitemata DHB before considering if there are any implications for Auckland DHB.

The presenters of the report were thanked.

The report was received, noting the requirement by the Waitemata DHB Board for an implementation plan including a funding model to be developed for the Board’s consideration prior to commencing implementation of the model of care.

4.2 Rheumatic Fever Prevention and Intervention Programme Update for Auckland and Waitemata DHBs (agenda pages 133-138)

Ruth Bijl (Funding and Development Manager, Women’s, Child and Youth Health, Auckland and Waitemata DHBs), Dr Alison Leversha (Community Paediatrician, Auckland DHB) and Dr Tim Jelleyman (Head of Division (Medical) Waitemata DHB) were present for this item.

Ruth Bijl introduced the report. Matters she highlighted or updated included:
• Overall progress was good, particularly with the primary school prevention programmes.
• Agreements with the PHOs on nurse led rapid response clinics.
• The Auckland Wide Healthy Housing Initiative (AWHHI) will be accepting referrals from 4 December.

It was noted that overall good progress is being made on bringing all the strands of the programme together.

The unusual use of the term “primordial” by the Ministry (with regard to housing issues) was noted. The term refers to highest level of prevention.

The Committee Chair congratulated those involved on progress and asked for a further progress report in the first quarter of the 2014 calendar year.

The report was received.

5. STANDARD MONTHLY REPORTS

5.1 Primary Care Update Quarter 1, 2013/14 (agenda pages 139-161)

Tim Wood (Funding and Development Manager, Primary Care, Auckland and Waitemata DHBs) presented the report. Matters he highlighted or updated included:
• After hours – significant work is taking place on a new business case which will be brought to both the DHB Boards and the PHO Boards. If approved, it will take effect from 1 July 2014.
• Localities – there had been a meeting in the Tamaki area the previous week, attended by over 60 participants, looking at Mental Health services in that area. This was the first of three workshops to be held there, looking at how to improve those services.
• Work is proceeding in West Rodney, looking at priorities for that area. A meeting with the community on that is taking place on 27 November.

• Long term conditions – this is an area of significant investment for both Auckland and Waitemata DHBs. They are starting to review how to close the gaps and have connected services across the two DHBs.

With regard to the question of the impact of increasing expectations on GPs to pick up services, Tim Wood advised that it had become obvious that to introduce such changes there needs to be better engagement with general practices and a proper change management process. They were at an early stage of a conversation with the PHOs about what that means. There is a lot of work to be done on better engagement with general practices, on how to make sure that what the DHB wants done will also work for GPs, and on how to support them to achieve what is needed. Direct engagement can be challenging as some PHOs are very protective about their relationship with general practices. There is an ability to make progress on this, but it will take time. Various approaches are being taken in terms of engagement.

The Committee Chair noted that the new primary care contract did have a wider range of expectations and there might be a need to convey that more. This also needed to be differentiated from the provision of secondary and tertiary services through the localities approach.

With regard to the Scorecard on page 141 it was noted that more Waitemata DHB results than normally had a negative trend. Auckland DHB Immunisation results had improved substantially following the establishment of the joint outreach service with Waitemata DHB.

The report was received.

4.16p.m – Allison Roe retired from the meeting.

5.2 Planning and Funding Update (agenda pages 162-168)

The report was taken as read.

Tim Wood updated the meeting on progress with the hearing by the Health Practitioners’ Disciplinary Committee into high levels of close control prescribing by Te Puna Pharmacy. An outcome from that was expected shortly.

The Oral Health achievement against the arrears target was acknowledged.

The report was received.

6. General Business

The Committee Chair advised that there would be a formal farewell for Rob Cooper from the two Boards. She thanked Susan Buckland for the contribution that she had made to Auckland DHB and invited her to that function.

Susan Buckland congratulated Board members on their re-election and conveyed her best wishes for the next term of the two boards.
7. Resolution to Exclude the Public (agenda page 169)

Resolution (Moved Warren Flaunty/Seconded Robyn Northey)

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

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

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting with Public Excluded 16/10/13</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Confirmation of Minutes As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&amp;D Act.</td>
</tr>
</tbody>
</table>

4.18 p.m. – 4.21 p.m. – Public excluded session.

4.21 p.m. – open meeting resumed.

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

The meeting concluded at 4.21 p.m.
### Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 28th January 2014

<table>
<thead>
<tr>
<th>Meeting Ref</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPHAC 04/09/13</td>
<td>2.1</td>
<td>Review of Child Health Services - engagement with Wilson Centre to occur as part of the Review - report on the Review to come to February 2014 CPHAC meeting, when a proposal is expected to be ready.</td>
<td>Tim Jelleyman/Linda Harun</td>
<td>CPHAC 20/03/14</td>
<td>Report delayed by one meeting.</td>
</tr>
<tr>
<td>CPHAC 27/11/13</td>
<td>Presentation</td>
<td>Haemophilia ADHB Initiative (as an example for other areas) - information to be shared with Funding Managers nationally. - information to be conveyed to clinicians within the two DHBs</td>
<td>Debbie Holdsworth Andrew Old, Andrew Brant</td>
<td></td>
<td>Actioned.</td>
</tr>
<tr>
<td>CPHAC 27/11/13</td>
<td>3.1</td>
<td>Child and Youth Mental Services – further update report on progress developing common systems and processes across Auckland and Waitemata DHBs to be provided in three months time.</td>
<td>Helen Wood</td>
<td>CPHAC 20/03/13</td>
<td>Actioned.</td>
</tr>
<tr>
<td>CPHAC 27/11/13</td>
<td>4.2</td>
<td>Rheumatic Fever Prevention and Intervention Programme - further update report to be provided in the first quarter of 2014 calendar year.</td>
<td>Ruth Bijl</td>
<td>CPHAC 20/03/13</td>
<td></td>
</tr>
</tbody>
</table>
3.1 Healthy Eating and Physical Activity in the Auckland Region

Recommendation:

That the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees:

1. Note that this paper follows on from, and is consistent with, a previous CPHAC paper “Improving Population Nutrition through Environmental Change” (18 July 2012).

2. Support greater priority being given to activities which promote healthy nutrition and physical activity and that a co-ordinated and strategic approach be taken to the planning and delivery of these activities.

3. Request that the Auckland Regional Public Health Service takes the lead in co-ordinating and drafting a regional intersectoral action plan.

4. Support applications for funding to the Ministry and Health and others in response to new funding opportunities being made available.

Prepared by: Simon Bowen (Director Health Outcomes WDHB/ADHB), Dr William Rainger (Service Manager ARPHS), Dr Julia Peters (Clinical Director ARPHS), Candace Bagnall (Public Health Contractor ARPHS)

Glossary

ACE - Australian Assessing Cost-Effectiveness
ARPHS - Regional Public Health
DHB - District Health Board
GP - General Practitioner
HPA - Health Promotion Agency
MOH - Ministry of Health
NGO - Non-Government Organisation
OECD - Organisation for Economic Co-operation and Development

1. Executive Summary

This paper builds on a previous CPHAC paper “Improving Population Nutrition through Environmental Change” (18 July 2012). It summarises the significant health impacts of increasing obesity rates on the people of Auckland, the evidence on effective interventions and the activities that are currently funded to promote physical activity and nutrition in the Auckland region.

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels and New Zealand has the third highest rate of obesity amongst OECD countries. The associated costs have been estimated at 4.4% of healthcare expenditure or $152 million dollars for the Auckland region and are likely to rise in the future.
A wide range of nutrition and physical activity interventions are being undertaken by NGOs, sports trusts, health promotion providers, health services, Auckland Council and the broader public sector. However current activities and resources are insufficient to counter the trend of increasing obesity-related health problems. Policy approaches, many of which require action at a national level, generally show greater cost effectiveness and have a stronger evidence base than health promotion or clinical interventions.

A strategic, innovative and sustained region-wide approach is therefore required to address the issues outlined in this paper. Initially this should focus on better coordination and strengthening of existing programmes as well as closer working with the range of partners involved. Over time existing programmes should be extended and new ones developed in response to the emerging evidence base and the availability of resources. Priorities for action include leadership and coordination; food environments; priority populations and settings; intersectoral working and innovation and development.

2. Introduction

1. The obesity rate in New Zealand has increased from 19 per cent of adults in 1997 to 28 per cent in 2011/12. About one in three adults are now obese, and over one third are overweight (but not obese). Only one in three adults had a normal weight in 2012, and the rate of obesity among children and young adults is also increasing. Obesity rates were higher among Maori (17%) and Pacific (23%) children, and children living in the most deprived areas (19%).

2. These trends are reflected in the Auckland region, which has lower fruit and vegetable intake and lower levels of physical activity compared with national levels, and increasing rates of obesity since 2006. The Auckland region carries the burden of over one third of the total impact of health conditions related to obesity. The situation across the wider Auckland region reflects these trends, and it is a concern that there are lower levels of physical activity and fruit and vegetable intake than the national average.

3. At the May 2013 meeting of the Waitemata DHB (District Health Board) it was noted that Waitemata had relatively low rates of adequate physical activity and vegetable consumption compared with the general population, and the minutes of the meeting note that “it was agreed that it would be worthwhile to assess where the Board sits currently in terms of supporting these underlying factors in population health.” A report on physical activity and vegetable consumption was the documented action.

4. The purpose of this paper is to provide advice on interventions to promote physical activity and vegetable consumption in Auckland and suggest a regional approach to improving health outcomes through building on current work being undertaken.

5. The paper summarises the physical activity and nutrition promotion activities funded in the Auckland region, in the context of their relationship to increasing levels of obesity and other significant health impacts on the people of Auckland. The paper also includes

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1 Ministry of Health 2013a, p. 35.
2 Ministry of Health 2013b.
information on burden of disease, national policy and funding, a brief summary of recent evidence on what appears to be driving the increase in obesity, and evidence for effective interventions.

6. The recommendations of the previous CPHAC paper “Improving Population Nutrition through Environmental Change” (18 July 2012) regarding the need for change in the food environment, are further developed. There has been considerable progress made within the Auckland DHB/Waitemata DHB environment as a result of follow-up to this paper, by the Healthy Food Environment Group.

3. **Burden of Disease**

1. Increasing rates of obesity amongst New Zealanders have been a concern for the health sector for some time, due to strong associations with type 2 diabetes, coronary heart disease, cancer, stroke, depression and a range of other health problems. Of the 225,731 people living with diabetes on the national Virtual Diabetes Register at December 2012, over 37 per cent were living in Auckland.

2. Poor nutrition, low intake of fruit and vegetables, and lack of physical exercise impact on a range of other health problems which may not be related to obesity. For example, the consumption of sugary drinks impacts on oral health, and this is a particular problem for children. High consumption of carbonated soft drinks has been found to have a strong association with dental caries amongst children (Sohn et al., 2006).

3. Conversely, case-control studies have demonstrated that diets rich in fruit and vegetables can significantly reduce risk for cancers of the oesophagus, lung, stomach and colorectum, and cohort studies suggest a protective effect for both fruit and vegetables for most cancer sites (Riboli and Norat, 2003). A strong protective effect was found for cancer of the oesophagus in a large prospective cohort study (Freedman et al., 2007). There is also good evidence that consumption of fruit is associated with lower risk of cardiovascular disease (Takachi et al., 2008).

4. Dietary risk factors for disease include high salt intake, high saturated fat intake, low vegetable and fruit intake and excess energy intake (high body mass index, BMI) and these accounted for 11.4 per cent of health loss in 2006 (Ministry of Health 2013). Other important risk factor causes of health loss in 2006 included high blood pressure (6.4%), low physical activity (4.2%), and high blood cholesterol (3.2%).

5. The NZ Health Survey results for children aged 0-14 years indicate that obesity rates increased from 8 per cent in 2006/07 to 11 per cent in 2011/12, after being stable between 2002 and 2006. Obesity rates were higher among Maori (17%) and Pacific (23%) children, and children living in the most deprived areas (19%)\(^6\).


\(^5\)‘Health loss’ estimated using the DALY (disability-adjusted life year) which combines information on early death and illness or disability in a way that makes it possible to compare the effects of different diseases and injuries across population groups and over time (Ministry of Health 2013).

\(^6\) Ministry of Health 2013b.
6. Obesity is more common in areas of high deprivation, with 40 per cent of those living in the most deprived areas being obese, compared with 23 per cent of those living in the least deprived areas. New Zealand adults had the third-highest obesity rate in the OECD in 2009 (Ministry of Health 2012).

Costs of obesity-related illness
1. Health care costs attributable to overweight and obesity were estimated to be NZ$624m or 4.4 per cent of New Zealand’s total health care expenditure in 2006 (Lal et al., 2012). For the three Auckland DHBs, 4.4% of healthcare expenditure in 2012/13 is approximately $152 million. Given the increasing prevalence of obesity these costs are likely to rise in the future.
2. The adverse workplace effects of obesity are also concerning. Obesity is associated with substantially increased rates of absenteeism (i.e. more days out of work) and presenteeism (i.e. reduced productivity while at work). Obese workers take more sick days, have longer sick leaves and incur greater productivity losses than do non-obese workers. (Borak, 2011).

Quality of life
1. The most widespread consequences of childhood obesity may be psychosocial. One study indicated that obese children and adolescents have lower health-related quality of life than children and adolescents who are healthy, and similar quality of life to those diagnosed as having cancer (Schwimmer et al., 2003).

4. Obesity, Vegetable and Fruit Intake and Physical Activity in Auckland
1. Over one-quarter of people in the Auckland region (27.4 per cent, 421,000 people) are obese. This represents an increase from 2006/07 of 2.6 per cent. The prevalence is broken down by DHB in the table below although confidence intervals are fairly wide at an individual DHB level.

### Obesity: Age-Standardised Prevalence (% adult population) in Auckland, Waitemata and Counties Manukau DHBs - NZ Health Survey 2011/12

<table>
<thead>
<tr>
<th></th>
<th>2006/07 (95% CI)</th>
<th>2011/12 (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>25.6 (24.7–26.6)</td>
<td>27.9 (26.7–29.1)</td>
</tr>
<tr>
<td>ADHB</td>
<td>20.0 (16.9–23.4)</td>
<td>22.2 (18.6–26.2)</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>21.6 (18.3–25.1)</td>
<td>20.7 (17.2–24.6)</td>
</tr>
<tr>
<td>CMDHB</td>
<td>32.9 (29.2–36.8)</td>
<td>39.3 (34.1–44.6)</td>
</tr>
</tbody>
</table>

Rates of obesity are particularly high amongst Maori and Pacific populations. Data is not yet available by ethnicity from the 2011/12 survey but data from the 2006/07 survey is shown in the table below.

### Obesity: Age Standardised Prevalence (% adult population) in Auckland and Waitemata DHBs - NZ Health Survey 2006/07

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>ADHB</th>
<th>Waitemata DHB</th>
<th>CMDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>33.6%</td>
<td>30.7%</td>
<td>50.2%</td>
</tr>
<tr>
<td>Pacific</td>
<td>51.3%</td>
<td>48.0%</td>
<td>78.6%</td>
</tr>
<tr>
<td>Asian</td>
<td>8.9%</td>
<td>8.1%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Other</td>
<td>19.5%</td>
<td>17.9%</td>
<td>29.3%</td>
</tr>
<tr>
<td>Total</td>
<td>21.3%</td>
<td>19.7%</td>
<td>32.3%</td>
</tr>
</tbody>
</table>

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2. Obesity rates for children are also of concern, with the unadjusted prevalence of obesity in children (aged 2-14 years) in the northern region (includes Northland: data not yet available by DHB) at 9.5 per cent in 2006/07, increasing to 11.2 per cent in 2011/12. Obesity rates for 2011/12 are higher for Maori children (11.4%) and Pacific children (26.5%) and lower for Asian children (7.9%).

3. Vegetable intake in the Auckland region (53.7%) is significantly lower than the national intake (66.8%), and is lower than 2006. Fruit intake has also reduced in the Auckland region since 2006 and is now 54.4%, slightly lower than the national rate (57.5%).

4. People in the Auckland region are less physically active than the national average, and have become less physically active since 2006.

<table>
<thead>
<tr>
<th>Physically Active: Age-Standardised Prevalence (% adult population) in Auckland, Waitemata and Counties Manukau DHBs - NZ Health Survey 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
</tr>
<tr>
<td>ADHB</td>
</tr>
<tr>
<td>Waitemata DHB</td>
</tr>
<tr>
<td>CMDHB</td>
</tr>
<tr>
<td>Auckland region</td>
</tr>
</tbody>
</table>

5. National Policy and Funding

1. In May 2013 the New Zealand Government signed up to the WHO’s “Global Action Plan for Prevention and Control of Non-communicable Diseases 2013-2020” which will help inform regional and local efforts in combating the impact of increasing obesity rates. Voluntary global targets include:
   - A 25% relative reduction in risk of premature mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.
   - A 10% relative reduction in prevalence of insufficient physical activity.
   - Halt the rise in diabetes and obesity.

2. Work led by Professor Sir Peter Gluckman (Gluckman et al., 2011) has resulted in funding being recently allocated for improving maternal and infant nutrition. A total of $1,636,300 has been allocated to DHB services in Auckland for this purpose.

3. The Ministry of Health provides comprehensive food and nutrition guidelines for different age groups. These include guidance for infants and toddlers (0-2 years), children and young people (2-18 years), pregnant and breastfeeding women, adults and older people. Guidelines for children and young people were updated in 2012.

4. New policy initiatives and potentially funding are expected to be announced on this issue by the Ministry of Health in the near future.

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8 Data extracted from 2011/12 New Zealand Health Survey: Results for children, MoH website.
6. Drivers of Obesity

1. Changes in food production, increasingly sedentary lifestyles and entertainment options, and the promotion of certain types of relatively unhealthy energy-dense food and beverages are some of the drivers of increasing obesity rates in developed countries, including New Zealand.

2. In recent years the concept of “obesogenic environments” has gained traction within public health research (coined by Swinburn et al., 1999). Contributors include the physical environment (access to physical activities through cycle paths, recreational spaces, sports and beaches, proximity and density of fast food outlets), economic environment (costs related to food and physical activity and the ability of people to pay for access), political environment (laws, regulations and policies that impact on people’s choices – e.g. school nutrition policies and local government planning processes such as ‘active transport’, urban design); and socio-cultural environment (societal attitudes, beliefs and values which impact on the behaviour of individuals).

3. It is well-established that obesity is strongly associated with relative socio-economic status (Clarke et al., 2009). Longitudinal studies consistently show that people living in more disadvantaged areas gain more weight than those in less disadvantaged areas.

7. Effective Interventions

1. Empirical evidence of how to prevent obesity is limited but growing. A summary of the strength of evidence and cost effectiveness of a range of interventions in terms of obesity is presented in the table below (Gortmaker et al., 2011). The table is based on the Australian Assessing Cost-Effectiveness (ACE) in Obesity and ACE–Prevention studies. More detailed information on effective interventions is available on request.

2. The strength of evidence for reducing obesity is highest for family based targeted programmes for obese children, gastric banding, programmes such as diet and exercise, low fat diets, weightwatchers and the use of Orlistat.

Family based targeted programmes are the only one of these which is net cost savings.
Note: DALY - Disability adjusted life years. The strength of evidence classification (1=strongest; 5=weakest) is based on criteria adopted in ACE-Prevention. 1=sufficient evidence of effectiveness. Effectiveness is shown by sufficient evidence from well-designed research that the effect is unlikely to be due to chance (eg, evidence from: a level I study design; several good quality level II studies; or several high quality level III-1 or III-2 studies from which effects of bias and confounding can be reasonably excluded on the basis of the design and analysis). 2=likely to be effective. Effectiveness results are based on sound theoretical rationale and programme logic, and level IV studies, indirect or parallel evidence for outcomes, or epidemiological modelling to the desired outcome using a mix of evidence types or levels. The effect is unlikely to be due to chance. Implementation of this intervention should be accompanied by an appropriate evaluation budget. 3=limited evidence of effectiveness is demonstrated by limited evidence from studies of varying quality (can be level II or IV studies). 4=may be effective. Effectiveness is similar to evidence of strength 2 but potentially not significant and bias cannot be excluded as a possible explanation. 5=inconclusive or inadequate evidence (5 or 6 in original studies)

3. In general programmes showing greater cost effectiveness are those that relate to policy approaches rather than health promotion or clinical interventions. Priority actions identified including regulations to restrict food and beverage marketing to children, front-of-pack traffic light labelling, and sugar-sweetened beverage taxes, are likely to be cost saving. Although there is limited evidence for some of these interventions if they have an impact on a large population, even a weak positive effect has the potential for significant population health gain at a modest cost.
4. This conclusion is consistent with other assessments and reviews (WHO 2013, Swinburn et al., 2005, Swinburn et al. 1999, Sacks et al., 2005, King et al. 2010). The WHO Global Strategy for the Prevention and Control of Non-communicable Diseases 2013-2020 Action Plan (2013) identifies policy approaches as a core component to address risk factors for obesity. A New Zealand study showed that food pricing policies have potential for improving population health, and it was suggested that such policies would have greater benefits for low-income and Maori households due to the greater sensitivity of these groups to price changes (Mhurchu et al., 2013).

5. According to the Ace-Prevention studies a number of school based programmes are likely to be cost saving but the strength of evidence for these is limited and of varying quality. A recent Cochrane Review (Waters et al., 2013) on interventions for preventing obesity in children came to a similar conclusion. It found that interventions can be effective, however the knowledge of which specific intervention components are most effective and what is affordable and cost-effective appears to be lacking.

6. The Waters 2013 review found the following activities were included in beneficial programmes for children:
   a. Curriculum on healthy eating, physical activity and body image integrated into regular school curriculum
   b. More sessions for physical activity and the development of fundamental movement skills throughout the school week
   c. Improved nutritional quality of foods made available to students
   d. Creating an environment and culture that support children eating nutritious foods and being active throughout each day
   e. Providing support for teachers and other staff to implement health promotion strategies and activities (e.g. professional development, capacity building)
   f. Engaging with parents to support activities in the home setting to encourage children to be more active, eat more nutritious foods and spend less time in screen-based activities.

7. Project Energise is a region-wide whole-school nutrition and physical activity programme established in Waikato. The programme is operating in all schools in the Waikato. Energizers (trained nutrition and physical activity specialists) work with eight to twelve schools each to achieve the goals of the programme, which are based on healthier eating and enhanced physical activity. A recently published evaluation of the programme (Rush 2013) reported that the prevalence of obesity and overweight among younger and older children in 2011 was lower by 31 and 15 %, respectively, than that among 'unEnergized' children. Similarly, BMI was lower by 3·0 % (95 % CI - 5·8, - 1·3) and 2·4 % (95 % CI - 4·3, - 0·5). Physical fitness (time taken to complete a 550 m run) was significantly higher in the Energized children (13·7 and 11·3 %, respectively) than in a group of similarly aged children from another region.

8. The Project Energise programme and the results published are impressive but methodological limitations undermine the reliability of the results. This is because they have compared weight and body fat of a non-random sample of 45% of a population of Waikato children in 2011 with a non-random sample of children from some Waikato schools in 2004. As a result there is likely to be considerable selection bias.
9. Observational studies have consistently shown that greater activity is associated with lower BMI and girth, yet there is strong evidence that physical activity interventions for children have had only a small effect on children’s overall activity levels (Metcalf et al 2012). Such interventions on their own have had limited success in reducing the body fat of children.

10. Regular physical activity can play an important role in preventing and treating cardiovascular disease, diabetes and other chronic health conditions in adults (Warburton et al, 2006) and interventions tend to focus on moderate to vigorous exercise. Among adults, it has been found that strategies combining both diet and physical activity are more effective than physical activity strategies alone (Miller and Dunstan, 2004). The health benefits of exercise have been found to be greatest in the case of daily repetitive activities as these are more durable over longer periods (Lawlor et al 2003).

11. A Cochrane Review on interventions for promoting physical activity (Foster et al., 2005) found that structured physical activity interventions delivered through “professional advice and guidance with continued support” could have a moderate effect on self-reported physical activity and fitness (19 studies; 7598 participants).

12. Recent studies are showing that sedentary behaviour, regardless of the amount of moderate to vigorous activity, is a health risk, with excessive sitting not able to be fully compensated for by 30 minutes of moderate to vigorous activity. Targeting sedentary behaviour is important (Rutten et al, 2013).

8. Physical Activity and Nutrition Promotion: National

1. Public health funding supports a number of agencies to deliver nutrition and physical activity programmes at a national level, and these also have an impact in Auckland. The Health Promotion Agency (HPA) has an annual budget of approximately $1 million (Swinburn & Wood, 2013) for activities and events that promote breakfast through education and sports and settings; increasing parent, caregiver and whānau knowledge about the benefits of their children eating breakfast every day; supporting the work of the nutrition and physical activity sector; and developing nationally-consistent messages that reflect the Ministry of Health’s Food and Nutrition Guidelines.10

2. Responsibility for funding and managing the Green Prescription (GRx) was devolved from the Ministry of Health to DHBs in July 2012. This long-running programme involving primary care referrals to a range of providers of physical activity programmes (primarily sports trusts) has proven itself to be effective in delivering against key performance indicators set by the Ministry (Johnson and Wood 2013). An early evaluation of the Green Prescription (Swinburn et al., 1998) found it effective in increasing recreational physical activity at 6 weeks.

3. Approximately $7 million is spent each year on Fruit in Schools, available to participating low-decile schools.

4. KickStart breakfast for low-decile schools is part-funded by up to $1.9 million per year by the Government in partnership with Sanitarium and Fonterra, who provide Weetbix and

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milk respectively. Breakfasts are delivered to children through the participating school communities.

5. Health Promoting Schools is an approach where the whole school community works together to address the health and wellbeing of students, staff and their community. Participating schools are supported by advisors from public health units, district health boards or local government, who are contracted by the Ministry of Health.

6. There are several non-Government organisations (NGOs) delivering nutrition and physical activity programmes at a national level in New Zealand, including the Heart Foundation and Agencies for Nutrition Action.

9. **Physical Activity and Nutrition Promotion: Auckland Region**

The following is not an exhaustive list of activities and more detailed information is available on request.

1. The Auckland Plan sets out the council vision for Auckland to be the world’s most liveable city. Within the Auckland plan there are many priorities that relate to physical activity and nutrition including promoting sport and recreation, valuing and protecting the natural environment, improving public transport, and restricting access to fast food outlets. The Sport and Recreation action plan which is currently being finalised by the council aims to increase participation in physical activity recreation and sport, develop and support the infrastructure to do this, nurture talent and excellence in sport and develop the sport and recreation sector.

2. Auckland Transport’s *Travelwise* programme delivers a whole school approach to improving road safety and reducing congestion around schools, as well as encouraging children to be active by walking and cycling or scooting to school. 356 schools across the Auckland region are now signed-up to the programme.

3. Auckland Transport also promotes increased access to a wider range of transport choices including walking and cycling. Seasonal cycling programmes are run which aim to encourage Aucklanders to attend free cycling training courses to enhance their skill level, confidence and knowledge of safe cycling behaviour. A range of cycling training courses for all ages and abilities are provided. The Auckland Transport *Commute Programme* works with businesses to reduce congestion in the peak hours and promote travel choices and increase the use of active travel.

4. Auckland Regional Public Health (ARPHS) works with representatives from the three Auckland DHBs in making submissions from a public health perspective, to Auckland Council and other agencies, on policies that impact on nutrition and physical activity, such as Auckland Council’s Unitary Plan.

5. A Healthy Food Environment policy applying to all DHB sites for staff, public and patients has been developed by the Healthy Food Environment Group, comprising membership from Waitemata DHB, Auckland DHB and ARPHS as a result of follow-up to a July 2012 CPHAC paper which recommended that policy and nutrition guidance be provided across the two DHBs. Progress to date includes:
   - Restrictions on vending machine
• Requirements for food vendors to provide healthy food with appropriate portion sizes
• All vendors to be exemplars for promoting healthy food.

6. ARPHS delivers *Early Childhood Education Centre* and *Refugee and Migrant Health programmes*, with a focus on healthy food policies, and promotes nutrition and physical activity through a workplace health programme *Heartbeat Challenge™*. This is a health improvement programme that addresses chronic risk factors in the workplace, including healthy eating, and physical inactivity.

7. The Ministry of Health funds Auckland, Waitemata and Counties Manukau DHBs to provide *nutrition and physical activity information through maternal and child health services*. The Auckland budget for 2013/14 is $1,636,300 across the three DHBs.

8. Pacific physical activity and nutrition activities through churches and community settings are provided through
   • *LotuMoui* in Counties Manukau DHB
   • *Healthy Village Action Zones* in Auckland DHB
   • *Enua Ola* Pacific programme in Waitemata DHB.

   Note: An evaluation of the *Enua Ola* programme was carried out by the University of Auckland in 2011 (Clinton et al, 2011). It found that there were over 1,200 active participants in the programme across 30 churches and there were many more by association. Of the 365 people included in the evaluation 43% were found to have lost weight, 30% maintained weight and 27% gained weight.

9. *Sports trusts* deliver physical activity promotion programmes at a community level, and in Auckland they are contracted to provide personalised support through *Green Prescription*, via referral from General Practitioners (GPs). Each Trust delivers physical activity promotion (e.g. walking programmes, community sports days) on the basis of plans submitted to Sports NZ for funding. There are four trusts in Auckland: Harbour Sport (delivers Green Prescription for North Shore), Sport Waitakere, Sport Auckland (has a contract to deliver Green Prescription for ADHB and CMDHB) and Counties Manukau Sport (*CM Active* delivers physical activity programmes in workplaces, schools, marae, etc in Counties Manukau).

10. *Play4Life* was set up by Waitemata DHB in 2008, aiming to increase health awareness and support healthy environments in the sport and recreation setting. It was piloted in five rugby league clubs across the Auckland region. A 2012 evaluation showed that health-related changes (smoking, alcohol and in club catering) in the club environment were being made as clubs implemented modules of the programme. More recently it has become *League 4 Life* and is run by National Rugby League.

11. *Project Energise* is being introduced to several schools in South Auckland by Sport Counties Manukau with support from Sport Waikato and Counties Manukau DHB.

12. The level of funding available for nutrition and physical activity promotion in the Auckland area is unclear. The Ministry of Health’s public health funding for regional nutrition and physical activity promotion in Auckland for 2013/14 is approximately $2.461m. Public health funding for national programmes (which also impact on Auckland) is $11.621m including the Heart Foundation’s work in Auckland schools, and
Fruit in Schools. Additional funding (not identified) is provided by Sport New Zealand and various commercial agencies.

10. Way Forward and Priorities for Action

1. A wide range of nutrition and physical activity interventions are being undertaken by NGOs, sports trusts, health promotion providers, health services, Auckland Council and the broader public sector, attempting to change behaviour and environments. However current activities and resources are insufficient to counter the trend of increasing obesity-related health problems.

2. A coordinated, strategic and innovative region-wide approach is required to address the issues outlined in this paper. This needs to be sustained over a long period of time. Initially this should focus on better coordination and strengthening of existing programmes as well as closer working with the range of partners involved. Over time existing programmes should be extended and new ones developed in response to the emerging evidence base and the availability of resources. Given the scale and costs of obesity and the limitations of the existing evidence base, an innovative and flexible approach will be required in some areas. Priorities for action include:

- **Leadership and coordination** is needed regionally across the range of activities currently being undertaken. An intersectoral working group should be established to lead and coordinate the response to obesity in Auckland. A workplan should be developed and agreed by the group. ARPHS should lead this work on behalf of the three DHBs. **A proposed draft action plan is provided in the Appendix.**

- **Food environments** work being undertaken across the three DHBs on a policy framework and action plan will be fully implemented across the DHBs and extended, during 2014, to prioritised external agencies. These include Auckland Council and tertiary education institutions. This work will include assisting agencies to:
  - establish coordinating groups to lead and promote healthy nutrition and physical activity
  - develop appropriate policies for their constituencies (for example ECECs and WINZ)
  - applying nutritional criteria to vending machines
  - supporting agreed messaging in respect to nutrition and physical activity
  - consideration of nutritional requirements to be included in contracts with food providers.

- **Priority populations and settings** - children and young people should be prioritised in the context of a comprehensive approach. The current focus on maternal and infant nutrition should be maintained. Preschools and schools are particularly important settings for working with children and young people and activities in these areas should be strengthened and extended. In line with Government priorities, during 2014 priority will be given to strengthening existing programmes which target Early Childhood Education Centres and young mothers in low decile areas.
- Maori and Pacific populations should be a priority. Efforts should be targeted at schools and preschools with a high Maori and Pacific population and in more deprived areas as well as sports such as the expansion of the Play 4 Life programmes, clubs, workplaces and churches with high Maori and Pacific populations.

- **Intersectoral work** - many of the determinants of obesity lie outside of the health sector and many of the actions and policies that will have the greatest impact on obesity are being undertaken by Auckland Council, Auckland Transport and the broader public sector. The health sector through ARPHS has successfully engaged with Auckland Council through the development of the Auckland Plan and the current development of the unitary plan. This engagement will be strengthened and further developed through greater involvement in the Sport and Recreation Strategy and involvement with Auckland Transport. This work will be prioritised for 2014.

- **Innovation and development** is required in order to address the scale of the obesity challenge and the gaps in the existing evidence base. Given the pressures on existing DHB budgets money will need to be identified from savings elsewhere or from bidding for new money. New initiatives and potentially funding is likely to be available from the MOH and others and the DHBs need to be well prepared and positioned in order to respond to new opportunities and initiatives. Robust monitoring and evaluation should be a key part of any innovation.

The proposed intersectoral working group, using a shared framework and common evaluation approach, will provide the mechanism for ensuring the region can most effectively leverage future funding opportunities. It will be essential to invest time in developing long term relationships with agencies for this purpose.

**References**


Harvard School of Public Health *The Obesity Prevention Source* [www.hsph.harvard.edu/obesity-prevention-source/](http://www.hsph.harvard.edu/obesity-prevention-source/).


Appendix 1. HEALTHY EATING AND PHYSICAL ACTIVITY IN THE AUCKLAND REGION
Provisional Action Plan for the period 1/1/14 to 31/12/15.
Version 1.2 Draft of 23/1/14

**Strategic Intent:** to reduce the long term impact of obesity on morbidity, disability and mortality rates.

**Strategic Approach:** to establish a regional framework and mechanisms for health and non-health agencies to collaborate on promoting healthy eating and physical activity.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Actions</th>
<th>Target / Milestone</th>
<th>Responsibility</th>
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</thead>
</table>
| 1. Leadership and coordination | • Establish obesity prevention working group  
• Initial workshop of key agencies  
• Agreement to develop a shared approach reached  
• Shared framework drafted to include:  
  o opportunities for greater collaboration re existing services,  
  o programmes for enhancement or development,  
Subsequent development to include:  
• shared key messages,  
  o a common approach to evaluation,  
  o agreement on next steps including innovative approaches to address gaps | By 30/4/14  
By 30/6/14  
Agreed actions for implementation from 1/7/14 with quarterly reporting on agreed performance measures. | ARPHS |
| 2. Food environments | • Food policy plans implemented in all DHBs  
• Stocktake of compliance with policy  
• Agreement to develop food policy plans with selected agencies such as Auckland Council and tertiary institutions.  
• Food policy plans drafted by selected agencies for sign off  
• Food policy plans commence implementation in selected agencies. | 30/6/14  
30/6/14  
31/2/14  
31/3/15 | DHBs and ARPHS |
### 3. Promote healthy eating and physical activity to prioritised populations and priority settings.

- Identify opportunities for increased support and enhancement of activities in high priority settings including:
  - maternal and infant nutrition
  - early childhood centres
  - workplaces
  - sports clubs
  - churches
  - primary care
- Support needs identified, agreed and resourced.
- Implementation of agreed activities

30/6/14

Agreed actions for implementation from 1/7/14 with quarterly reporting on agreed performance measures.

DHBs and ARPHS

### 4. Intersectoral policy work

Promote healthy eating and physical activity through influencing regional policy, and intersectoral action.

- Provide policy advice through submission opportunities including Auckland unitary plan and relevant plans such as Auckland Transport policies and the Sport and Recreation Strategy
- Identify and agree priorities for collaboration with Auckland Council.
- Implementation of agreed priorities.

1/3/14

30/6/14

Agreed actions for implementation from 1/7/14 with quarterly reporting on agreed performance measures.

ARPHS

### 5. Innovation and development

Develop innovative approaches to promoting healthy eating and physical activity.

- Utilise monitoring information from regional activities and feedback from interagency group to develop status report and recommendations to inform future plans and funding proposals.

Quarterly reports.

Proposals submitted to DHBs (and other agencies) by 31/11/14 for consideration in 2015/16 funding process.

ARPHS
3.2 Auckland Regional Public Health Service Submission on the Unitary Plan

Recommendation:

That the Auckland and Waitemata DHBs Community and Public Health Advisory Committees:

a) Note the advice provided.

b) Agree the sign off process for the Auckland Regional Public Health Service to make the submission on behalf of the three DHBs.

Prepared by: William Rainger (Service Manager Auckland Regional Public Health Service), Scott Abbott (Programme Supervisor Auckland Regional Public Health Service)
Endorsed by: Simon Bowen (Director Health Outcomes)

Glossary

ARPHS - Auckland Regional Public Health Service
EAG - Expert advisory group (EAG)

1. Purpose

This briefing provides an overview of Auckland Regional Public Health Service’s (ARPHS’s) submissions on Auckland Council’s Unitary Plan as well as timelines for responding to the second round of consultation and our key recommendations.

2. Background

The Auckland Unitary Plan is the next step in bringing Auckland together and delivering the vision of the Auckland Plan. It replaces the existing Regional Policy Statement and 13 existing district and regional plans. It will ensure that Auckland can meet its economic and housing growth needs and help its centres meet their real potential, while protecting and enhancing what already makes the region great.

The unitary plan will determine:
- what can be built and where
- how to create a higher quality and more compact Auckland
- how to provide for rural activities
- how to maintain the marine environment.
3. **Submissions**

   1. **First Submission, May 2013**
      ARPHS produced a submission for the first round of consultation in May 2013. Of our 125 total recommendations, 29 were fully successful, 36 were partially successful and 60 were unsuccessful.

   **Our major successes included:**
   - Enhancement of allowances for increased open space for new housing areas and in areas where there is already a lack of recreational facilities.
   - Restrictions on fast food and takeaway outlets through zoning restrictions in certain areas.
   - Green roofs in certain areas. This is advocated in the Auckland Design Manual that accompanies the plan.
   - Recognition of the risks associated with climate change.
   - Projected sea level rise and associated planning issues are factored into the plan.
   - Improvements to the health requirements of clean fill and landfill areas.
   - Improvements to air quality requirements, especially for early childhood centres.
   - Controls on potential noise pollution to sensitive activities. These include residential care, educational facilities and early childhood centres, marae and papakainga.
   - Reverse sensitivity considerations regarding noise for residential developments in the CBD area.
   - Successful inclusion of considerations regarding adequate access to light (necessary for vitamin D synthesis) for those in high density buildings.
   - Enhanced consideration of social infrastructure and urban design considerations in new Greenfields developments.
   - Enhanced consideration of reverse sensitivity effects for developments that are utilized for vulnerable members of the community.

   **Recommendations which were unsuccessful include:**
   - Enhancing Open Space and Green Open Space
   - Ensuring Good Air Quality
   - Infrastructure Capacity
   - Contaminated land
   - Structure Plan requirements for Future Urban Zoned Greenfield Land
   - Area Renewal vs. Single Site Development
   - Changing Status of Areas
   - Protecting or Avoiding Harm to Health
   - Matters for Discretion
   - Resilient Infrastructure
   - Mana Whenua, Taurahere Maori and Mataawaka (includes Maori health models).
   - Community Gardens
   - Biodiversity (includes issues regarding vector borne diseases).
   - Identification of Land Subject to Natural Hazards
   - Minimising Exposure of Vulnerable Activities to Risk
   - Retain Natural Defence Systems
   - Transportation Network (strong advocacy for active and public transport), alignment with Auckland Plan targets for greater physical activity amongst Aucklanders.
   - Assessment of Sustainability Using the Homestar and Greenstar Tools
   - Dwelling Mix Rules
• Control of Liquor
• Smokefree Auckland
• Gambling Venues and the Unitary Plan
• Freshwater Standards
• Coastal Water Quality
• Kai Moana Collection
• Un-Serviced Villages
• Protection of Drinking Water Sources
• Water Allocation
• Hazardous Substances
• Auckland Design Manual (while we support the provisions within the manual, we would like to see a greater number of mandatory rather than voluntary provisions in areas that influence health outcomes).

2. Second Submission, February 2014
In order to inform the direction of our second submission ARPHS Policy Analysts and Senior Medical Officers have evaluated our first submission. Major successes will be acknowledged to try and ensure these are not changed through this round. Areas we feel can still be influenced will be re-stated in an attempt to have some earlier failed recommendations undertaken.

The timetable for planning our response to the latest draft of the plan is as follows:

<table>
<thead>
<tr>
<th>No</th>
<th>Task</th>
<th>When</th>
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<tbody>
<tr>
<td>1</td>
<td>Evaluation of previous submission</td>
<td>15/11</td>
</tr>
<tr>
<td>2</td>
<td>Final subject input provided by Subject Matter Experts (Clinical and Technical leads)</td>
<td>6/12</td>
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<tr>
<td>3</td>
<td>Draft Submission</td>
<td>31/1/14</td>
</tr>
<tr>
<td>4</td>
<td>Internal Peer Review</td>
<td>3/2</td>
</tr>
<tr>
<td>5</td>
<td>Draft Submission circulated for internal (Service Manager, Clinical Director, SMT, relevant Programme Supervisors and other staff who have contributed) and external (DHBs and Auckland Intersectoral Health Group) peer review</td>
<td>11/2</td>
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<tr>
<td>6</td>
<td>Final draft submitted to Service Manager and Clinical Director/Partner for final signoff</td>
<td>20/2</td>
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<tr>
<td>7</td>
<td>Final Submission document sent to Council</td>
<td>28/2</td>
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The technical work and analysis will be carried out internally as part of our core business. The DHBs (through AIHG) will be provided with a polished draft for comment and input; the week-long consultation period mirrors the process carried out for the development of the first submission.

We propose that the advice contained within this memo is provided to both CPHAC and CHAC (Counties Manukau DHB) at their February meetings to keep them informed of the process.
The major themes of our second submission will be as follows:

- Emphasis of health related aspects of the Regional Policy Statement. We have suggested inclusion of an additional specific health section amongst the eight ‘issues of regional significance’ for Auckland under the Unitary Plan.
- We have also generally emphasised a holistic tool for assessing health impacts of all planning decisions such as a health impact assessment tool (HIA). There may be potential here to also incorporate Maori health models, which we will advocate for inclusion of as well (in consultation with Maori liaison officer and manawhenua).
- Potential use of WHO international guidance, such as the International Alliance for Healthy Cities, and the development of a ‘Healthy City Action Plan’ in collaboration with the Auckland health sector, in order to guide health related public planning.
- Analysis has shown that in some aspects realisation of the Health Auckland Plan objectives and targets is likely to be hampered by traditional methodologies and planning instruments within the unitary plan. The gap between strategy and implementation is something that is experienced by cities all over the world, and the WHO Alliance for healthy cities guidance on instruments such as HIAs, and the development of collaborative ‘Healthy City Action Plans’ (with DHBs) is means of providing effective realization of health related strategic aims and targets.

Restated, partially successful issues and new issues for inclusion within the Unitary Plan

- Environmental influences on Levels of Obesity
- Safe Neighbourhood Design
- Children and Driveways
- Five or More Dwellings (reducing perverse incentives to development)
- Universal Design, Aging and Disability
- Social Infrastructure
- Clean fill, Managed Fill and Landfill
- Communicating Risk
- Disposal of Bio solids
- Minimising Exposure of Vulnerable Activities to Risk
- Access to Specific Plan Provisions Applicable to a Property
- Climate Change (while we are pleased with some of the proposed measures, we would like to see stronger mitigation measures as well as other adaptation measures, particularly to address projected climate change health impacts)
- Minimising Urban Heat Island Effects
- Compliance with national standards and guidelines.

New issues for inclusion:

- Retention of Natural Defence Systems (includes mangroves which also provide ecosystem services – such as filtering heavy metals and contaminants from water ways).
- Protection of Drinking Water Sources (including from agricultural runoff).
- Gender and urban design.

Our submission will also include a number of issues in the appendices for reference and to reinforce our recommendations in the body of the submission. These include:

- A comparative table of the health related Auckland Plan objectives and targets, and the ARPHS recommendations on the current plan that reinforce these.
- Poverty related illnesses in Auckland, and measures to reduce these (such as reductions in housing costs, local government related recommendations from the expert advisory group (EAG) report on child poverty).
• Global issues that have impacts on health over the next 30 years: climate change, changing resource costs (projections)
• Overview of health in Auckland (particular focus on Maori health)

Please note that we are still working on this draft. Some issues outlined above, such as the strategic objectives and frameworks for collaboration with Council will need to be discussed by senior management at ARPHS. These could provide excellent vehicles to provide a greater health focus in the future for many areas that could benefit from specialist assessment of public health effects (such as community water fluoridation). Final submissions are due 28 February 2014.

4. Process for approving February 2014 Submission

In view of the deadline of 28th February 2014, it is not practically feasible to finalise and then have the proposed submission formally agreed at the three DHB Board meetings. Therefore CPHAC is asked to indicate which sign off process it would prefer for the submission to be approved on behalf of the Auckland and Waitemata DHBs.

A suggestion for consideration is delegation to the Board Chair, the CPHAC Committee Chair and the Auckland and Waitemata DHB Chief Executives.
4.1 Ethnicity Data Audit Toolkit

Recommendation:

That the report be received.

Prepared by: Marty Rogers (Manager Māori Health Gain), Dr Sue Crengle (Public Health Physician), Dr Karen Bartholomew (Public Health Physician), Darna Appleyard (Policy and Planning Manager Māori Health Gain)

Glossary

DHB - District Health Board
EDAT - Ethnicity Data Audit Toolkit
PHO - Primary Health Organisation
PMS - Practice Management System
RFP - Request for Proposals

1. Executive Summary

Waitemata DHB has taken a natural leadership role in the past in efforts to analyse and improve ethnicity data collection. Having accurate ethnicity data is a necessary and critical step in tackling health inequalities. The Ethnicity Data Audit Toolkit (EDAT) is a package developed by the Ministry of Health with input from academics as well as staff from Waitemata DHB to provide a baseline assessment of the quality of ethnicity data in primary care and to provide practice level information for developing quality improvement activities.

The EDAT is relevant to all ethnic groups; however the largest issue of misclassification in primary care data is for Māori. Implementation of the EDAT is being led by the Māori Health Gain team in partnership with primary care. Auckland and Waitemata District Health Boards (DHBs) were successful in tendering for funding to support implementation of the EDAT within the region’s 240 general practices. Auckland and Waitemata DHBs are also developing a training and support package to share the learnings from the Waitemata DHB EDAT pilot and the Cervical Screening Ethnicity Data Quality Improvement Project with other DHBs around the country.

2. Introduction/Background

High quality ethnicity data is important in health sector strategy and policy. In the New Zealand primary health care context, the purposes of ethnicity data collection include:

- Guiding implementation of individual care plans and interventions (e.g., risk assessment tools).
- Supporting clinical audit and quality improvement activities in general practice.
- Measuring and monitoring population health (including health risk factors, incidence, outcomes and experiences of care) over time.
- Monitoring policy and service performance, effectiveness and equity at a broader system level.
- Planning for population priorities.
- Efficient targeting of funding and allocation of resources.

There are known issues with misclassification of ethnicity data in all health data sources, including in primary care, which results in an undercount of Māori, Pacific and Asian
ethnicities.\textsuperscript{1} The largest misclassification has been recorded for Māori, of the magnitude of 20\%.\textsuperscript{2} Apart from the legislative and consumer rights perspectives, this kind of incorrect classification of data is problematic for the accurate monitoring and reporting of programme performance, the appropriate targeting of individual patients and resource for certain programmes, and for the allocation of funding in primary care.

Waitemata DHB and the Ministry of Health funded a pilot Primary Care EDAT several years ago with Harbour Health PHO. The purpose of the tool is to assess ethnicity data collection, recording and storage at the primary care level. The EDAT was formally evaluated and subsequently further refined by Te Rōpū Rangahau a Eru Pōmare, University of Otago, Wellington and the Ministry of Health.

Primary care data is increasingly being used in the monitoring of programme performance, including health targets. The ability for this data to be disaggregated by ethnicity is critical for monitoring and action on inequalities in health status and outcome. Accurate recording and reporting of data, including ethnicity, is one of the requirements under legislation\textsuperscript{3} and under the Primary Health Organisation (PHO) agreement. In addition data quality is a national Māori Health Priority area within the Māori Health Plans for 2013-14 and 2014-15.

The final EDAT was released in June 2013 followed by a Request For Proposals (RFP) process in July 2013 for a small implementation fund. Auckland and Waitemata Māori Health and Primary Care teams developed the RFP response in collaboration with the five PHOs in the region. More detailed discussions about the implementation process are now being initiated with PHOs through the Auckland and Waitemata DHB EDAT project team. Early response has been supportive.

**The Toolkit**

The EDAT toolkit is intended to be a diagnostic aid to highlight issues that need further action. Implementation across the majority of practices throughout the country is intended to give a baseline assessment of data quality, and support quality improvement activities based on this information. The EDAT is in three stages, and the RFP has associated completion requirements (linked to the funding allocation) for each stage:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Activity</th>
<th>People involved</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>One</td>
<td>Systems compliance questionnaire completion and marking – one per practice</td>
<td>Practice manager/clinical lead</td>
<td>100% of practices</td>
</tr>
<tr>
<td>Two</td>
<td>Staff questionnaire completion and marking</td>
<td>All frontline reception staff and some clinical staff</td>
<td>95% of practices</td>
</tr>
<tr>
<td>Three</td>
<td>Re-collect of 100 consecutive patients ethnicity data on form provided (using the Census ethnicity question) Coding the PMS* data and the forms and reporting the proportion matching</td>
<td>Reception staff</td>
<td>95% of practices</td>
</tr>
<tr>
<td></td>
<td>Practice manager/clinical lead</td>
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* PMS=Practice Management System (eg MedTech, My Practice)

Implementation of the audit tool therefore requires moderate practice level time and activity, and the RFP requires a very high level of compliance.

\textsuperscript{1} Bramley D, Latimer S. The accuracy of ethnicity data in primary care. New Zealand Medical Journal. 2007;120(1264);
\textsuperscript{3} The New Zealand Public Health and Disability Act 2000, the Privacy Act 1993 and the Health Information Privacy Code 1994 Rule 8.
RFP Response
Significant work has been undertaken with primary care in order to assess a full range of implementation options and understand the feasibility of these options.

This work was informed by:
1. The formal evaluation of the Waitemata DHB-Ministry of Health EDAT pilot.⁴
2. The learning from the Waitemata DHB Cervical Screening Ethnicity Data Quality Improvement Project.
3. Preliminary discussions with the five PHOs in the Auckland and Waitemata DHB area.

The option for delivery favoured after this work is a PHO-led phased approach with DHB support for training and implementation guidance.

Phased approach
The phased approach was developed out of the learnings from the Cervical Screening Ethnicity Data Quality Improvement Project. This project involved working with PHOs to contact women enrolled in the National Cervical Screening Programme to clarify their ethnicity where the relevant data sources recorded different ethnicities. The project required practice permission and activity to be completed, and found that there were three groups of practices:
1. Early responders
2. Responders with increased input
3. Non-responders (including those who actively declined).

Based on this finding PHOs were asked to identify the practices which were likely to fall into the ‘Early Responder’ phase, in order for EDAT implementation to be undertaken with these practices first. The five PHOs identified that approximately 35% of the 240 practices would be identified as Phase 1. Further PHO input and DHB PHO project liaison/training input would be anticipated for practices identified as falling into Phase 2 and 3.

Each PHO has also identified a planned start time for EDAT implementation; therefore the implementation by each PHO will be staggered to allow for delivery of a DHB-led train-the-trainer package to optimise completion of the tool within general practices.

3. Risks/Issues
The high levels of compliance required in the RFP (linked to funding) are going to be challenging (95% of practices completing all three stages of EDAT activity). There was awareness of the compliance requirements throughout the RFP discussion process, and the PHO-led and phased approaches were strategies developed to address the compliance requirements. In addition an EDAT project manager has been proposed for PHO and practice liaison as well as ongoing training, support and mentoring as required.

4. Progress/Achievements/Activity
The Auckland and Waitemata DHBs response to the RFP for support to implement the ethnicity data audit tool was successful. The service specifications have been agreed verbally

and are expected to be signed-off for project commencement in February 2014. Preliminary work with PHOs who will lead the phased implementation has been undertaken, and a PHO specific training package is being developed.

**Additional DHB leadership component**

A supplementary bid for funding was placed with the Ministry of Health. This largely included leadership, support and training. This was originally discussed with the North Island DHBs who had put in an RFP response, but was later widened to some interested South Island DHBs.

While this is still under being finalised with other regions at present, the leadership component is intended to cover:

1. Leadership and guidance regarding approach: background to approach, resources, training, funding options, barriers/enablers, limitations (quality and IT), scheduling considerations, planning and reporting templates.
2. Training for other DHB regions: train-the-trainer development and implementation guidance (EDAT and the Ethnicity Data Protocols).
3. Ongoing mentoring and guidance for interested DHBs from the EDAT team via teleconference (or videoconference) for the first six months of project implementation.

The current proposal is for the Auckland and Waitemata DHB EDAT team to offer a full-day forum at two different North Island locations (more training may be available on request). This supplementary funding bid has verbally been confirmed as successful.

### 5. Conclusion

EDAT will be implemented across the majority of general practices in 2014-15 through a PHO-led approach. The project team will provide PHO liaison and support, training and reporting to ensure that the high compliance targets are met. Completion of this project will provide a baseline assessment of the quality of ethnicity data in primary care, and identify areas for focussed quality improvement activities. This will be a significant step towards improved ethnicity data quality for accurate monitoring of health inequalities.
4.2 Primary Care Update – The Alliance and Localities

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

MOH - Ministry of Health
PHO - Primary Health Organisation

1. Summary

This report provides an update on the development of an Alliance between the DHBs and the PHOs and on the locality work programme.

Discussions on the formation of the Alliance are progressing and it is anticipated an agreement will be available during February for consideration by PHO and DHB Boards.

The three localities are making steady progress; a summary is provided below.

2. Localities

Auckland and Waitemata District Health Boards (DHBs), Primary Health Organisations (PHOs), clinical leaders and NGO providers are working with communities within a locality framework to increase capacity and capability of primary care services. The locality framework has allowed focus on specific geographical areas of need and to implement locally designed solutions.

The Localities Establishment Governance Group (LEGG) has been formed to oversee the locality development (see Appendix 1 for the Terms of Reference).

Auckland health localities align with council ward and board boundaries wherever possible. This supports infrastructure planning including the formation of clusters of providers in a community to support the desired outcomes. West Auckland was the first locality established and covers the Waitakere Ranges and Whau boards. Initial focus was on the development of Integrated Family Health and Whanau Ora Centres, and the creation of clinical networks. In 2013 localities in West Rodney and Maungakiekie-Tamaki have been formed. Clinical Directors, who are general practitioners, are in place for each locality.

The intent is to design and develop improved healthcare through a range of new services, models of care and integrative approaches with secondary care for individuals, family and whanau that can be used as a template in other localities and to share resources collectively. For this to be effective we need to identify and implement mechanisms to increase the
capacity and capability of primary care and for General Practice to understand and engage with the available opportunities. Not doing so will not enable our collective goals of increased integration and managing the investment in hospital based services to occur.

The figure below defines the localities. At this time there are the three above mentioned localities. Other localities may be added at a later date.

**Figure 1: Overview of Auckland and Waitemata DHB Localities**

2.1 Progress to date

Each locality has a differing focus so we can maximise our learning and respond to local communities and providers, see below. However, the underlying principles of the locality direction remain consistent.

Significant progress has been made in defining and establishing localities and clusters of providers, along with developing relationships with communities. Work now needs to start on developing new models of general practice that allows all practitioners to work at the top of their clinical scope, and to expand types of workforce available. This has a primary purpose of creating increased capacity and capability in primary care that supports a model with the patient, family and whānau at the centre.
We now are seeking support from the Implementation Support Groups (ISGs). Primary care requires increased independent support and advice to develop practice and cluster level business models that allow capability and capacity development and support increased understanding and cooperation. The partners in locality planning and development will agree with each cluster of providers as to which ISG would most benefit the desired objectives. It is an imperative that providers are involved in the selection of the ISG so they have confidence in the process and have appropriate input in to the scope of activity.

Clinical leaders from general practice have been appointed to each locality. The clinical leader roles work closely with general practice to ensure that their input, concerns, and issues are both acknowledged, fully considered, and where possible incorporated into plans. The clinical leaders have been selected by PHOs and DHB collectively.

2.1.1 Auckland and Waitemata
The work that was started in 2012 with the facilitation of workshops with West Auckland GPs resulted in the formation of three clusters and agreement to develop three new models of care through clinically led work streams of:
1. Diabetes. A Locality and Cluster level analysis of practice and secondary care level data highlighted diabetes as one of the three highest age-standardised adult hospitalisation rates in Henderson.
2. Child Health. Asthma and skin infections are the priority areas along with Rheumatic Fever prevention and management.

The cluster demographics are presented in the following table.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Cluster</th>
<th>PHO name</th>
<th>No. of practices</th>
<th>Total enrolment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitakere</td>
<td>Henderson</td>
<td>ProCare Networks Ltd</td>
<td>13</td>
<td>75,628</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Waitemata PHO Ltd</td>
<td>1</td>
<td>6,283</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td><strong>14</strong></td>
<td><strong>86,995</strong></td>
</tr>
<tr>
<td>Waitakere</td>
<td>Massey*</td>
<td>ProCare Networks Ltd</td>
<td>6</td>
<td>28,673</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Waitemata PHO</td>
<td>1</td>
<td>2,325</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td><strong>7</strong></td>
<td><strong>30,998</strong></td>
</tr>
<tr>
<td>Whau &amp; Waitakere</td>
<td>New Lynn</td>
<td>Alliance Health Plus Trust</td>
<td>1</td>
<td>7,835</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auckland PHO Ltd</td>
<td>5</td>
<td>16,852</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ProCare Networks Ltd</td>
<td>11</td>
<td>61,016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>17</strong></td>
<td><strong>85,703</strong></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td><strong>38</strong></td>
<td><strong>203,696</strong></td>
</tr>
</tbody>
</table>

*Work has not begun with the Massey cluster as yet but they were invited as part of the Henderson cluster when work began in 2012.

**Diabetes Integration**
A clinical advisory group of general practice members along with secondary care specialists have been collaboratively developing a new model of diabetes care. This model is general practice lead with specialist support. We are now in the early stages of implementation. Diabetes clinics and practitioner continuing education sessions are being held in New Lynn. The clinic model which comprises an educational and joint patient review component will be

1 Figures are from Northern Region Capitation Report Q4 2013 Sept-Dec 2013.
refined within New Lynn before it is rolled out. The model requires general practice to operate within a cluster and all practitioners to operate at the top of their scope. To be able to expand this model widely ISG support is required to assist general practices to make the required changes.

The model will also be supported by a Quality Improvement Team, that is being recruited to start early in 2014. The Quality Improvement Team will apply a collaborative approach with general practice to look at performance, identify areas of improvement and innovation, and support improved care of diabetic patients in the community. The Quality Improvement Team will consist of general practitioner and nursing resource with support from secondary care diabetes specialists.

The model will be rolled out across the clusters, prioritising practices with high numbers of Maori and Pacific enrolees.

**Child Health**

The West Auckland Locality and Cluster analysis identified asthma and cellulitis as the second and third highest contributors to Ambulatory Sensitive Hospitalisations. The Henderson area will lead the asthma project to improve asthma management in children through the implementation of best practice guidelines. This is supported by the implementation of electronic shared care plans and the Pathway Navigator, a new electronic clinical pathway tool.

The New Lynn area will lead the cellulitis project to up skill nurses and General Practitioners in identification of skin infections and aim to reduce ambulatory sensitive admissions, increase health literacy and reduce pharmaceutical usage. The main focus of the project will be to implement agreed pathways and support the implementation of shared care for identified children to support continuity of care.

The roll out of both these models will require general practice to consider how they most effectively use their workforce to increase access and provide services as effectively as possible.

**2.1.2 Auckland North – West Rodney**

A number of provider and community engagement meetings have taken place which sought to identify what services were working well, what is not working so well, and what could be improved on. The main themes are access to services due to the rural nature of the community. Further work is required to refine the area of focus.

The practices in the area already work closely with management of after hours services. There is strong support from the practices to see if this can be further refined and what other opportunities there are of working collaboratively.

The cluster demographics are presented in the following table.
A Locality planning profile has been prepared. The purpose of this profile is to describe the health needs, service use, and population characteristics of the West Rodney area. The report describes these through looking at different aspects of the population groups of interest including demographics, social and economic factors, health status, and utilisation of health services.

2.1.3 Auckland Central – Maungakiekie-Tamaki
The first of a series of community and provider co-design workshops has occurred. A further two are planned for early 2014. These workshops follow on from extensive community consultation that identified mental health as a priority issue.

The cluster demographics are presented in the following table.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Cluster</th>
<th>PHO name</th>
<th>No. of practices</th>
<th>Total enrolment²</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ProCare</td>
<td>5</td>
<td>18,452</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Waitemata PHO</td>
<td>1</td>
<td>2,002</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>6</td>
<td>20,454</td>
<td></td>
</tr>
</tbody>
</table>

The project focused on a model for a new model of mental health care in Tamaki is in its early stages. The outline of the three workshops is below:

- **Workshop 1** – Understand the problem and develop a shared vision for the patient and the system. This was held on 20th November 2013 with well over 50 participants.
- **Workshop 2** – Develop a model of care to achieve the shared vision using evidence and best practice. This will include measures and associated timeframes that are explicit, realistic and meaningful to both clients and providers / clinicians.
- **Workshop 3** – Develop an implementation plan to include change management and communications plans.

2.2 Proposal for Ministry of Health Support
PHOs and the Auckland and Waitemata DHBs are in discussions with the MoH to secure additional funding to support the following proposed schedule of work. The MoH have a specified pool of funding for such support. This will support and build on the emerging momentum towards service integration across the two DHBs within the locality framework. The overall goal is to assist the transformation of services consistent with the Government’s strategic direction of Better, Sooner, More Convenient health care.

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² Figures are from Northern Region Capitation Report Q1 2013 Jan-Mar 2013.
³ Figures are from Northern Region Capitation Report Q4 2013 Sept-Dec 2013.
The schedule of work includes:

**Building Capacity in Primary Care**
- Support the evolving integrated health networks.
- Support practice and cluster level business process re-engineering to improve capacity and capability in general practice.
- Support the development of clinical networks and practice clusters to support the sharing of scarce healthcare resources including workforce.
- Support the implementation of tools which support a multi-disciplinary approach to patient care.

**Build Capability in Primary Care**
- Benchmark participating practices to enable comparison in current and future service delivery models.
- Support the implementation of skills transference to primary care.

**Support Primary and Secondary Integration**
- Provide analytical support and expertise in developing new models of care and funding models.
- Provide support regarding the integration of non government organisation providers across and within the models of care.
- Develop a process for adapting new models of care across other localities and clusters to enable resources to be shared collectively.
- Support the implementation of key enablers to integration such as shared care, clinical pathways and other tools.

**Build Viability of Primary Care**
- Provide support to general practice to review financial and business models to maximise financial viability.

3. **The Alliance**

The formation of a new Alliance of the DHBs and PHOs will further develop our relationships and focus on a collective approach to development of primary care. This will enable improved healthcare through a range of new services, models of care and integrative approaches with secondary care for individuals, family and whanau.

A draft Alliance agreement is with the PHOs for comment. The draft agreement is the result of several months of discussion on the focus of the Alliance, alignment with existing activity and scope. It is anticipated that an agreement will be available during February for consideration by PHO and DHB Boards.

Both PHOs and DHBs are cognisant of a far reaching work programme and other commitments already in place and do not wish, through the development of an Alliance, to develop significant additional commitments over and above those already agreed.
APPENDIX I
Locality Establishment Governance Group (LEGG)
Auckland & Waitemata Districts

Terms of Reference

May 2013

Purpose
To oversee the development and implementation of the agreed ‘locality approach’ across the Waitemata and Auckland DHB areas.

Background
Auckland and Waitemata District Health Boards are using a locality approach to develop more responsive, efficient and integrated ways of delivering healthcare services to meet our population’s health needs. The Locality Establishment Governance Group (LEGG) will assume a high level governance and monitoring role across the developing localities and provide recommendations and reporting on progress to the Collaboration Executive Group (the combined executive tasked with overseeing the development of collaboration activity of the Waitemata and Auckland DHBs) and the combined Community and Public Health Advisory Committees (CPHAC).

Alignment with organisational purpose and strategy
The locality approach has a strong grounding in the values of both Districts, and activities will be undertaken in ways that demonstrate commitment to these values:

<table>
<thead>
<tr>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrity</td>
<td>Best care for everyone</td>
</tr>
<tr>
<td>Respect</td>
<td>Better, best, brilliant</td>
</tr>
<tr>
<td>Innovation</td>
<td>Everyone matters</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Connected</td>
</tr>
<tr>
<td></td>
<td>With compassion</td>
</tr>
</tbody>
</table>

Consistent with our goal of self-directed care we will support the people of Auckland & Waitemata to maximise their health and well being by ensuring:
1. people will control and be empowered to maximise their own health and well being and enhance the quality of their life
2. peoples different beliefs about their health or their role in care will be respected
3. services will be prioritised based on patient / whānau need and we will work with the community to deliver services that meet their expressed health needs
4. people will have rapid and convenient access to high quality cost effective evidence based services
5. a focus on reducing health inequalities
6. responsiveness to the aspirations of Māori and be inclusive of whānau ora approaches
7. responsiveness to other ethnic communities such as Pacific and Asian peoples.

Objectives
The LEGG will:
• Agree on a collaborative way of working
• Set goals, priorities and aspirations for the locality approach
• Set and monitor performance criteria for each locality
• Recommend to the Collaboration Executive Group agreed ‘locality plans’ for approval for each locality (Annual Plan deliverable)
• Recommend to the Collaboration Executive Group business cases for the reconfiguration of services which by their nature need to be planned and funded at a higher level.

Overtime, formal mechanisms will need to be developed to link the LEGG with the Primary Care Clinical Advisory Group and the HealthLinks.

**Membership**

- Lead CEO for Primary Health Care (ADHB) – Chair
- Lead CMO for Primary Health Care (WDHB) – Deputy Chair
- Executive Director Allied Health Scientific and Technical (ADHB)
- A nursing representative
- Chief Planning & Funding Officers\(^4\) x 2
- A representative from Auckland Regional Public Health Service
- A representative of Te Runanga o Ngati Whatua
- A representative of Te Whanau o Waipareira
- Planning and Funding Manager Maori Health Team (ADHB/WDHB)
- Planning and Funding Manager Pacific Health Team (ADHB/WDHB)
- Planning and Funding Manager Asian Health
- PHO CEOs x 5
  - Alliance Health Plus
  - Auckland PHO
  - National Hauora Coalition
  - ProCare
  - Waitemata PHO
- A representative of Healthlinks Central\(^5\)
- A representative of Waitakere HealthLink
- A representative of the HealthLinks North

**Guiding Principles**

- Members will commit to attending meetings and engaging in good faith
- Members will ensure that they communicate with the people they are representing. They will routinely provide feedback on issues discussed at meetings to their own organisations and ensure relevant papers are circulated.
- The process will be transparent with minutes and agendas published and easily accessible.
- Members will act with openness, honesty and integrity
- The LEGG will endeavour to operate on the basis of consensus.
- The LEGG will provide and free up resources, as required and intervene on roadblock issues, where appropriate.

**Meetings**

The LEGG will meet on the second Tuesday of the month, for up to two hours. Minutes of the meeting will be circulated within 7 days of the meeting after approval by the Chair. Papers will be circulated five working days in advance.

**Quorum**

A quorum will be half the members + 1, including at least one DHB, PHO and community member.

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\(^4\) Note these roles are subject to a restructuring proposal

\(^5\) Note this group is not yet established so we will utilise an elected Local Board member in the interim
5.1 Planning and Funding Update

Recommendation:
That the report be received.

Prepared by: Dr Debbie Holdsworth (Director Funding WDHB/ADHB), Simon Bowen (Director Health Outcomes Waitemata DHB/ADHB), Wendy Bennett (Manager Planning and Health Intelligence), Tim Wood (Funding and Development Manager Primary Care Waitemata DHB/ADHB) and Cliff La Grange (Manager Finance and Support Services)

Glossary
ARHN  -  Auckland Refugee Health Network
CEO  -  Chief Executive Officer
DHB  -  District Health Board
MELAA  -  Middle Eastern, Latin American and African
MHP  -  Maori Health Plan
MOH  -  Ministry of Health
NHC  -  National Hauora Coalition
OPF  -  Operational Policy Framework
PHO  -  Primary Health Organisation
PSA Plan  -  Pacific Strategic/Action Plan

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

2. Summary of activities in common

2.1 Collaboration in Planning, Funding and Outcomes
The collaboration in Planning, Funding and Outcomes across Auckland and Waitemata DHBs is progressing steadily. A proposed structure is being developed for the Tier four and five posts to support optimal outcomes for both DHBs in term of delivery and service provision. 17 Shea Terrace has been fitted out and the Primary Care and Maori Health Gain teams have moved into the new offices. Proposals for the seating and optimal use of the space at 15 Shea Terrace are being developed.

2.2 Planning
Annual Plan 2014-15
Both the Auckland and Waitemata DHB 2014/15 Annual Plans are being prepared by the collaborative Planning Team this year. Further alignment of the plans is being undertaken so that the two Boards arrive at Plans that are as similar as possible. There will be differences in content between the two DHBs in some places. The strategic direction of each DHB currently remains distinct as does the financial material and the special arrangements re nationally provided specialist services offered by Auckland DHB.
The document is under construction with sections being discussed by our various stakeholders. Successful Annual Planning Days held at both Waitemata DHB (16 January) and Auckland DHB (21 January) – this being the first time for this event at Auckland DHB. More than 130 people attended each and many priority planning sections are now well advanced. Useful collaborative work was undertaken between DHBs, PHOs and NGOs in relation to 2014/15 priority activity. More engagement is planned for February and March, including work with the operational arm of our Treaty partners – Kahu Pokere and our primary care partners. Working drafts will be provided to respective February Board meetings and members will have the opportunity to give feedback/provide input. Changes will be incorporated prior to the submission to the Ministry of Health on 14 March.

Feedback on our draft work will be provided via the National Health Board in April. The final Board-approved Annual Plan is currently due with the National Health Board on 26 May. We intend to submit on this date subject to the Boards’ consideration of the respective plans at May Board meetings.

2.3 Child, Youth and Women’s health

2.3.1 Q2 2013-14 Immunisation Update
Waitemata and Auckland DHBs are working to improve the health and wellbeing of all children through achieving the immunisation health target – 95% of children fully immunised at 8 months of age by 30 December 2014 (90% by 30 June 2014). Waitemata DHB plans to reach the 95% target by 30 June 2014.

Waitemata DHB
The 8 month immunisation result for Waitemata DHB to December 2013 is at 92% overall (Maori 87%, Pacific 94%). This equates to an increase of 2% overall and 5% for Maori, from September to December 2013. Pacific remained at 94% over the same period. Waitemata has made steady gains and reduced the equity gap for Maori and Pacific since the 8 month target was introduced 1 July 2012 with an increase of 7% overall, 16% for Maori and 6% for Pacific.

Auckland DHB
The 8 month immunisation coverage for Auckland DHB is currently at 94% (Maori 91%, Pacific 93%) to December 2013. The increase of 4% overall in September was sustained to December with an increase of 2% for Maori and a decrease of 1% for Pacific. Since the 8 month target was introduced, Auckland coverage has increased 4% overall, 14% for Maori and 6% for Pacific.

Achievement of the 8-month immunisation rate increase was accomplished through increasing knowledge and awareness of immunisation guidelines and providing support for midwives and general practice staff as well as developing robust referral processes to Outreach Services and a strong and experienced steering group.

2.3.2 1 July 2014 Immunisation Schedule Changes
In December 2013, PHARMAC announced it will add rotavirus and varicella vaccines to the national immunisation schedule, along with improved versions of previously funded vaccines such as the pneumococcal vaccine Prevenar 13. The changes to the national immunisation schedule will come into place from 1 July 2014.

Rotavirus is a gastric infection mainly affecting children, causing illness and diarrhoea that can lead to hospital admission. In severe cases, the infection can be fatal. Introducing the rotavirus immunisation programme is likely to reduce demand for acute admissions to hospitals. The
rotavirus vaccine is an oral liquid easily administered to infants and given while babies are very young. This may have benefits in children obtaining other vaccines as well, leading to higher rates of immunisation.

Varicella (chickenpox) vaccine will be funded to protect the most at-risk patients – children with reduced immune systems (for example, because of chemotherapy). People in direct contact with these children will also be eligible for funded vaccine.

Prevenar 13 which offers protection against an additional three strains of invasive pneumococcal disease will replace the existing pneumococcal conjugate vaccine, Synflorix.

2.3.3 Well Child/Tamariki Ora Quality Improvement Framework
In July 2013 the Ministry of Health (MOH) released ‘The Well Child/Tamariki Ora Quality Improvement Framework’. The MOH asked each DHB to lead the process to select 3-5 indicators that they would focus on. The Auckland and Waitemata DHB Planning and Funding Child Health team facilitated a Well Child/ Tamariki Ora Quality Improvement Framework workshop, 5 December 2013. The workshop was well attended by a large number of organisations and services involved in child health. There were representatives from Well Child/Tamariki Ora providers, Non-Government Organisations, DHB services and the DHB Maori and Pacific teams.

Five indicators from the Quality Improvement Framework were identified by the group as priority areas for 2014-15. These were that:
- Newborns are enrolled with a general practice by two weeks of age
- Infants (0-12 months) receive all WCTO core contacts in their first year of life
- Children aged 0-4 are enrolled with child oral health services
- Children are enrolled in early childhood education
- Infants are exclusively or fully breastfed at three months

The Women, Child and Youth Team are working on the implementation plan which is due with the Ministry of Health on 21st February 2014.

2.4 Maori Health

Maori Health Plan 2014/15
All District Health Boards are required to develop and submit a 2014/15 Māori Health Plan (MHP) to document how the DHB will improve Māori health and reduce Māori health outcome disparities. The MHPs are required to be submitted as a stand-alone document to accompany each DHB Annual Plan. The general requirements of the MHP are set out in the Operational Policy Framework (OPF) in conjunction with the Annual Plan Toolkit which guides overall DHB planning requirements and contains more detailed guidance regarding AP mandatory requirements for Māori Health.

The Māori health plan template sets out the following requirements:

Section one
- A summary of DHB Māori population and health needs.

Section two
- 10 national mandatory health priority areas and 18 associated indicators
- DHBs required to state targets and activities and monitoring mechanisms.

Section three
- DHBs can select up to 3 local priority areas consistent with the health needs identified in section 1.
A Maori provider forum was convened on the 23rd of January to discuss Maori Health Plans. The provider forums are convened by the Iwi MoU partner and hosted by both MoU partners in partnership with the Maori health gain team. The forum was well attended by 25 representatives from a range of Maori providers in Auckland and Waitemata. The purpose of this forum was explicitly to meet Operational Policy Framework (OPF) requirements to provide mechanisms for robust Maori participation in DHB planning.

Significant changes for 2014/15 include the requirement to specify DHB and PHO activities and include stipulated monitoring mechanisms for each across all MHP priorities. The Primary care and Māori health teams will meet with PHOs on an individual basis to develop content for MHPs over the next three weeks.

2.5 Pacific Health

2.5.1 Pacific Strategic/Action Plan (PSA Plan) Update

The development of a joint Pacific Plan for Waitemata and Auckland DHBs is a requirement of the current annual plan for both DHBs. Previous Pacific DHB Plans had not involved community representatives in their development (but communities were consulted). This year the approach has been to further develop the partnership that has developed between the DHBs and the communities through the HVAZ and Enua Ola programmes to include community input into the development of the Plan as well as community consultation.

The PSA Plan 2013 – 2016 attempts to reflect a partnership approach between Auckland/Waitemata DHBs and Pacific communities in addressing the challenges that Pacific families and communities experience and has a focus on community development and health promotion.

The PSA draft Plan has been developed by a working group that includes three members of Pacific communities, representatives of AH+ and Procare PHOs, West Fono Health Trust and Pacific Integrated Healthcare and ADHB/Waitemata DHB staff from both planning and funding and provider arms.

236 people attended six community consultation meetings. The Chief Executive Officers (CEOs) and senior management teams of both DHBs, planning and funding teams as well as 27 Pacific employees were consulted. Individual meetings were held with the CEOs of Auckland PHO, National Hauora Coalition, Waitemata PHO, Procare and AH+ and one combined meeting that included some CEOs and some clinical directors.

The Plan identifies six main priorities that we believe will impact positively on the health of Pacific people. They are:

1. Children are safe, well and loved and that families are free of violence
2. People are smoke free
3. People eat healthy and stay active
4. People seek help early
5. People use hospital services when needed
6. Families live in warm and adequate houses.

The priorities identified necessitate not only partnership with Pacific communities but strong inter-sectoral collaboration. In relation to the above priorities, actions are identified for the DHBs, for the community, for PHOs in some areas and for inter-sectoral work.
The involvement of community representation in the planning process has positively influenced the approach in that:

- the audience of the Plan are the DHBs and the Pacific communities
- the language and the format of the Plan is to be easily understood by Pacific people as well as the DHBs
- the Plan is jointly owned by the DHBs and the Pacific communities (community being represented by the leadership of the HVAZ and Enua Ola churches and groups)
- the responsibility and accountability for the implementation of the Plan is held jointly by both the DHBs and the community
- the Plan does not focus on negative health statistics or comparisons between the health status of Pacific people and others as that is perceived negatively by Pacific people in the community (but the Plan does not deny that reality)
- the first priority is children being safe and families being free of violence
- the focus is on lifestyle issues, of being smoke free, eating healthy and staying active as that requires community support and changes to some Pacific social norms and practices
- housing is a major issue for Pacific families and is a contributor to ill health and although it is appreciated that DHBs are not responsible for the provision of housing, health workers can assist families to better access housing assistance by identifying the family’s specific health problems that are linked to poor housing.

An initial intention of the Plan was to have a three way partnership between DHBs, community and PHOs. The PHOs agreed in principle but more discussion needs to occur before specific actions are agreed to, especially in relation to community development and health promotion.

Addressing family violence requires strong inter-sectoral collaboration especially with Ministry of Social Development, Police and Justice. There are a number of inter-sectoral forums that are already established and in the current financial year, participation in these forums is a priority with involvement in funding decisions and delivery of programmes to follow in subsequent years.

The draft plan is currently now going through a process of internal signoff and the development of the resource implications for its implementation before being brought formally to CPHAC for endorsement.

2.5.2 DNA Work

A phone survey for Pacific people who do not attend (DNA) appointments with the ADHB Eye Clinic is in progress. Members of the Pacific Planning and Funding Team as well as the Pacific Family Support Units of the hospitals are undertaking the phone survey in Tongan, Samoan and English languages.

Agreement between West Fono and Dr. Tim Jelleyman and Linda Harun has been reached regarding West Fono ensuring that children referred by their GPs to Waitakere Hospital outpatient clinics are able to keep their appointments. The project will also “dig deeper” into the reasons and/or barriers that prevent parents/children from attending their appointments. This will include the GPs’ role in explaining to parents the reason/s for the referral, as well as other issues such as transport, child care, parking etc.
2.4.2 Smoke Free Environments

One of the questions asked in the Pacific Plan consultation in relation to smoke free environments was “would you participate in a group stop smoke competition?” There was strong support for the suggestion.

Agreement has been reached with the School of Population Health WERO stop smoking contest project to run a specific WERO competition for Pacific churches / groups in the Auckland and Waitemata areas. The competition will kick off on 1 June 2014, the day after World Smoke Free Day, 31st of May. In the New Year, WERO personnel will start training Pacific smoke free coaches to support the groups that will be part of the competition.

3. Waitemata DHB Update

3.1 Sleepover Settlement Agreements

Background
The Sleepover Wage (Settlement) Act 2011 came into effect on 18 October 2011. The Ministry of Health has led the work in relation to the settlement process.

All NGO providers using “sleepovers” in residential services, and not paying at the minimum wage, have been entitled to enter a Sleepover Agreement.

The process has been that eligible providers:
1. Register an interest in having a settlement agreement with the Crown in relation to sleepovers.
2. When a settlement agreement is reached, the provider is joined to the Act (via an Order in Council).
3. The DHB then receives Crown Funding to cover the cost and the DHB enters into an agreement to pay the provider.

There are two main parts to the funding. There is a back pay component that providers need to pay for claims made by employees. The Crown pays this directly to providers out of a central fund.

The second part of the funding is for the phasing in of the minimum wage from 30 June 2011 (the “forward arrangements”) as follows:
a. 50% of the cost of Sleepovers from 1 July 2011 to 30 June 2012 (First and Second Transitional Periods)
b. 75% of the cost of Sleepovers from 1 July 2012 to 30 June 2013 (Third Transitional Period)
c. 100% of the cost of Sleepovers from 1 July 2013 (Future Period).

This forward payment component is paid by the DHB. Funding is transferred to DHBs from the Ministry of Health as part of the regular funding baseline updates.

Northern Region position:
A regional position to the Sleepover Settlements has been reached, through the Regional Mental Health Funding and Planning forum, with the support of the NRA, and involvement of the legal departments of each DHB.
1) “Future Period”
Of significant concern was the potential inequitable funding across providers. A number of providers across the Auckland region have not submitted claims because they have already been paying the minimum wage for sleepovers. It is also considered that existing contractual payments cover all costs associated with the delivery of the service.

If Agreements were made to continue to fund some providers for sleepover, indefinitely into the “future period”, this would result in some providers being paid a higher bed day rate than others, for the provision of the same service.

Consequently a recommendation was made to the Northern Region DHBs, by the legal advisors, that any provider claiming into the Future Period would have the following proviso in their Agreement with the DHB.

“….The DHB considers that your current contract rates cover all costs associated with the provision of the services but has agreed to make the above payments to you on a time limited basis in order to assist you to resolve sleepover issues. You acknowledge that the DHB will make no further or additional payments to you for sleepovers performed after 30 June 2014 and that from 1 July 2014, the contract rates shall be deemed to cover all costs associated with the provision of X Services and shall fully meet any of the DHB’s obligations to pay funding under the settlement agreement.”

This recommendation was endorsed by the GMs Funding and Planning.

Claims made by Waitemata DHB NGO Providers
All claims received from Waitemata DHB NGO providers have been settled and totalling $351,316. Settlements have been with:
- Framework Trust
- Mental Health Solutions (Wise Group)
- Walsh Trust
- Te Kotuku Ki Te Rangi Charitable Trust
- Challenge Trust (Recovery Solutions Ltd)

Claims made by Auckland DHB NGO Providers
Claims received from Auckland DHB NGO providers which have been settled total $226,741. Settlements have been with:
- Beth Shean Trust
- Walsh Trust
- Framework Trust
- Challenge Trust (Recovery Solutions Ltd)
- Hinemoa Lodge
- Salvation Army

There remain two claims from Arahura Trust and Richmond Services Limited where settlement is still to be finalised. The Arahura Trust settlement is in the final stages.