Community and Public Health Advisory Committees Meeting

Wednesday, 19\textsuperscript{th} March 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)

2.00pm PRESENTATION: Cervical Screening Ethnicity Data Quality Improvement Project (Karen Bartholomew - Public Health Physician, Waitemata DHB)

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES

2.15pm  2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 05/02/14

3 DECISION ITEMS

2.20pm  3.1 Pacific Health Action Plan 2013 - 2016
2.50pm  3.2 Auckland Metro Clinical Governance Forum

4 INFORMATION ITEMS

3.00pm  4.1 Child Health Service: Planning a Sustainable Future
3.15pm  4.2 Women’s Health Collaboration

5 STANDARD MONTHLY REPORTS

3.25pm  5.1 Primary Care Update
3.45pm  5.2 Planning and Funding Update

3.55pm  6 GENERAL BUSINESS
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<th>Committee Member</th>
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<tr>
<td><strong>Lester Levy</strong></td>
<td>Chair – Auckland District Health Board&lt;br&gt;Chairman – Auckland Transport&lt;br&gt;Deputy Chair – Health Benefits Limited&lt;br&gt;Independent Chairman – Tonkin &amp; Taylor&lt;br&gt;Chief Executive – New Zealand Leadership Institute&lt;br&gt;Professor of Leadership – University of Auckland Business School</td>
<td>11/11/13</td>
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<td><strong>Max Abbott</strong></td>
<td>Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology&lt;br&gt;Patron – Raeburn House&lt;br&gt;Board Member – Health Workforce New Zealand&lt;br&gt;Board Member, AUT Millennium Ownership Trust&lt;br&gt;Chair – Social Services Online Trust&lt;br&gt;Board Member – The Rotary National Science and Technology Trust</td>
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<td><strong>Jo Agnew</strong></td>
<td>Professional Teaching Fellow – University of Auckland&lt;br&gt;Casual Staff Nurse – Auckland District Health Board</td>
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<td><strong>Peter Aitken</strong></td>
<td>Pharmacist&lt;br&gt;Shareholder/Director, Consultant - Pharmacy Care Systems Ltd&lt;br&gt;Shareholder/Director – Pharmacy New Lynn Medical Centre</td>
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<td><strong>Judith Bassett</strong></td>
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<td><strong>Pat Booth</strong></td>
<td>Consulting Editor – Fairfax Suburban Papers in Auckland</td>
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<td><strong>Chris Chambers</strong></td>
<td>Employee – Auckland District Health Board (wife employed by Starship Trauma Service)&lt;br&gt;Clinical Senior Lecturer – Anaesthesia Auckland Clinical School&lt;br&gt;Associate – Epsom Anaesthetic Group&lt;br&gt;Member – ASMS&lt;br&gt;Shareholder – Ormiston Surgical</td>
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<td><strong>Sandra Coney</strong></td>
<td>Elected Member – Chair: Waitakere Ranges Local Board, Auckland Council</td>
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<td><strong>Warren Flaunty</strong></td>
<td>Member – Henderson - Massey and Rodney Local Boards, Auckland Council&lt;br&gt;Trustee - West Auckland Hospice&lt;br&gt;Trustee (Vice President) - Waitakere Licensing Trust&lt;br&gt;Shareholder - EBOS Group&lt;br&gt;Shareholder – Pharmacy Brands Ltd&lt;br&gt;Director – Westgate Pharmacy Ltd&lt;br&gt;Chair – Three Harbours Health Foundation&lt;br&gt;Director - Trusts Community Foundation Ltd</td>
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<td><strong>Lee Mathias</strong></td>
<td>Chair – Counties Manukau District Health Board&lt;br&gt;Managing Director – Lee Mathias Ltd&lt;br&gt;Trustee – Lee Mathias Family Trust&lt;br&gt;Trustee – Awamoana Family Trust&lt;br&gt;Director – Pictor Ltd&lt;br&gt;Director – John Seabrook Holdings Ltd&lt;br&gt;Chair – Health Promotion Agency&lt;br&gt;Director – iAC IP Ltd&lt;br&gt;Advisory Chair, Company of Women Ltd</td>
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<td><strong>Robyn Northey</strong></td>
<td>Project management, service review, planning etc. – Self employed Contractor&lt;br&gt;Board member – Hope Foundation Northern Region&lt;br&gt;Trustee, A+ Charitable Trust</td>
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<td><strong>Christine Rankin</strong></td>
<td>Member - Upper Harbour Local Board, Auckland Council&lt;br&gt;Director – The Transformational Leadership Company&lt;br&gt;CEO – Conservative Party</td>
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### Register of Interests continued...

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<td><strong>Allison Roe</strong></td>
<td>Member – Devonport-Takapuna Local Board, Auckland Council&lt;br&gt;Member – Board of Kaipara Medical Centre&lt;br&gt;Chairperson – Matakana Trail Trust</td>
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<td><strong>Gwen Tepania-Palmer</strong></td>
<td>Chairperson – Ngatihine Health Trust, Bay of Islands&lt;br&gt;Life Member-National Council Maori Nurses&lt;br&gt;Alumni – Massey University MBA&lt;br&gt;Director – Manaia Health PHO, Whangarei&lt;br&gt;Board Member – Auckland District Health Board&lt;br&gt;Committee Member – Lottery Northland Community Committee</td>
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<td><strong>Co-opted Members</strong></td>
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<td><strong>Dr Tim Jelleyman</strong></td>
<td>Head of Division (Medical) - Child Women and Family Services, WDHB&lt;br&gt;Member - Active Clinic Network for Greater Auckland Integrated Health Network&lt;br&gt;Member - ASMS&lt;br&gt;Chair - Child Health Network, Northern Regional Health Plan&lt;br&gt;Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland</td>
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<td><strong>Eru Lyndon</strong></td>
<td>Honorary Research Fellow – Auckland University&lt;br&gt;Member – AUT Business School Industry Advisory Committee&lt;br&gt;Regional Commissioner, Social Development, Northland - Ministry of Social Development&lt;br&gt;Director – Tamaki Development Company</td>
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## Auckland and Waitemata District Health Boards
### Community and Public Health Committees

**Member Attendance Schedule 2014**

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<th>NAME</th>
<th>FEB</th>
<th>MAR</th>
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**Co-opted members**

| Dr Tim Jelleyman                    | ✓    |     |     |      |      |      |     |     |
| Eru Lyndon                          | ✗    |     |     |      |      |      |     |     |

* absent
* attended part of the meeting only
# absent on Board business
2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 05\textsuperscript{th} February 2014

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 05\textsuperscript{th} February 2014 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 05 February 2014

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.03p.m.

COMMITTEE MEMBERS PRESENT:

Warren Flaunty (Acting Committee Chair) (WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair) (present until 3.30p.m.)
Max Abbott (WDHB Board member)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Pat Booth (WDHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Lee Mathias (ADHB Deputy Chair)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Allison Roe (WDHB Board member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT:

Ailsa Claire (ADHB, Chief Executive)
Dale Bramley (WDHB, Chief Executive)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Tim Wood (ADHB and WDHB, Funding & Development Manager, Primary Care)
Marty Rogers (ADHB and WDHB, Manager, Maori Health Gain)
Wendy Bennett (ADHB and WDHB, Manager Planning and Health Intelligence)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Lynda Williams, Auckland Women’s Health Council
Anne Curtis, Health Link North
Tracy McIntyre, Waitakere Health Link
Lorelle George, Comprehensive Care/Waitemata PHO
Rocky Tahuri, Health West
Jeremy Olds, New Zealand Doctor magazine

APOLOGIES:

Apologies were received and accepted from Gwen Tepania-Palmer and Judith Bassett.

KARAKIA

The Committee joined in the English version of the karakia.
WELCOME

Warren Flaunty, the Acting Committee Chair, welcomed those present. He paid tribute to Dr Philip Rushmer, a general practitioner in west Auckland and recently retired Chair of Health West, who had passed away on 3 February.

DISCLOSURE OF INTERESTS

Lee Mathias had advised of a number of changes to the register of interests shown in the agenda for this meeting. Her revised list is: Managing Director, Lee Mathias Limited; Trustee, Lee Mathias Family Trust; Trustee Awamoana Family Trust; Chair Counties Manukau DHB; Chair Health Promotion Agency; Director, Pictor Limited; Director, iAC Limited; Advisory Chair, Company of Women Limited; Director, John Seabrook Holdings Ltd.

Allison Roe advised that she is now a Member of the Board of Kaipara Medical Centre. Some of the other interests listed in the agenda no longer applied and she would advise the Board Secretary of the details.

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

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 27 November 2013 (agenda pages 1-12)

Resolution (Moved Lee Mathias/Seconded Jo Agnew)

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

Carried

Matters Arising:

Review of Child Health Services:

Dr Tim Jelleyman summarised the position. The Wilson Trust has proposals to enhance its facilities which it wishes to discuss. These need to be married up with Waitemata DHB’s needs as tenant of the facilities and service provider of child rehabilitation services. Model of Care discussions are taking place between Auckland DHB and Waitemata DHB to inform discussions with the Wilson Trust.

It was pointed out at the meeting that these are regional services and the whole region needs to be involved, including Counties Manukau DHB and Northland DHB. Tim Jelleyman confirmed that the service line for the child rehabilitation services provided extends to north of Taupo.
It was also noted that the current review of spinal services for the whole region needs to be taken into account, as that does affect rehabilitation services for children as well as adults.

**Fluoridation**

Allison Roe raised the question of follow up on the issue of fluoridation (Page 5 of the minutes). She also raised concerns that she had about the validity of a particular study in the Napier area relating to fluoridation, after listening to Dr Paul Connett, international spokesperson for the (anti-fluoridation) Fluoride Action Network.

Discussion on this included:

- The Auckland Regional Public Health Service’s position on this issue is clear from its website and the press release they had issued relating to Dr Connett’s visit to Auckland. Information on ARPHS’s briefing on fluoridation of the new Auckland Council and local board members had also been sent to CPHAC members in December.
- The importance of carefully evaluating research papers and not relying on individual opinion of their validity.

Dr Julia Peters (Clinical Director ARPHS) (present for the following agenda item) advised that:

- They had received feedback that information on their website concerning fluoridation is too technical and not sufficiently user friendly. They are looking at that.
- Based on over 60 years of research, the evidence overwhelmingly is that fluoridation does more good than harm. The only proven adverse effect is mild discolouration of teeth and this is barely seen in New Zealand because of the level of fluoridation here. Four major international studies in the last year supported the overall positive effect of fluoridation. In New Zealand, Professor Gluckman had stated that the science on this issue is settled.
- She believed that the issue is not about science, but about community values and the need to be thinking about the health of the whole population. Fluoridation has the greatest benefit for those who live in more deprived areas.
- ARPHS is willing to attend CPHAC to provide further updates relating to fluoridation when requested.

3 **DECISION ITEMS**

3.1 **Healthy Eating and Physical Activity in the Auckland Region** (agenda pages 13-31)

Simon Bowen (Director Health Outcomes WDHB/ADHB), Dr William Rainger (Service Manager ARPHS) and Dr Julia Peters (Clinical Director ARPHS) presented this item.

Simon Bowen introduced the report and summarised the background to it.

Dr William Rainger and Dr Julia Peters provided a power point presentation, highlighting key aspects of the agenda report (copy of the presentation available on request from the WDHB Board Secretary).

Matters covered in discussion and response to questions included:
• The Board Chair congratulated the authors on an exceptional paper. He suggested that in addition to supporting the recommendations, CPHAC members also needed to reflect on how to make more resources available to get momentum in this area.

• It was suggested that the $152M estimate of health care costs attributable to overweight and obesity for the three Auckland DHBs for 2012/13 (page 16 of the agenda) seemed smaller than one would expect. Simon Bowen advised that the figure is based on the estimated 4% of health care costs for New Zealand, applied to the costs of the three DHBs. However there are a range of costs from obesity beyond health care costs. He thought that the figure is comparable to estimates in other countries.

• It was noted that the approach being proposed seemed largely reliant on health promotion and activities within the region, not on advocating to Government for legislative change such as removal of G.S.T from fruit and vegetables or for constraints on industry in terms of food products. Working with the food production industry to improve products and to promote healthy food was also suggested as another avenue. In response William Rainger advised that they had deliberately taken a regional approach and taken the view that higher level policy issues of a national nature are outside the scope of this paper. However the approach proposed, with its emphasis on co-ordination with other agencies, might lead into work with the food production industries.

• It was noted that there had been some progress at national level with these issues, for example the Heart Foundation had been quite successful in working with bread producers to reduce the level of salt in bread. The Health Promotion Agency had achieved some success in getting voluntary agreements with major suppliers not to supply sugary drinks to schools. The Government tended to favour voluntary agreements rather than regulation in this area.

• The Ministry of Education and other Government agencies are involved in the forums looking at collective activities on this issue.

• It was suggested that the new Healthy Families New Zealand Project may intersect with activities in this area.

• Ailsa Claire noted that as someone returning to New Zealand from living in the United Kingdom, it is noticeable how expensive healthy food is in New Zealand by comparison. She also noted that there are some symbolic acts that the DHBs could undertake, for example not having a stack of sweets visible at the main entrance at Auckland DHB, and that in the past there had been some success in persuading supermarkets not to have sweets in checkout areas.

• In answer to a question, Tim Jelleyman advised that when all four year olds are checked, body mass index is calculated, which provides a pathway for assessing obesity and overweight. The key question however is whether the next step of follow up actually occurs.

It was agreed that the proposed resolution be extended by including clause 5 below.

Resolution (Moved Sandra Coney/Seconded Allison Roe)

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 of Health and others in response to new funding opportunities being made available.

5. Request that the Auckland Regional Public Health Service bring back a report to CPHAC on opportunities for interventions in the production and promotion of products that influence levels of obesity.

Carried

3.2 Auckland Regional Public Health Service Submission on the Unitary Plan (agenda pages 32-36)

Dr William Rainger (Service Manager Auckland Regional Public Health Service) and Dr Julia Peters (Clinical Director, Auckland Regional Public Health Service) were present for this item.

William Rainger introduced the report. He noted the submission closing date of 28 February and the numerous specific issues it is intended to raise in the submission, many of which are listed in the report. The overall high level message to Auckland Council would be that they wished to provide the Council with better mechanisms in the Unitary Plan for delivering health outcomes. They would be suggesting a specific health section in the Unitary Plan so that health issues are not lost sight of. In the past ARPHS had made submissions on a wide range of policy issues stipulating that the submission did not necessarily represent the views of the DHBs. However in this case this is such an important document that the DHBs may wish to have a mechanism for endorsing the submission.

Matters covered in discussion and response to questions included:

- With regard to the issue summarised as “Five or more dwellings (reducing perverse incentives to development)”, Sandra Coney explained that with site intensification the draft plan had allowed up to four dwellings as a permitted activity, with five or more requiring resource consent. The decision finally taken had been to make four or more dwellings require resource consent. The reason was that design standards only come into play if there is a need for resource consent. There is a fear that there will be a lot of intensification on very small sites without design standards being considered. For that reason she did not support the ARPHS approach to that issue.

- On the issue of open space, Sandra Coney advised that some Auckland Councillors had argued for some sort of formula requirement when intensification occurred. She thought that this was an issue that had to be looked at. So far the Council had been extremely poor at acquiring new open space.

- Sandra Coney advised that she supported the proposed submission making more provisions of the Auckland Design Manual mandatory rather than voluntary. She considered that there is a risk that Auckland could end up with extremely poor urban design.
• The question was raised of whether there is a danger of having a submission covering too many points and whether it might have more impact if concentrated on a few aspects with a very strong health evidence base. In subsequent discussion, the Committee indicated that the way to avoid that would be to organise the various points into categories, but that the issues listed should not be lost.

• There was strong support for having the submission endorsed by the three Auckland region DHBs.

• With regard to encouraging cycling but concerns over safety, the Board Chair advised that Auckland Transport is developing a transformational approach to this issue, with an emphasis on how to separate cyclists from other road traffic and how to achieve safe cycle routes to schools. The picture could change dramatically over the next five years. Another issue is that a lot of children do not know how to ride bicycles at present. Auckland Transport is also supporting addressing that issue.

Resolution (Moved Warren Flaunty/Seconded Max Abbott)

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

a) Note the advice provided.

b) Delegate the authority to approve the Auckland Regional Public Health Service submission to the Unitary Plan on behalf of the Auckland and Waitemata DHBs to the Board Chair, the CPHAC Committee Chair and the Auckland and Waitemata DHBs’ Chief Executives.

Carried

4. INFORMATION ITEMS

4.1 Ethnicity Data Audit Toolkit (agenda pages 37-40)

Marty Rogers (Manager Maori Health Gain), Dr Sue Crengle (Public Health Physician), and Dr Karen Bartholomew (Public Health Physician) were present for this item.

Marty Rogers introduced the report and Dr Karen Bartholomew summarised the key features of it.

Matters covered in discussion and response to questions included:

• The issue of matching databases was raised. Sue Crengle advised that this was an unresolved national question. This toolkit was one suite of the tools being developed with the aim of achieving greater accuracy. Hopefully all activity will align over time. Dale Bramley noted that the issue had first been highlighted here with research into meningococcal disease in 2006 which showed a 30 percent miscoding in terms of ethnicity. There is no single source of ethnicity data and because it is based on self identification, coding of individuals can change over time. The important issue is to have linkages across databases so those changes can be made contemporaneously. At the moment different data sets are collected in different places. It is important to have one system to collect information and a standardised way to do that.

• Dale Bramley advised that the issue was well highlighted in a recent report to Manawa Ora on cervical screening which had shown that because of ethnicity miscoding Maori screening rates have been understood for some time to be much
lower than they actually are. He suggested that it would be worthwhile for CPHAC to see the presentation made to Manawa Ora on this.

- One of the elements in miscoding is general practitioners and even receptionists not asking the ethnicity question, but guessing the answer. This toolkit addressed that issue.
- This initiative can also be seen in the context of trying to address the wider issue raised by the Office of the Auditor General which had lead to audit qualifications – to what extent can the data collected by the DHBs from third party primary care providers be relied on?

3.30p.m – Lester Levy retired from the meeting.

Resolution (Moved Robyn Northey/Seconded Lee Mathias)

That the report be received.

Carried

4.2 Primary Care Update – The Alliance and Localities (agenda pages 41-48)

Tim Wood (Funding and Development Manager Primary Care, Auckland and Waitemata DHBs) and Dr Stuart Jenkins (Clinical Director Primary Care, Auckland and Waitemata DHBs) were present for this item.

Tim Wood introduced the report. Matters he highlighted included:

- While progress is slow, a great deal of energy is being put into the localities approach by a wide range of stakeholders.
- In West Auckland there had been good progress with diabetes integration and child health initiatives.
- One of the issues faced is the multitude of different structures and infrastructure across primary care. This is addressed in various ways, for example new guidelines involve upskilling and making sure that what is required fits with work practices.
- In Maungakiekie-Tamaki a lot of the work has been about engaging with the community to identify priority needs. Only in late 2013 had this moved on to engaging with providers. Mental health had been identified by the community as a priority issue and is being focused on strongly. Procare has provided one of their project managers to drive that process.
- There are many areas where the DHBs wish primary care to do better. Pursuing that requires an intelligent approach. They are working closely with PHOs and the Ministry of Health to get some help on that.
- With regard to formation of a new Alliance of the DHBs and PHOs, a complication is that two PHOs: AH+ and the National Hauora Coalition are already in Alliance agreements and commitments made there need to be factored in. The Draft Alliance agreement will come back to CPHAC.

Matters covered in discussion and response to questions included:

- With regard to general practices engaging to upskill their skill base, some are very engaged in that and some are hard to engage. Tim Wood advised that they are looking at the clinical leadership model to try and drive this as well. It is true that potentially business propositions may be need to encourage change in some general
practices. Stuart Jenkins also noted that there are other elements helping produce change such as the health targets.

- The opportunity is taken to remind those involved in providing primary care about what capitation means and the requirements of the new contract.
- Ailsa Claire noted that it needs to be remembered that this approach is not just about individual primary care practices and many of the benefits come from basic coordination. An example of practices starting to focus on how best they can work together to serve the population is what is happening with the six Kaipara practices.

**Resolution** (Moved Robyn Northey/Seconded Lee Mathias)

That the report be received.

**Carried**

5. **STANDARD MONTHLY REPORTS**

5.1 **Planning and Funding Update** (agenda pages 49-55)

Dr Debbie Holdsworth and Simon Bowen summarised the report.

In reply to a question regarding Sleepover Settlement Agreements (pages 54-55 of the agenda), Tim Wood advised that employment issues had been avoided in the Mental Health area by changing the model of care and removing sleepover provisions. Staff are now providing care at night or not on the premises at all. Lee Mathias noted that there are still potential issues with Home Care Support Services, where family members are providing the equivalent of sleepover services.

In answer to questions relating to Immunisation (pages 50-51 of the agenda), Tim Jelleyman said that he was not sure if having the chickenpox vaccination prevented people getting shingles later. He would check and advise Warren Flaunty who had raised the question. The meeting was also advised that the rotavirus vaccine is not particularly new. New Zealand is a late adopter of it and it has been used in the United States for some time.

The report was received.

6. **General Business**

There was no general business.

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

The meeting concluded at 3.55 p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 05 FEBRUARY 2014

_________________________________________ CHAIR
## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 10th March 2014

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPHAC 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>Refer report 4.1 on this agenda.</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 30/04/14</td>
<td>Report delayed by one meeting.</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 30/04/14</td>
<td></td>
</tr>
<tr>
<td>ADHB HAC 11/12/13 (transfer to CPHAC)</td>
<td>5.2</td>
<td>Diabetes Checking – report to be provided on how screening and monitoring is undertaken for those reported as positive during diabetes checking.</td>
<td>Debbie Holdsworth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPHAC 05/02/14</td>
<td>3.1</td>
<td>Healthy Eating and Physical Activity – request to ARPHS to bring back a report to CPHAC on opportunities for interventions in the promotion of products that influence levels of obesity.</td>
<td>William Rainger</td>
<td>CPHAC 11/06/14</td>
<td></td>
</tr>
<tr>
<td>CPHAC 05/02/14</td>
<td>4.1</td>
<td>Ethnicity Data – presentation given to Manawa Ora relating to miscoding of Maori cervical screening to be provided to CPHAC.</td>
<td>Karen Bartholomew</td>
<td>CPHAC 20/03/14</td>
<td>Will take place at the meeting.</td>
</tr>
<tr>
<td>CPHAC 05/02/14</td>
<td>5.1</td>
<td>Chickenpox vaccine – whether or not this prevents people getting shingles later in life to be checked and Warren Flaunty advised.</td>
<td>Tim Jelleyman</td>
<td>Actioned – e-mailed to Warren 10/03/14.</td>
<td></td>
</tr>
</tbody>
</table>
3.1 Pacific Health Action Plan 2013 - 2016

Recommendation:

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


Prepared by: Lita Foliaki (Pacific Health Gain Manager), Bruce Levi (Acting General Manager Pacific Hospital Services) and Julie Helean (Deputy Director Strategy ADHB)
Endorsed by: Dr Dale Bramley (Lead Pacific Health ADHB and WDHB), Dr Debbie Holdsworth (Director Funding); Executive ADHB and Executive WDHB

Glossary

AH+ - Alliance Health Plus PHO
DAP - District Annual Plan
ECE - Early Childhood Education
Enua Ola - Waitemata DHB’s Pacific community development and health promotion programme
HVAZ - Healthy Village Action Zone - ADHB’s Pacific community development and health promotion programme
MSD - Ministry of Social Development
PHO - Primary Health Organisation
PHA Plan - Pacific Health Action Plan (DRAFT)

1. Executive Summary

The Pacific Health Action Plan 2013 – 2016 (PHA Plan) is a joint plan for the Pacific populations of Auckland and Waitemata DHBs. The plan is submitted as part of the consultation process undertaken in its development. Feedback and input from CPHAC is being sought.

The PHA Plan 2013 – 2016 reflects a partnership approach between Auckland/ Waitemata DHBs and Pacific communities in addressing the challenges that Pacific families and communities experience. The partnership is based on the strengths of the DHBs and the Pacific communities. The audience for this Plan is Waitemata and Auckland DHBs as well as Pacific communities.

The PHA Plan does not duplicate any of the other DHB Plans. It accepts accountability to all the requirements of those Plans. This Plan has a focus on community development and health promotion but the activities identified are expected to contribute towards meeting government and DHB targets.

The PHA Plan was 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/WDHB staff from both planning and funding and provider arms.

236 people attended six community consultation meetings. The 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.

2. Introduction/Background

The development of a joint Pacific Health Action Plan for Waitemata and Auckland DHBs is a requirement of the current DAPS of both DHBs. Previous Pacific DHB Plans had not involved community representatives in their development but communities were consulted. A decision was made by the DHB Pacific Team and agreed to by DHB management, 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 involvement of community representation in the planning process has generated other decisions:

• that the audience of the Plan are the DHBs and the Pacific communities
• that the language and the format of the Plan is to be easily understood by Pacific people as well as the DHBs
• that 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)
• that 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
• that the first priority is children being safe and families being free of violence
• that the focus is on lifestyle issues, of being smoke free, eating healthy and staying active as that require 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 involvement of the PHOs in community development and health promotion activities.

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.

3. **Progress**

The activities that are identified in the 2013/2014 year are in progress. Meetings with ECE and MSD regarding contracts that we have in relation to child health and education are in progress. Participation in inter-sectoral forums concerned with family violence is in progress.

Collaboration with the WERO smoke free project, Pacific Heartbeat, Heart Foundation and the Enua Ola and HVAZ churches are in progress. The Wero smoke free group competitions are set to start of 1 June 2014.

4. **Resource Implications**

The resourcing requirements of the action plan have been identified within the plan. A significant number of the actions can be undertaken within baseline funding and this plan is endorsing this existing resource to be focused on these priorities.

There are a few areas where additional resourcing is required to make the necessary progress for change. These have been staged over the three years and are summarised as:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost ($000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enua Ola Parish Nurses</td>
<td>280</td>
</tr>
<tr>
<td>Roll out of pilot to increase CVD management adherence</td>
<td>331</td>
</tr>
<tr>
<td>Pacific pregnancy and parenting education programme</td>
<td>240</td>
</tr>
<tr>
<td>Pacific Diabetes Nurse</td>
<td>100</td>
</tr>
<tr>
<td>Project Management 2 FTE</td>
<td>240</td>
</tr>
<tr>
<td>Workforce 0.5 FTE</td>
<td>50</td>
</tr>
<tr>
<td>Pacific trainer 0.5 FTE</td>
<td>40</td>
</tr>
<tr>
<td>Matua 2 FTE</td>
<td>150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,431</strong></td>
</tr>
</tbody>
</table>

These are all subject to successful bids for additional funding.

A number of these have been submitted for funding consideration in the Waitemata DHB 14/15 planning round and relate to Waitemata specific initiatives to improve performance where it currently lags behind Auckland. These include a parish nurse to work with the Enua Ola program to increase health literacy in the community and churches. Specific outcomes sought are improved engagement with cervical screening and CVD risk assessment. These targets have been met at Auckland DHB and it is believed the work of the parish nurses have made a contribution towards this. There is also a proposal to roll out a successful pilot at
West Fono which resulted in improved compliance, improved outcomes and increased engagement with CVD risk assessment.

It is recognised the current environment is resourced constrained and we will seek to reconfigure current contracts in addition to reconsidering funding in future years where there are shortfalls.

There are a number of proposed new roles within the provider arm to facilitate the development of Pacific workforce, to increase the effectiveness of the clinician cultural competency and to increase the notion of cultural leadership and expertise. The activities identified will contribute towards improving health of Pacific people, however until these roles can be funded or reconfigured from other roles, then we will implement what can be done within current resources.

5. Recommendations

That CPHAC recommends to the Auckland and Waitemata DHB Boards that the Pacific Health Action Plan 2013-2016 be endorsed.
Our Health in Our Hands

Pacific plan for a long, healthy life

Draft 7th March 2014

A joint plan for Pacific health
For Auckland and Waitemata DHB’s Pacific populations 2013 - 2016
Our vision for 2016 is for Pacific families to live longer and healthier lives. Is it possible to see real improvements in a short time? Yes! It’s possible to increase the trend in life expectancy even within five years.

The DHBs will work with doctors and nurses, Pacific communities, churches, schools and families. We’ll do this together – we’ll make things better for people who are sick and for those who are struggling or are isolated. Whanau Ora, cooperation: that’s the Pacific way.

When it comes to our lives we are the experts. A community development approach works because it builds from the grass roots up. There is the leadership and resources to drive our own solutions. We will work with our families, churches, Pacific ethnic communities, our health leaders, our networks of elders, and our children and youth to get results. We have the answers to our problems.

As a family we have each other. Our strength is in our values and our deep connections. We hold to our values; we work to our strengths. We are strengthened by the support from the DHBs, Primary Health Organisations and some agencies outside of health.

We warm our collective hearts by:

✓ Hoping and dreaming
✓ Thinking and praying
✓ Talking and laughing
✓ Singing and dancing
✓ And loving

The health of our families is in our hands. Family is the pillar of the house. Our families keep us well and happy. Our Churches help to keep us together and working as a community. We are proud of our culture and our languages. Our children and youth define our future and we define theirs. Our elders are important in our lives. There is a place for everyone.

Most Pacific families are happy with their health, but too many die early from heart disease, lung cancer, diabetes, obesity and stroke. The DHBs, Primary Health Organisations and Pacific communities know that our health issues and the solutions are interwoven into Pacific families and our community. Some problems are directly linked to poverty and social policy but we can still tackle these.

Getting healthier won’t happen overnight but we have a plan . . . .
What are we trying to achieve?

The health of our Pacific communities will improve if we plan ahead. We know the problem areas. We have some solutions and also good ideas that are worth exploring. In the short term we can’t fix poverty and all the other factors that affect families, but we can still make a difference, we being Pacific families, communities and the health sector working together and each playing their part to maximum effect.

1. **We’ll work together to keep families safe, well and happy**
   
   This means:
   - families take primary responsibility for their health and well being
   - families seek and access services as they require
   - family members participate in healthy lifestyle, parenting programs and programs to support violence free families,
   - Pacific service users engage in the design of services alongside health providers

   **Everyday family choices make the biggest difference. Small steps in a healthy direction add up to big changes**

2. **We’ll make better use of the health services in our local community**
   
   This means:
   - communities and churches get active in health networks
   - church and community leaders take a public stand against all forms of violence
   - communities and churches become co-designers of lifestyle and violence free programs as well as participate in the programs
   - churches and communities support people with disabilities to be active members of the community

   **The best health system is one that keeps the family and all our local supports at the centre**

3. **We’ll make certain that the health services are the very best for Pacific people**
   
   This means:
   - Services are accessible and affordable for families
   - health services engaging with their Pacific patients
   - health providers work towards a whanau ora approach to support families
   - health providers screen for violence

   **Our GPs and hospital services are there to help when we need them. Health services, the hospital in particular, needs to focus on the people with the highest need; those who are sickest and most vulnerable**
against children and family members and provide appropriate referrals

• every health professional and care worker is family focused, culturally appropriate and positive

• more Pacific students going on to train for careers in health
Most health care takes place at home. Most of the hands-on caring work is done by women but many women also work outside the home. Pacific men need to be supported to be more involved in the daily care of their family. Grandparents provide childcare when both parents work but this can become a burden for elderly grandparents. Young people need to have a “voice” in the family but may feel that there is no opportunity for them to be heard. Families on low income may experience chronic stress because of their fundamental needs being constantly greater than their resources. Unresolved and increasing stress may be acted out in differing forms of violence and against the most vulnerable members of the family.

WE WANT TO SUPPORT FAMILIES TO BE HEALTHY AND WELL.

The various Pacific communities in Auckland are tightly connected. Social connection is one of the main protectors against disease and problems.

WE WANT PACIFIC COMMUNITIES TO WORK AS PARTNERS WITH DHBS AND OTHER GOVERNMENT SECTORS TO RESPOND TO THE CHALLENGES, TO CREATE THE SOLUTIONS.

Our health is in our hands.
Our health across the Pacific life span

As Pacific families, we understand that every member of the family has different priorities for health. Age and gender make a difference when it comes to health problems. The priorities for health shift a bit as we get older. The picture shows the things that really matter at each age and stage of life.

We can judge a community’s health by how well it treats its vulnerable member. Children are vulnerable because they depend on adults to survive and thrive. Vulnerable includes the isolated, lonely, and those who cannot look after themselves.
The four big health issues

**Obesity**
Being overweight is a problem. Carrying too much weight increases the chances of: heart attacks, stroke, high blood pressure, diabetes

**Smoking**
Give up smoking.
1 person making a healthy choice can influence 27 others. That makes a difference

**Diabetes**
Diabetes shouldn’t feel normal for Pacific
There are too many young children with diabetes
Even unborn babies can be affected by gestational diabetes

**Cardiovascular disease**
Heart problems and stroke
High blood pressure, diabetes, high cholesterol.
Smoking, being overweight, binge drinking; these all increase the chances of heart disease and stroke.

For example a 40 year old Pacific man increases his risk of a heart attack by being overweight, by smoking, by having high blood pressure and by consuming more than one standard drink per day.
Four ways to improve quality of life

**Employment**

Being employed means being part of society, making a contribution, and being valued

Earning money to cover expenses gives a great sense of autonomy and personal power

Education helps to secure good employment

**Raise kids in families**

Parenting is easier when there’s more adults in the house

Raising children as a single parent is really hard work

Getting parenting help from other adults makes difference to stress levels

Even being able to take a break away from the kids helps

**We need to feel Connected**

Know who we are and where we Belong

Have skills and knowledge to function well in the world

With a strong attachment to our Culture and Values

To stand Proud

**A decent place to live**

A decent house provides a feeling of security and safety

And a sense of belonging

Warm dry houses that have spaces for everyone help us to stay healthy

Being safe and warm and well fed helps us to learn

**Ways of coping**

The more skills you learn the more options are on hand when things go wrong

Skills and coping strategies help to reduce stress

They also help us make good choices

Most of us have to learn how to manage problems

And men and women have different ways of coping
What can we achieve?

The DHBs will track improvements in Pacific health over time. We already collect information about Pacific health as part of measuring our DHB performance against national health targets and other government expectations. The table below includes some areas where the DHB measures activity. It’s only by collecting data and studying what it’s telling us it that we can understand if our actions have been successful.

<table>
<thead>
<tr>
<th>A big increase in these areas</th>
<th>A big decrease in these areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies have the full course of immunisation on time</td>
<td>Fewer Pacific children will be hospitalised from preventable problems</td>
</tr>
<tr>
<td>Pacific people engaged and using GPs services</td>
<td>Fewer Pacific children hospitalised because of abuse and neglect</td>
</tr>
<tr>
<td>Pacific people get their cardiovascular risk assessed regularly</td>
<td>Fewer cavities and fillings in Pacific children’s teeth</td>
</tr>
<tr>
<td>Pacific people with diabetes will manage their condition well (be self managing)</td>
<td>The smoking rate will drop. No women smoking during pregnancy</td>
</tr>
<tr>
<td>Pacific participation in screening programme (bowel, cervical, breast)</td>
<td>Fewer Pacific people admitted to hospital for problems that could have been managed by GPs and other community based services</td>
</tr>
<tr>
<td>The number of Pacific youth receiving services from the Youth Hub and youth health services</td>
<td>Our Body Mass Index will come down</td>
</tr>
<tr>
<td>Pacific people use the health and disability services in their community and the hospital</td>
<td>Our blood pressure will be lower</td>
</tr>
<tr>
<td>Pacific families get earlier help for mental health and addiction problems</td>
<td>Fewer Pacific people in hospital as a result of a heart attack</td>
</tr>
<tr>
<td>Pacific people engaged with services and hooked into treatment and medication plans</td>
<td>Fewer Pacific people will develop diabetes</td>
</tr>
<tr>
<td>Mainstream health workers are good at working with, and understanding, Pacific families</td>
<td>Fewer women with diabetes in pregnancy</td>
</tr>
<tr>
<td>The various social services will work together to wrap services around Pacific families in need</td>
<td>Reduce the complications from diabetes, like amputations and renal dialysis</td>
</tr>
<tr>
<td>We rate our health more positively</td>
<td>The DNA rate will drop for specialist service appointments, follow-ups etc</td>
</tr>
<tr>
<td>We rate the health services we receive more positively (very good or excellent)</td>
<td>Turn-over of our Pacific staff will decrease. We want staff to stay working with us</td>
</tr>
<tr>
<td>More Pacific people engaged in the workforce</td>
<td>gap in life expectancy between Pacific and Palagi</td>
</tr>
<tr>
<td>We will contribute to Pacific life expectancy</td>
<td></td>
</tr>
</tbody>
</table>

Living longer

With better quality of life
We want to live longer

Today’s choices will make a difference to life expectancy figures in 5 years’ time

A Pacific baby boy today can be expected to live to 75 years, yet in the same DHB area, a Palagi / Pakeha boy can be expected to live to 83. That’s an eight year gap in life expectancy. Pacific women live about four to six years longer than Pacific men.

Over time we want to see Pacific people living as long as Palagi. We also want the gap between Pacific men and Pacific women to close.

Poverty can explain some of the difference in life expectancy, but not all of it. Pacific lives are shorter because of a few diseases – heart disease, lung cancer, diabetes, obesity and stroke. These are mostly related to lifestyle.

The DHBs are working together across the region to agree the best way to reduce health inequalities. The actions are covered in the Northern Regional Plan for 2013 -2014.

While we can’t change genetics, and we can’t change socioeconomic status in the short term, lifestyle changes can happen immediately.

Choosing healthy options on a daily basis can help improve the quality of life and also how long we live.

Along with the advice from GPs and nurses, there are excellent local and national organisations running health programmes. These understand that change is hard and that people often need real help to quit smoking, or manage their diabetes better, or reduce alcohol, or cook in a healthier way.

The trend towards healthier lives is already noticeable. Pacific life expectancy at birth has been increasing on average approximately two years each decade for people living in the Auckland and Waitemata DHBs.

The graphs above show fluctuations over time because the Pacific population is small in each DHB area, especially when broken down by sex. In spite of these fluctuations, there is a general trend of Pacific people living longer.
Six priorities to make a positive difference

<table>
<thead>
<tr>
<th>Healthier Pacific people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using the very best of health and disability services</td>
</tr>
<tr>
<td>With better quality of life</td>
</tr>
</tbody>
</table>

Everyday actions can make a big difference

1. Our children are safe, well, and loved and our families are free of violence
2. We are Smokefree
3. We eat healthy and we stay active
4. We seek help early
5. We use hospital services when needed
6. Our family lives in a warm, healthy house that is not overcrowded

Healthier Pacific People

Our families — Our ethnic communities

Other sectors — The DHBS and everyone who works for one

Churches, Schools, Workplaces — GP practices, PHOs, NGOs

Everyone is involved and committed
We plan to make a difference
1. Pacific children are safe, well, and loved and our families are free of violence

As our top priority, we want to promise every child the very best start in life. Most children are enrolled with a doctor and Well Child provider. This doesn’t always mean that children are seeing their doctor as often as needed. Although these visits are free for under six years olds, you can still be asked to pay a part charge, and afterhours co-payment can be out of reach of most pockets.

Good rates of Pacific immunisation mean children and babies are protected from preventable illness. Still, too many Pacific children are admitted to hospital with serious problems that could have been fixed at the doctor’s much earlier. The main ones being cellulitis, rheumatic fever, asthma and pneumonia – all of which are linked to poverty and to poor housing.

Too many Pacific children are growing up in cold, damp houses; too many don’t get the kind of food they need to be healthy; too many adults are taking stress out on their kids.

The services we need are the kind that will help families who are worried about their children or who are struggling. This might be parenting: providing practical help with big families where there is lots of pressure and too much stress in the system.

While health services can do their bit, it’s the other sectors we need to get involved with, especially hooking into the whanau ora (wrap around) programmes underway.

Pacific children across Auckland and Waitemata DHBs have high rates of immunisation coverage at eight months and two years of age.
Family and partner violence, assaults, bullying and abuse should never occur to members of Pacific families.

Across the Waitemata District, police attendances at family violence related incidents have increased over the period from 1997 to 2006. Nationally, assaults on children are rising.

Addressing family violence is important as other health issues cannot be addressed if violence exists in a family and is not addressed.

Government has made reducing assaults on children a key goal across the public service. The aim, by 2017, is to halt the 10 year rise in children experiencing physical abuse and reduce current numbers by 5%.

As people become aware of child abuse, there is likely to be more reporting of assaults. Actions to stop assaults are in the national Children’s Action Plan and include: screening to find vulnerable children, assessing their needs, make it easy for people to say when they are concerned about children, make services focused on results.

![Police attendances at family violence related incidents in the Waitemata District](image)

![Number of children experiencing substantiated physical abuse, national figures](image)


## We plan to make a difference

### Auckland and Waitemata DHBs

1. Deliver integrated and seamless maternity services designed with and for Pacific women
   1.1. Deliver the maternal and infant nutrition and physical activity programme
   1.2. Trial the Pacific pregnancy and parenting education programme TAPUAKI with the maternity services at Waitemata DHB
   1.3. Explore expansion of TAPUAKI programme to Waitemata and Auckland DHB maternity services
   1.4. Review maternity and child health services provided by Alliance Health+ and link to ADHB maternity services
   1.5. Implement maternity and child health services at AH+ providers and link with ADHB maternity services

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>MOH Funding</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Uniservices contract with MOH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submission by maternity service for WDHB funding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>current ADHB baseline funding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>as above</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27 of 92
### 2. Community education programme for children on dental health and asthma

2.1. WDHB to develop a community education programme for children on dental health and asthma

<table>
<thead>
<tr>
<th>Status</th>
<th>No funding required (from current resources)</th>
</tr>
</thead>
</table>

2.2. Explore resources for delivery of programme for children on dental health and asthma in conjunction with other child health related programmes

| Status | Submission for WDHB funding for 2015/16 financial year or re-configure current services to include this component |

### 3. Parenting Programmes

3.1. Explore appropriateness of “Incredible Years” parenting programme for Pacific families

<table>
<thead>
<tr>
<th>Status</th>
<th>No funding required</th>
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</table>

3.2. Find resources to implement “Incredible Years” parenting programmes through the HVAZ and Enua Ola churches / communities if appropriate

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<tr>
<th>Status</th>
<th>No funding required</th>
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</table>

### 4. Violence Free Families

4.1. Establish working relationship with Ministry of Social Development (MSD) to identify current work being undertaken to support violence free families

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<thead>
<tr>
<th>Status</th>
<th>No funding required</th>
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</table>

4.2. Establish links with MSD’s Proud Pasifika Campaign

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<thead>
<tr>
<th>Status</th>
<th>No funding required</th>
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</table>

4.3. Participate in inter-sectoral forums that focus on violence free families

<table>
<thead>
<tr>
<th>Status</th>
<th>No funding required</th>
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</thead>
</table>

4.4. Link HVAZ and Enua Ola churches / communities to violence free family programmes

<table>
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<tr>
<th>Status</th>
<th>No funding required</th>
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</table>

4.5. Participate in the implementation of the recommendations of ADHB’s review of its Family Violence Prevention Services

<table>
<thead>
<tr>
<th>Status</th>
<th>No funding required</th>
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</table>

4.6. Review effectiveness of DHB provider response to Pacific patients experiencing violence

<table>
<thead>
<tr>
<th>Status</th>
<th>No funding required</th>
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</thead>
</table>

### 5. Inter-sectoral Collaborations

5.1. Establish relationship with Early Childhood Education to explore areas of collaboration

<table>
<thead>
<tr>
<th>Status</th>
<th>No funding required</th>
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</table>

5.2. Participate in the network of senior Pacific managers to help with inter-sectoral collaboration

<table>
<thead>
<tr>
<th>Status</th>
<th>No funding required</th>
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</thead>
</table>
### Community

<p>| | | | | | |</p>
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</thead>
<tbody>
<tr>
<td>6.</td>
<td>Participate in workshops on maternal and infant nutrition</td>
<td>✓</td>
<td>✓</td>
<td>No funding required</td>
<td>✓</td>
</tr>
<tr>
<td>7.</td>
<td>Participate in reviewing “Incredible Years” parenting programmes</td>
<td>✓</td>
<td>✓</td>
<td>Current ADHB baseline funding</td>
<td>✓</td>
</tr>
<tr>
<td>8.</td>
<td>Community leaders will take a stand against all form of violence, including the use of physical discipline against children</td>
<td>✓</td>
<td>✓</td>
<td>No funding required</td>
<td>✓</td>
</tr>
<tr>
<td>9.</td>
<td>Community and church leaders will participate in the development and delivery of parenting programmes</td>
<td>✓</td>
<td>✓</td>
<td>Current ADHB baseline funding</td>
<td>✓</td>
</tr>
</tbody>
</table>
2. We’re Smokefree

About one in four Pacific adults smoke; almost the same rate as five years ago.

Pacific people identify smoking and also being overweight as reasons for our poor health.

Stop smoking programmes (like Quitline) and the Pacific Quit Smoke Service work well for Pacific people but more people could use them.

Competitions like WERO challenge are popular and get people working in teams.

We plan to make a difference

<table>
<thead>
<tr>
<th>Source of Funding</th>
<th>Auckland and Waitemata DHBs</th>
<th>Primary Healthcare (PHOs, GPs, Nurses, NGOs and others)</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. DHBs will work with other agencies to see what more can be done to refer more Pacific people to smoking programmes e.g. WINZ, Auckland Council</td>
<td>√ 2013 - 2014 √ 2014 - 2015 √ 2015 - 2016 No funding required</td>
<td>√ 2013 - 2014 √ 2014 - 2015 √ 2015 - 2016 as above</td>
<td>√ 2013 - 2014 √ 2014 - 2015 √ 2015 - 2016 as above</td>
</tr>
</tbody>
</table>

13. Offer quit smoking advice to every Pacific patient, along with a referral to support services for those who wish to quit (all GP practices) and share Pacific quit smoking success stories with other providers.

14. Make all HVAZ and Enua Ola church halls and grounds smoke free.

15. Identify potential smoke free champions in the community and support their participation in training.

16. Participate in the WERO smoke free competition.
3. We Eat Healthy and We Stay Active

Just over half (56%) of Pacific adults eat at least two servings of fruit per day (an adequate serving). 46% of Pacific adults eat at least three servings of vegetable per day (considered adequate).

Nationally, Pacific adults have low levels of physical activity. At the moment half of Pacific adults meet the physical activity guideline, which is having at least 30 minutes of moderate physical activity, five times a week. Low levels of activity are linked to obesity. Around two in three Pacific adults are classed as obese.

In the 2012 Health Survey, Auckland DHB found that Pacific people didn’t always identify exercise or diet as positive influences on their health. We are more likely to identify family as a motivating influence on our health.

The best way to make change is as a family. Success in achieving small goal can encourage us to try for more ambitious goals.

![Proportion of NZ Pacific people who are active and obese](image)

![Adequate Fruit and Vegetable Consumption for Pacific (NZ)](image)

We plan to make a difference

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<thead>
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</thead>
<tbody>
<tr>
<td>17. Keep growing our community action programmes (Healthy Village Action Zones and Enua Ola)</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>WDHB &amp; ADHB current base line funding</td>
</tr>
<tr>
<td>17.1. Continue to fund the Enua Ola and Health Village Action Zone healthy eating and physical activity programmes</td>
<td></td>
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</tr>
<tr>
<td>18. Work with other organisations to promote healthy lifestyle, such as Pacific Heartbeat – National Heart Foundation, regional sports organisations, School of Population Health, Auckland Council</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>No funding required</td>
</tr>
<tr>
<td>19. Collaborate with PHOs to implement annual weight loss competitions through the Enua Ola and HVAZ churches and communities</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>No funding required</td>
</tr>
<tr>
<td>20. Develop and implement a Pacific Wellness at Work Programme for Pacific employees of Waitemata and Auckland DHBs</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>No new funding required</td>
</tr>
</tbody>
</table>
4. We Get Help Early

Regular screening can detect problems at an early stage. Breast, cervix screening saves lives, as do checks to assess a person’s risk of heart disease. Pacific women aged 45-69 years living in Auckland and Waitemata DHB areas have high rates of breast screening – higher than the 70% target.

While Pacific women aged 25-69 years in Auckland DHB have higher rates of cervical screening than the national target of 80%, those living in Waitemata DHB have much lower rates.

The two most significant long term conditions for Pacific people are cardiovascular disease (heart attacks and strokes) and diabetes. Heart disease can be prevented by assessing people’s risk and treating those who need it.

In 2012-13 Auckland exceeded the DHB’s Pacific population’s national target of 75% for CVD risk assessment (heart check). Waitemata DHB reached 72%. From July 2013 the new national target is 90%.

People with diabetes do well if they learn to manage their diabetes and see their doctor regularly. Self-management of chronic diseases like diabetes and heart problems is very successful. People learn to get good control of blood sugar levels and other risks such as blood pressure.

Auckland and Waitemata DHB Pacific diabetics need to get better management of their diabetes. 60% of diabetics who had an annual review had satisfactory diabetes management. This means the proportion of diabetics who have an HbA1c equal to or less than 64mmols. The target across both DHBs is around 77%.

There is poor uptake of podiatry services and retinal screening. These services are available in the community and really help with the management of any complications associated with diabetes.
We plan to make a difference

|----------------|-----------|-----------|-----------|

**Auckland and Waitemata DHBs**

21. Increase health literacy through community based education programmes

21.1. ADHB to continue to fund parish nurses to provide church-based health education

21.2. WDHB to explore option of funding parish nurses alongside the Enua Ola programme

21.3. WDHB child health specialist services work with West Fono to identify and respond to the needs of families whose children DNA appointments

21.4. Explore the development of community based education to address child health issues especially the need to seek medical help early

21.5. WDHB child health services will reconfigure service delivery mechanisms if required

**Primary Healthcare (PHOs, GPs, Nurses, NGOs and others)**

22. Develop Pacific Diabetes Strategy in conjunction with DHBs, Alliance Health+ and Pacific GP practices will

22.1. Actively participate in the work of the Northern Regional Diabetes Network and in the development of service delivery models

22.2. Explore mechanisms to improve compliance with diabetes and CVD medication specifically the CDM programme implemented at West Fono for WDHB

22.3. Adopt a model that responds to the issues experience by Pacific people with diabetes and CVD

23. Increase the number of diabetes self-management education (DSME) workshops delivered to Pacific patients and their families

23.1. Train 20 Pacific facilitators (clinical and lay people) to deliver the diabetes self-management education (DSME) workshops

23.2. Train 4 Master Trainers of Self Management Education

23.3. Run 10 Self Management Education/Diabetes Self Management Education Groups

23.4. Translate Stanford University SME Manual into Tongan

23.5. Implement SME education in Tongan language

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## Community

24. Encourage Pacific people to participate in the programmes that screen for breast cancer, cervical cancer, and the bowel screening pilot (at Waitemata DHB only).  

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<thead>
<tr>
<th></th>
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<th>Current base line funding</th>
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<tbody>
<tr>
<td>✓</td>
<td>✓</td>
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25. Encourage people to participate in heart disease and diabetes risk assessment  

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<th>Current baseline funding</th>
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<td>✓</td>
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26. Encourage people to adopt healthy lifestyle and prevent onset and improve management of chronic diseases  

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<th>Current baseline funding</th>
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<tbody>
<tr>
<td>✓</td>
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</table>
5. **We Use Hospital Services when needed**

Key issues for our hospitals are:

Getting the best practice guidelines widely accepted across all services.

Understanding why Pacific people miss appointments and ways to get our DNA rate lower. They are about 18% for Auckland DHB and higher at Waitemata DHB.

We need more Pacific staff on the workforce. More support is needed at every step of the training and recruitment process to make sure that Pacific people are successful in applying for jobs and for succeeding in positions. In particular, there is not enough support at the pre-interview stage.

Getting more information from patients and family about their experience as an inpatient.

Patient experience surveys tell us a lot about how people find our services. Two factors in particular contribute to poorer quality ratings from Pacific (and also from Maori) respondents:

- waiting times to be seen
- negative experiences with staff

---

### We plan to make a difference

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<tbody>
<tr>
<td><strong>Auckland and Waitemata DHBs</strong></td>
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<tr>
<td>27. Engage Pacific service users and families in the review and design of current services</td>
<td>√</td>
<td>√</td>
<td></td>
<td>Current baseline funding</td>
</tr>
<tr>
<td>27.1. Patients have more say in how they are treated and will participate in decisions about their care</td>
<td>√</td>
<td>√</td>
<td></td>
<td>Current baseline funding</td>
</tr>
<tr>
<td>27.2. Greater collection of patient experience data with results to drive improvements</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>Current baseline funding</td>
</tr>
<tr>
<td>27.3. Align Pacific-focused activities across Auckland and Waitemata DHB hospital services</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>Current baseline funding</td>
</tr>
<tr>
<td>28. Mainstream staff will be highly competent working with Pacific patients and family members.</td>
<td></td>
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<tr>
<td>28.1. Further develop Pacific clinical leadership at ADHB and establish clinical leadership forum at WDHB</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>Increase Workforce role from 0.5 to 1 FTE</td>
</tr>
<tr>
<td>28.2. Engage more staff in Pacific Best Practice training in ADHB</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>0.5 FTE for Pacific Best Trainer Educator</td>
</tr>
<tr>
<td>28.3. Introduce Pacific Best Practice training in WDHB</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
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<tr>
<td>28.4. Interpreters and cultural advisers are used more regularly and add value to the communication</td>
<td>√</td>
<td></td>
<td></td>
<td>Increased capacity for 2 FTE frontline Matua</td>
</tr>
</tbody>
</table>
29. Increase the number of Pacific people in the DHB workforce and ensure that these Pacific staff are retained

29.1. Develop Pacific staff networks that can do more to support our Pacific health workforce and to implement their initiatives in ADHB  
√  √  √  Current baseline funding

29.2. Develop Pacific staff networks that can do more to support our Pacific health workforce and to implement their initiatives in WDHB  
√  √  Current baseline funding

30. Do more to advertise the type of specialist services available to Pacific people, and the best way to access these  
√  √  Current baseline funding

31. Educate Pacific patients as to how to change hospital appointments when not suitable  
√  √  Current baseline funding

32. Drive the DNA rate down by working with patients, and with those clinics where Pacific people are most likely to miss scheduled clinics and follow up appointments

32.1. Support WDHB’s Outpatients Improvement Project  
√  √  √  Current baseline funding. May need project management support

32.2. Support ADHB’s Eye Clinic to survey Pacific patients that DNA appointments

33. Project management capacity to lead and develop health gain strategies in the hospitals such as reducing DNA and ASH rates, developing suitable model of care. 2 FTE $240k. Improving patient/client experience and better connections. Values: Better, best, brilliant  
√  √  2FTE project managers

34. Provide Pacific leadership in improving Diabetes rates for Pacific peoples  
√  √  1 FTE Pacific Diabetes Nurse

Community

35. Communicate to hospitals when appointments are not suitable  
√  √  √  Current baseline funding
6. Our family lives in warm, healthy houses that are not overcrowded

The strong relationship between poor housing (such as cold indoor temperatures, poor choices of heating (non-ventilated gas heaters), mould and dampness, and overcrowding) and poor health outcomes are well known.

We see too many Pacific people coming into hospital with problems that come about because of poor housing. Conditions like asthma and other respiratory problems get worse in cold and damp conditions.

Census data shows high proportions of Pacific households are overcrowded with around half of all Pacific households in Auckland DHB requiring at least one extra bedroom, and four out of ten of all Pacific households in Waitemata DHB requiring at least one extra bedroom.

Financial problems can lead to overcrowding, cold and damp housing situations and to eating poorer quality food.

We plan to make a difference

Auckland and Waitemata DHBs

36. Work with other sectors to drive initiatives that are focused on health and wellbeing

36.1. The DHB representatives on the Auckland Intersectoral Health Group will continue to advocate for housing improvements across the three DHB areas

36.2. The Child Health Stakeholder Group will continue its advocacy work which focuses on making Auckland DHB homes dry and well insulated

Primary Healthcare (PHOs, GPs, Nurses, NGOs and others)

37. Support patients’ application for housing support

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<tbody>
<tr>
<td>No funding required</td>
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<tr>
<td>No funding required</td>
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Measures that help track Pacific Health improvements

This Plan is focused on further development of a partnership approach between Auckland and Waitemata DHBs and Pacific communities, improved engagement of Pacific populations with services that address lifestyle issues, early engagement with treatment services and inter-sectoral collaboration. Immediate measures are process measures, intermediate measures are output measures. Outcome measures will not result from the activities identified in this Plan, but activities in this Plan can and will contribute to longer term outcomes. Output measures identified in other DHB plans including national health targets are not repeated in this Plan. The measures for longer term outcomes are not identified in this Plan.

<table>
<thead>
<tr>
<th>Our key actions</th>
<th>Process measures</th>
<th>Output measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Our children are safe, well, and loved and our families are free of violence</td>
<td>Maternal and infant and nutrition / physical activity service is implemented</td>
<td>Number of community workshops delivered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of pregnant women and other family members who participate in programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of radio programmes delivered</td>
</tr>
<tr>
<td></td>
<td>Agreement reached between HVAZ / Enua Ola churches / communities as to violence free and parenting programmes to be implemented</td>
<td>Number of HVAZ and Enua Ola churches / communities that participate in violence-free programmes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of HVAZ and Enua Ola churches / communities and number of individuals that participate in parenting programmes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of violence-free champions trained and working in churches and communities</td>
</tr>
<tr>
<td></td>
<td>Collaboration between DHBs and other sectors in specific projects are established</td>
<td>Future programmes to be jointly funded and implemented by MSD, Early Childhood Education, DHBs and other sectors</td>
</tr>
<tr>
<td></td>
<td>Referral protocols between ADHB maternity services and AH+ child/family support families are established</td>
<td>Number of pregnant women /families that ADHB maternity services and AH+ jointly work with and main issues addressed</td>
</tr>
<tr>
<td>Our key actions</td>
<td>Process measures</td>
<td>Output measures</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Protocols of WDHB Child Health Services and West Fono working together to address DNA issues are established</strong>&lt;br&gt;<strong>Issues that led to DNA are clearly understood</strong>&lt;br&gt;<strong>Services are reconfigure to better meet the needs of parents / caregivers</strong></td>
<td>DNA rates of children enrolled with West Fono are reduced</td>
<td></td>
</tr>
<tr>
<td><strong>2. We’re all Smokefree</strong>&lt;br&gt;Working protocols between HVAZ / Enua Ola churches / communities and the School of Population Health WERO project established**</td>
<td>Number of churches / communities and individuals that participate in the WERO project</td>
<td>Number of people who become smoke-free as a result of the project</td>
</tr>
<tr>
<td><strong>Working protocols between HVAZ / Enua Ola churches with communities with National Heart Foundation established</strong></td>
<td>Number of churches that are totally smoke-free (both halls and grounds)</td>
<td>Number of smoke free champions that have been trained</td>
</tr>
<tr>
<td><strong>PHO process for sharing Pacific quit smoke success stories established</strong></td>
<td>Number of events organised. Improvements in offer and referral to quit smoke services by GPs</td>
<td></td>
</tr>
<tr>
<td><strong>3. We eat healthy and we stay active</strong>&lt;br&gt;Review current Enua Ola and HVAZ programmes</td>
<td>Increased participation</td>
<td>Increased overall sustained weight loss by participants</td>
</tr>
<tr>
<td><strong>Protocols for annual weight loss competitions are established</strong>&lt;br&gt;(criteria for competition, data collection and PHO involvement)</td>
<td>Increased % weight loss by participants</td>
<td></td>
</tr>
<tr>
<td><strong>Number of churches / groups and individuals who participate in the competition</strong></td>
<td>Number of people who achieve sustained weight loss</td>
<td></td>
</tr>
<tr>
<td><strong>4. We get help early</strong>&lt;br&gt;Working protocols between WDHB child health services and West Fono established**</td>
<td>Reduced DNA of children enrolled with West Fono</td>
<td></td>
</tr>
<tr>
<td><strong>5. We use hospital services when needed</strong>&lt;br&gt;Barriers to attending out-patient clinics identified</td>
<td>Decrease in DNA rates</td>
<td></td>
</tr>
<tr>
<td><strong>6. Our family lives in a warm, healthy house that is not overcrowded</strong>&lt;br&gt;Consistent referrals of Pacific families by health providers to housing support services</td>
<td>Decreased acute respiratory admissions (pneumonia and bronchiolitis) for Pacific children</td>
<td></td>
</tr>
</tbody>
</table>
Family Centred Care: Where home is the heart of health

We have a vision of a health system that puts the home and family at the centre. Health services are there to support the family and to offer specialist care and interventions when this is needed. This picture shows some of the services available to Pacific communities and how these get more and more specialised as we move to the outer circle.
Services for Pacific mentioned in this Plan

Most of the **publicly funded health services** for Pacific people living in Auckland DHB or Waitemata DHB are provided by mainstream health and disability services. There are a few services funded to provide for Pacific communities or communities where there is high need. We don’t list all the health and disability services but simply explain those that have been mentioned in this Plan.

There are **five primary health organisations** across Auckland and Waitemata DHB:

- Alliance Health Plus (AH+), ProCare, HealthWEST, National Haurora Coalition, Auckland PHO

Services mentioned **in this Plan** (or the graphic above):

- West Fono - affordable, accessible and culturally appropriate and meet the needs of Pacific families
- Pasifika Integrated Health Care Limited (PIHC) - a provider of home based support services
- Lotofale at Auckland DHB - mental health and general wellbeing services for Pacific adults who have serious mental health problems
- Isa Lei at Waitemata DHB - Pacific Island Community Mental Health service that provides cultural-clinical care coordination to Pacific mental health consumers and their families
- The WERO project - a quit smoking competition, developed by researchers at the University of Auckland, which runs for 3 months and offers a prize to the winning team
- Pacific Heartbeat / National Heart Foundation programme – part of the national Heart Foundation. Focuses on Pacific health through nutrition and exercise
- Incredible Years parenting programme - run by the ADHB Kari Centre for parents who need help with parenting their challenging children
- TAPUAKI programme - Pacific pregnancy and parenting education

The DHBs also support two **Church-based programmes** for health promotion and early intervention.

- Enua Ola - helps to reduce obesity in the Pacific communities of Waitemata through increased physical activity and better nutrition

- Health Village Action Zones - a partnership between the Auckland District Health, Primary Health Organisations (PHOs) and Pacific church communities in the Auckland DHB area
This plan was developed by a Working Group consisting of community, PHO and Pacific provider representatives and ADHB & WDHB personnel from both planning and funding and provider arm.

All enquiries to Lita Foliaki
Waitemata DHB, Shea Terrace, North Shore

Thank you to those in the working group who assisted with this plan:

Reverend Dr Featuna’i Liuaana (Community representative)
Edwin Talakai (Community representative)
Loto Tukutama (Community representative)
Rita Maro-Brothers (community representative)
Viviene Pole (Alliance Health+)
Alan Moffit (Alliance Health+)
Rachel Enosa-Saseve (Alliance Health+)
Wilmaeson Jensen (ProCare Network)
Tevita Funaki (West Fono Health Trust)
Dahlia Naepi (Pasifika Integrated Healthcare)
John Hu’akau (WDHB Epidemiologist)
Tom Robinson (WDHB Public Health Physician)
Bruce Levi, Acting General Manager ADHB/WDHB
Tuliana Guthrie (ADHB-WDHBPacific Hospital Services Team Leader)

There is one Pacific health team across Auckland and Waitemata DHB

The Pacific Health Gains Team
Lita Foliaki
Leani Sandford
Faimafili Tupu
Sione Feki

The Pacific team working in the hospitals

<table>
<thead>
<tr>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
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</thead>
<tbody>
<tr>
<td>Bruce Levi, Acting General Manager Pacific</td>
<td>Puleiali Tofaeono (Ala)</td>
</tr>
<tr>
<td>Tuliana Guthrie</td>
<td>Tauafu Moala</td>
</tr>
<tr>
<td>Abel Smith</td>
<td>Sera Tagaloa</td>
</tr>
<tr>
<td>Siai Sausau</td>
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<td>Sene Fuimaono</td>
<td>Galuafi Lui (Galu)</td>
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Published, January 2014
3.2 Auckland Metro Clinical Governance Forum

Recommendation:

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

That the Board endorse the terms of Reference for the Auckland Metro Clinical Governance Forum.

Prepared by: Tim Wood (Deputy Director Funding, Waitemata and Auckland DHBs)

Glossary

CGF  -  Auckland Metro Clinical Governance Forum
DHB  -  District Health Board
PHO  -  Primary Healthcare Organisation

Summary

The three Auckland DHBs (District Health Boards) have had differing arrangements for clinical governance for primary care. With the development of District Alliances and Localities it has been agreed that a single clinical governance arrangement for metro Auckland has a number of benefits including minimising clinician time involved in clinical governance meetings, and to maximise consistency, effectiveness, and efficiency.

Clinical leaders across the PHOs (Primary Healthcare Organisations) and DHBs have been discussing how this might be implemented. Appendix I has the Terms of Reference for the Auckland Metro Clinical Governance Forum.

The Community and Public Health Committee are asked to endorse the Terms of Reference.
Appendix I

Auckland Metro Clinical Governance Forum

Terms of Reference

Background

As a result of forming district alliances between the three Auckland DHBs and the various PHOs across metropolitan Auckland it has been agreed that a single clinical governance arrangement should be formed. The intent of a single arrangement is to minimise clinician time involved in clinical governance meetings, and to maximise effectiveness, efficiency and consistency, where this is required. This single arrangement shall be known as the Auckland Metro Clinical Governance Forum (CGF).

Purpose

The single forum will provide advice and direct improvement in care and services across metropolitan Auckland with a particular focus on integration and interface issues. CGF will advise the district alliance partners on clinical issues that impact primary healthcare and community services providing a single integrated clinical governance across localities, to address quality concerns, service development and integration or interface issues. This will include providing advice to GAIHN ALT and DHB District Alliances with PHOs governing localities, the Auckland Regional After Hours Network, and the Northern Regional Alliance governing the Regional Health Plan. The forum will make recommendations to these alliances regarding safety and effectiveness of primary, community and other relevant services, and will ensure a strong primary care clinical view is provided to assist policy and funding decisions by DHBs.

Scope

The scope of the group shall be determined by the District Alliances between the various parties. The intent is that the Auckland Metro Clinical Governance Forum will discuss and advise on matters pertaining to:

1. clinical issues relating to locality governance – in particular things that need to be consistent across metro-Auckland, enablers, metrics and performance relating to triple aim outcomes: cost effectiveness and efficiency; patient experience; and population health including equity.
2. managing variation in performance and outcomes and required improvement activities;
3. the GAIHN work programme – particularly regionally consistent care pathways;
4. the Regional Health Plan as it relates to integration, primary & community services; service integration and interface issues;
5. clinical issues relating to I.T. particularly programmes that integrate across sectors; and
6. be the key decision making forum for agreeing sharing of population level information between practices, PHOs and DHBs.

As a matter of principle quality issues relating to individual providers or contractual obligations would be dealt with between the relevant parties and only be referred to the CGF where issues remain unresolved or there is systems learning for dissemination.
The initial focus will be on PHO/DHB related matters but it is envisaged that the CGF will cover wider responsibility as membership broadens to include broader community services including allied health (e.g. community pharmacy), aged residential care, maternity services, mental health and palliative care, to name a few.

**Functions**

Primarily the CGF will operate as a forum to provide advice to decision makers at the various alliance tables. To fulfil the purpose of reducing duplication and remaining efficient, where possible other clinical groups and work-streams will report in to CGF. In principle, papers being considered by the district alliances should come through the CGF for prior comment and clinical input with a clear recommendation being made where appropriate. It is envisaged that the GAIHN Work-streams will report to the CGF in the same way that they used to for the GAIHN Alliance Clinical Network.

Provide advice and direction to promote integration and improvement of services aspiring to seamless patient journeys so that people access the right care, at the right time, in the right place by the right person.

To provide strong clinical leadership across the whole system of healthcare with oversight of standard of care, and quality and safety pertaining to primary and community services.

Provide clinical governance, monitor performance over and receive reports from:

- ‘GAIHN’ work streams & Clinical Pathways Implementation Group
- Auckland Regional After Hours Alliance
- Urgent Care Network
- Primary Options for Acute Care
- Access to Diagnostics
- Care Connect & other Regional I.T. initiatives.
- Locality Clinical Leaders.

Leadership and oversight of model of care development across localities and endorsement of models of care and pathways developed at the local level.

Advise on prioritisation of resources and effort, including providing advice on workforce issues.

Provide a safe forum for discussion and peer support for organisational improvement.

Provide representatives to various fora where primary care input is desired.

Be the key decision making forum for agreeing sharing of population level information between practices, PHOs and DHBs.

Be a conduit for information transfer particularly relating to dissemination of clinically related information to the front-line networks of clinicians through PHOs.

Finally, to delegate to sub-groups as appropriate.
Permissions

CGF is a decision making body to the extent that the delegated authority from the District Alliances allows. It shall have complete clinical freedom to advise on resource allocation, the design and implementation of the various work programmes.

Guiding Principles

Decision making will be on the basis of “best for patient best for system” and be agnostic toward management/provider organisations.

Members will commit to attending meetings with apologies given in advance.

Members will make best efforts to be informed re subject matters discussed and will ensure that they read meeting papers in advance.

The membership will foster open sharing and transparency of information and maximise benefit from the individual expertise around the table.

The Forum will provide a vehicle for clinical input (particularly from primary care) into various DHB groups and programmes of activity.

The group will seek to learn from others’ experience including what is already happening in Auckland and elsewhere in New Zealand and internationally.

The 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.

The Group will endeavour to operate on the basis of consensus, however, where this is not possible the majority view will prevail.

Membership

- The Clinical Directors and Nurse leaders from each PHO
- One representative from the PHO CEO group.
- A DHB Chief Executive from each of the District Alliances
- A Planning & Funding representative from CMDHB and one from ADHB/WDHB (Director Primary & Community Services; Director Health Outcomes)
- Each Chief Medical Officer of the DHBs or their nominee
- The Primary Care Nurse leaders (or equivalent) for each DHB
• The Clinical Directors of Primary Care (or equivalent CMA) for each DHB
• A representative of the Directors of Allied Health (or equivalent) for the DHBs
• A community Pharmacist and DHB Pharmacy representative
• A Public Health Physician (or epidemiologist) to provide population health expertise
• A clinical representative from an Aged Residential Care provider
• GP Liaisons / CDs for each locality - are in attendance.

Initial membership shall be the PHO and DHB representatives with others to be appointed by resolution of the committee.

Except for ex-officio members, members are appointed for a two year term and shall be available for reappointment. In addition to this core membership, it will be appropriate to invite other attendees as per areas being discussed on the agenda e.g. for specialist expertise, additional allied health view, this will cover off specialist and subspecialty competencies as required.

The committee has the power to co-opt additional membership as required.

Members can resign by giving at least one month’s notice in writing.

**Chairman**

The Chairman will be elected annually from amongst the committee membership.

The deputy chairman shall also be elected annually from amongst committee membership.

Unless otherwise agreed the chair shall be paid an honorarium to be determined by the DHBs’ remuneration policy.

**Secretariat**

Secretarial support will be provided by one of the organisations represented and shall rotate on a yearly basis.

**Meetings**

The CGF will meet monthly for up to two and a half hours.

Alternates are permitted with the permission of the chair.

Minutes of the meeting will be circulated within 6 working days of the meeting after approval by the chair.

The minutes of these meetings will be circulated to the ‘Clinical Board’ meetings of the three DHBs.

There will be an annual review of the work programme and Meeting Plan for the following calendar year to be signed off at the last meeting of each year.
Papers are considered in the public domain unless expressly stated otherwise.

Members will respect the confidentiality where noted and not comment on committee business to the media.

All media contact shall occur through the chairman or deputy chairman (in his/her unavailability).

A register of interests shall be maintained and members shall declare potential conflicts at the start of each meeting and the committee will determine how any potential conflict should be handled, including whether that member should remain present and have speaking rights or not for the item concerned.

If any member is absent, without the agreement of the chair, for three or more consecutive meetings then, that member shall be deemed to have resigned from CGF.

**Quorum**

The quorum shall be at least five members from the broader primary care representatives with at least four of these being different PHO representatives; AND at least one representative from each DHB (regardless of office).

**Reporting**

The CGF will report to the District Alliances and minutes will be sent to the appropriate secretary for circulation to all Alliance Leadership Team members. Operationally the DHB/PHO CEOs’ Forum(s) may provide instructions to or request advice from the CGF – minutes will be circulated to the CEOs’ Forum(s).

**Review**

These terms of reference will be reviewed by the CGF annually.

**Date last reviewed: 26/2/2014**
4.1 Child Health Service: Planning a Sustainable Future

Recommendation:

That the report be received.

Prepared by: Stephanie Doe (Operations Manager, Child Health Services)
Endorsed by: Linda Harun (General Manager, Child Women & Family) and Dr Tim Jelleyman (Head of Division Medicine, Child Women & Family Service)

Glossary

ACC - Accident Compensation Corporation
DisAC - Disability Support Advisory Committee
DHB - District Health Board
SCI - Spinal Cord Impairment

1. Introduction

Waitemata District Health Board (DHB) provides a range of local secondary inpatient and community based Child Health Services and is also the provider of the national Child Rehabilitation Service and the regional Out of Home Children’s Respite Service.

This paper describes two major change processes that are being undertaken within the service at present:

1. The Child Health Redesign
2. The development of the future configuration of the Child Rehabilitation Service.

In addition, a brief overview is provided of the work currently underway to develop a National Spinal Cord Impairment (SCI) Strategy and the potential impact of this on the Child Rehabilitation Service.

2. The Child Health Redesign

In June 2013 it was agreed that Child Health would undertake a Redesign process, as the service was aware that it had a number of areas of strength, but that there were opportunities to reduce duplication, improve co-ordination of care and further target services to the children and young people with greatest health and social need. The primary drive of the process was to ensure that the Child Health Service was sustainable, effective and efficient and supports improved health outcomes for children, young people and their families within the Waitemata District.

The Redesign has been inclusive of all local secondary inpatient and community based child health services. The Child Rehabilitation Service was not included, because of the joint Auckland-Waitemata review process (described below). Given the regional nature of the service, the Out of Home Respite service was also excluded.
It was agreed that the Redesign would focus on six priority work streams. These were:

1. Entry and referral pathways
2. Care co-ordination
3. Clinical pathways
4. School based services
5. Administration and reporting
6. Vulnerable families

The Redesign has been overseen by a steering group, which included clinical leaders, managers, the Child Health consumer advisor, human resources advisor, and Child and Adolescent Mental Health Services and Planning and Funding representatives. The process was sponsored by the General Manager and Head of Division (Medicine) of Child, Women and Family Services. The process has been completed in partnership with staff working within the service and in consultation with families. (Appendix I)

Following consultation with staff, a number of key decisions were made on the future of the service. These included:

- The service will move to a single point of entry
- The service will adopt a defined care co-ordination model for children who receive care from multiple teams and/or clinicians
- The service will work in partnership with the Waitemata DHB funder to identify priority schools and agree on service provision levels
- Public health nurses will take responsibility for delivering prophylactic antibiotic treatment to children and young people who have had rheumatic fever
- A further consultation process will be undertaken that examines how the school based immunisation programme is co-ordinated across the service
- The service will adopt a formalised process for developing clinical pathways. These will be developed collaboratively with other internal and external service providers
- The development and implementation of a continence, autistic spectrum disorder and multiple disabilities pathway will be prioritised
- A further consultation process will be undertaken that examines how senior administrative support can best be provided to the service
- Child & Family, Home Care for Kids, the Child Development Service and Paediatric Outpatients will be reconfigured into integrated Community Child Health and Disability Teams. These teams will service a population within a defined geographical area and will be inter-disciplinary
- An in-reach model will be adopted where all allied health clinicians will be based in community teams and work into Rangatira ward and the Special Care Baby Units to support continuity of care for children and families
- The service will develop a reporting framework with defined measures. These measures will be established in consultation with clinicians and other stakeholders.

3. The Development of the Future Configuration of the Child Rehabilitation Service

The Child Rehabilitation Service is a national, specialist paediatric rehabilitation service that provides comprehensive and intensive rehabilitation to children aged 0 – 16 years (or for
older children who are still at school). Specifically, the service provides rehabilitation to children and adolescents following a severe illness, injury or complex surgical interventions. This includes an assessment of the child’s functional abilities and provision of intervention to maximise the child’s potential to ensure a successful return to community living and school.

The Auckland DHB and Waitemata DHB Child Health Collaboration Leadership Group prioritised the establishment of a work stream to review the model of care provided by the Child Rehabilitation Service because:

1. Auckland and Waitemata DHBs have jointly appointed two Paediatric Rehabilitation Specialists and clarity was required on the model of care across the two DHBs
2. The Child Rehabilitation Service provides care to children from DHBs across the country however there are no clearly defined referral pathways or a common understanding of the role of the service and local DHB services.
3. The Wilson Home Trust had proposed the development of the Takapuna site and required a decision regarding the long term lease and future facility requirements.

The Collaboration Leadership Group established a joint work stream with clinical (medical, nursing and allied health) and operational representatives from both DHBs and a representative from the Wilson Home Trust. It was agreed that the work stream would develop a plan for consideration that:

- Described the preferred model of care for Child Rehabilitation services including recommended referral pathways
- Confirmed the roles and responsibilities of the Paediatric Rehabilitation Specialists within services provided by Auckland and Waitemata DHBs
- Confirmed the roles and responsibilities of the Child Rehabilitation Service provided by Waitemata and referring DHB services
- Reviewed rehabilitation budget arrangements at Auckland and Waitemata and identified how available resources might be managed in a combined way.
- Identified what is required to establish a national clinical network for Child Rehabilitation Services and a proposed approach for national consultation and implementation
- Confirmed future facility requirements to support the proposed national and regional models of care.

4. Progress to Date

4.1 The Child Health Redesign

To date, there has been significant progress towards:

- Further defining and developing a single point of entry for Child Health Services
- Implementing the care co-ordination pilot
- Transitioning the prophylactic antibiotic programme for children who have had rheumatic fever
- The development of continence and autistic spectrum clinical pathways.

In addition, a consultation process is underway that proposes a new model of immunisation co-ordination across Child Health Services. Work has also commenced on scoping the integrated community child health and disability teams and reviewing service provision to schools within the Waitemata district.
An implementation plan is in place, with indicative time frames. Progress is being closely monitored and reported monthly to the sponsors.

4.2 The Development and Future Configuration of the Child Rehabilitation Service

Initially, the work stream focused on confirming the most appropriate location of the Child Rehabilitation Service. As a result of this work a paper was presented to the Waitemata DHB Board which recommended:

- That support is given to the development of a purpose built rehabilitation facility. The preferred site of this facility would be at Grafton Road alongside Starship Children’s Hospital. However, if this is not possible services are developed on the Wilson Centre site and approval is sought from the Minister for a 20 year lease.
- Rental costs at the Wilson Centre are maintained at current levels with no more than 2% increase per year.
- A lead clinician and manager are appointed from the Waitemata Child Health Services to the Wilson Home Trust Board.
- The Wilson Home Trust is encouraged to discuss fundraising activities in collaboration with the Starship Foundation to support services to children with disabilities and their families.

The outlined recommendations were endorsed by the Board. Discussions were undertaken with Auckland DHB and it was determined the Wilson Centre site would remain the future location of the Child Rehabilitation Service.

The working group have now finalised a current state analysis of the service and have begun work on defining rehabilitation and drafting the future model of care. Once this has been completed a consultation process will occur with referring DHBs across the country, the Ministry of Health and the Accident Compensation Corporation (ACC).

Over the coming months the working group will:

- Finalise the model of care, including recommended referral pathways and entry criteria
- Confirming roles and responsibilities of the paediatric rehabilitation specialists
- Clarifying the roles and responsibilities of the Child Rehabilitation Service in relation to referring DHB services
- Continue to advocate for the development of a national clinical network
- Develop an approach for national consultation (i.e. outreach model)
- Identify future facility requirements
- Develop a workforce development plan.

5. The Development of a National Spinal Cord Impairment Strategy

ACC and the Ministry of Health have established a project to develop a SCI strategy and implementation plan. The project spans all ages and the continuum (from pre-hospital care through to reintegration and ongoing support in the community) a person might experience when they have spinal cord impairment.

The project is being undertaken collaboratively with stakeholders (service providers and consumers) to ensure that the gaps are understood and that the future direction of services will result in the best outcomes for consumers, their family and whanau. The project has
included research facilitated by ACC that provides an evidential review, consumer and family perspectives and relevant data about utilisation and demand for services.

While the strategy has not yet been completed, it is anticipated that it will result in the development of a national pathway for all children with spinal cord impairments. It is likely that the implementation of the Strategy will have a minimal impact on the Child Rehabilitation Service, as the project has indicated that nationally on average there are up to five children per annum who obtain spinal cord impairments.

6. Conclusion

In conclusion, there are two significant change processes underway in Child Health Services at present. These are separate and distinct pieces of work. The Child Health Redesign is internally led and has established a process to review the efficiency, effectiveness and future configuration of secondary child health services delivered by Waitemata DHB. The development of the future model of the Child Rehabilitation Service is being undertaken in partnership with Auckland DHB and further consultation will occur nationally once a draft model is agreed.
7. Appendix One: Phases of the Child Health Redesign

The phases of the Redesign are outlined in the diagram below:

Phase I
- Identify the context in which Child Health Services currently operates within
- Document the current structure, funding arrangements and staffing of the teams
- Identify the key factors that are influencing paediatric service design internationally
- Identify what consumers and families want from services
- Develop service delivery principles
- Develop a proposed future Child Health Service framework

CONSULTATION PHASE I

Phase II
- Finalise future Child Health Service framework
- Develop a proposal for the future configuration of the service
- Develop a proposal around the future structure of Child Health to support service delivery
- Identify initiatives that will ensure service sustainability over the next five years

CONSULTATION PHASE II

Phase III
- Review feedback and finalise proposed configuration and service structure
(please note: if significant changes are made to the proposal a second consultation process will be completed)

CONSULTATION PHASE III

Phase IV
- Implement

REVIEW AND EVALUATE
4.2 Women’s Health Collaboration

Recommendation:

That the Committee notes that the planned Women’s Health Collaboration project will focus on maternity services across Auckland and Waitemata DHBs over a ten year planning horizon.

Prepared by: Ruth Bijl (Funding and Development Manager, Women, Children and Youth, Auckland and Waitemata DHBs)

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CS</td>
<td>Caesarean Section</td>
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<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>GCC</td>
<td>Greenlane Clinical Centre</td>
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<tr>
<td>NWH</td>
<td>National Women’s Hospital</td>
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<tr>
<td>RFP</td>
<td>Request for Proposals</td>
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<tr>
<td>WTH</td>
<td>Waitakere Hospital</td>
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1. Executive Summary

Auckland and Waitemata DHBs have agreed to work collaboratively to plan the future of women’s health services. With a particular focus on maternity services, independent advisors have been engaged to assist with developing a preferred configuration model for service provision over a ten year horizon. The focus of the project will be on improving patient outcomes, equity and fair access to services, while living within our means. The project has been approved by the Auckland and Waitemata District Health Boards’ Collaboration Steering Group.

This information paper contains background information and project timelines.

2. Introduction/Background

Women’s Health services have been tasked by their Chief Executives with creating a strategic and innovative plan that will reduce the “duplication of services”, better use the “combined resources, expertise and facilities”, and “look at options around the acute theatre requirements out of hours” for women’s health services. Of particular interest to the Chief Executives are maternity services along the “western corridor”\(^1\).

The Women’s Health group sought approval to progress a project supported by external advisors. Approval to the proposed approach was obtained from the Auckland and Waitemata District Health Boards’ Collaboration Steering Group.

\(^1\) The ‘western corridor’ extends west of Auckland city to Waitakere and is served by both ADHB and Waitemata DHB services.
The aim of the project is to develop a collaborative primary and secondary maternity service model across the two DHBs, with a focus on improving patient outcomes, equity and fair access to services. Critical to the success of the project is early, close and meaningful engagement of clinicians, management teams, consumers, primary care and the DHB Boards and Committees.

Recognising the importance of maternity services to the wider community and the value of independent advice, the DHBs have engaged an external provider to support this project. Health Partners Consulting Group has been engaged following a strongly contested Request for Proposals (RFP) process.

Facilities and Service Provision
Waitemata DHB and ADHB currently provide primary, secondary and tertiary Women’s Health services to their respective populations and contract with non-government organisations for the provision of primary maternity services. Both DHBs provide women’s health services across multiple sites.

ADHB provides inpatient care, acute services and major surgery at National Women’s Hospital (NWH) (Auckland City Hospital) and outpatient services, ambulatory care and day stay surgery at Greenlane Clinical Centre (GCC). In addition, ADHB contracts Birthcare Auckland to provide primary maternity services and post natal care in Parnell.

Waitemata DHB provides primary and secondary services at Waitakere Hospital (WTH) and North Shore Hospital (NSH). Both WTH and NSH provide similar services, although NSH delivers the majority of high acuity healthcare, medical training, teaching and support services. High risk secondary obstetric services are concentrated at NSH due to co-location of ICU facilities.

Waitemata DHB also contracts three private providers for primary maternity care at Helensville, Warkworth and Wellsford.

National Women’s Health (NWH) provides tertiary care to the Northern region and Waikato DHB for Maternal and Fetal Medicine (MFM) and oncology and quaternary care for some MFM diagnoses for the whole of New Zealand.

Maternity Volumes
In 2012, 7,690 women birthed at NWH, and 6,873 at Waitemata DHB (3,839 at NSH and 3,034 at WTH); a total of 14,563 women giving birth in ADHB or Waitemata DHB facilities. In addition 693 women birthed in primary birthing facilities. Overall ~ 22% of New Zealand women birth in the facilities within the catchment of the two DHB’s.

Of this total, 396 women domicile in ADHB birthed in Waitemata DHB facilities while 1,125 women domiciled in Waitemata DHB birthed at NWH.

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2 Northland, Waitemata, Auckland and Counties Manukau DHB catchments.
3 2011 data.
Project Drivers

Auckland DHB - current challenges

- Women with low risk pregnancies receive midwifery-led care co-located with women with complex health problems. It is likely that this intermixing contributes to NWH’s higher intervention rates in low risk pregnancies, notably in epidural and caesarian section (CS) rates.
- Safely managing the volume and complexity of work within current resources, particularly ‘after hours’. NWH does not currently comply with best practice or RANZCOG recommendations for consultant cover or acute theatre availability.
- Managing demand for elective CS in the level 9 operating theatres, which also service emergency CS as well as elective and acute gynaecology.
- The low number of primary births at the primary maternity facility (Birthcare).

Waitemata DHB - current challenges

- Providing secondary services across two sites has led to a duplication of some services and inefficient ways of working.
- The addition of the Diabetes in Pregnancy service in 2012 has increased the level of acuity and service workloads.
- It is difficult to attract high quality specialist medical staff to WTH because of the demands of providing acute cover after hours and the limited opportunities for professional development.
- Lack of access to primary birthing facilities for the majority of the Waitemata population (all three Waitemata primary birthing units are located in remote rural localities).

Shared Challenges

- Any changes within one DHB’s maternity service configuration may significantly impact the other. DHB boundaries are artificial and do not take account of natural population flows across them. The concept of women’s choice of primary maternity facility is an inherent part of New Zealand’s maternity service design and as a result, flow between DHBs already occurs. The travel time to a maternity facility is an important factor for women and for safe provision of care. For ADHB and Waitemata DHB, the ‘western corridor’ defines an unnatural geographical border of healthcare provision between the DHBs so women domiciled in Waitemata DHB may prefer to attend a facility in ADHB.
- Population growth in Auckland is anticipated in the coming years, with a likely increase in birth numbers across both districts. This requires strategic planning to cater for future demand.
- Based on a combined current birth population of ~ 14,500, four after hours acute theatres are required to meet RNZCOG recommendations. Currently, only three after hours acute theatres are available.

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4 Best practice requires 24 hour consultant led care in delivery ward and the provision of two acute after hours theatres. RANZCOG recommends that one acute theatre is available per 4000 births, or part thereof.
3. Project Planning

The proposed phases of the project are as follows:

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<th>Completed by</th>
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<tr>
<td>Modelling and analysis</td>
<td>March-May</td>
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<tr>
<td>Options identification and development of paper</td>
<td>June-July</td>
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<tr>
<td>Stakeholder workshops</td>
<td>June-July</td>
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<tr>
<td>Draft service plan with proposed options for DHB sign off</td>
<td>31 August</td>
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<tr>
<td>Interim sign off process</td>
<td>September</td>
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<td>Steering Group agreement</td>
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<td>CEO agreement</td>
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<td>PFO Management Committee agreement</td>
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<td>CPHAC meeting</td>
<td>15 October</td>
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<td>ADHB Board meeting</td>
<td>29 October</td>
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<td>WDHB Board meeting</td>
<td>5 November</td>
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<td>Public consultation</td>
<td>November-early December</td>
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<td>Final report to DHB</td>
<td>January 2015</td>
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<td>ADHB Board meeting</td>
<td>February 2015</td>
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<td>Waitemata DHB Board meeting</td>
<td>February 2015</td>
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4. Conclusion

The Women's Health Collaboration Group is committed to providing the best services for our community within available resources. This project will inform planning in Women’s Health services over the next ten years. Strong community and stakeholder engagement and input will be required to develop fully informed options and the best outcomes from this project.
5.1 Primary Care Update Quarter 2, 2013/14

Recommendation:

That the report be received.

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

Glossary

A&M - Accident and Medical Centre
AH+ - Alliance Health Plus
APHO - Auckland Primary Healthcare Organisation
ARC - Aged Residential Care
ATD - Access to Diagnostics
CFA - Crown Funding Agreement
CT - Computed tomography [radiology imaging]
DAP - District Annual Plan
DAR - Diabetes Annual Review
DCIP - Diabetes Care Improvement Package
DHB - District Health Board
GAIHN - Greater Auckland Integrated Health Network
HML - Health Medical Limited
HRI - High Risk Individual
IFHC - Integrated Family Health Centre
LHP - Local health profile
MoH - Ministry of Health
MRI - Magnetic resonance imaging
NHC - National Hauora Coalition
NIR - National Immunisation Register
OIS - Outreach Immunisation Services
PARR - Patients at risk of readmission
PHO - Primary Health Organisation
PIMS - Patient Information Management System
PMH - Primary Mental Health
PMS - Patient Management System
PNL - ProCare Networks Limited
POAC - Primary Options for Acute Care
POC - Packages of Care
PPP - PHO Performance Programme
RAPD - Risk of admission based on primary care data
VDR - Virtual Diabetes Register
1. **Summary**

   This report provides an update on matters relating to Auckland and Waitemata District Health Board (DHB) primary care for quarter two 2013/14. The report is presented in the following sections:
   - primary care scorecard with additional commentary on the three primary care health targets
   - objectives set in our annual plan and other key primary care projects
   - primary care nursing
   - PHO operational issues.

2. **Primary Care Scorecard**

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

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

   **Summary Performance Against Targets**

   **Priority One Targets**

   The scorecard provides a snapshot of the three primary care health targets. Further detail on Auckland and Waitemata DHB’s performance against these targets is provided directly after the scorecard.

   **Service Delivery Targets**

   For PHO enrolment, Auckland DHB is sitting at 92% and Waitemata DHB 94%. Asian enrolment rates (71% and 75% for Auckland and Waitemata DHB respectively) has seen a slight increase of 1% for each of the DHBs between quarter one and quarter two. However their enrolment is lower than those of other ethnicities. Māori enrolment rates have also increased slightly with both Auckland and Waitemata DHBs on 80% (up from 79% and 78% respectively).

   **Improving Population Health Targets**

   Auckland and Waitemata DHBs are currently at 8.8% and 8.6% arrears respectively for child oral health which are above the target of 10% arrears. More information on oral health can be found in the Funder update paper.
For cervical screening, Auckland DHB is sitting at 77.1% and Waitemata DHB at 75.8% for their total population. Māori cervical screening rates continue to be lower than other ethnicity groups.

### Auckland and Waitemata DHB Primary Health Care Scorecard

#### 2013/14 Q2

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better help for smokers to quit (primary care) - Total</td>
<td>55%</td>
<td>90%</td>
</tr>
<tr>
<td>More Heart and Diabetes Checks - Total</td>
<td>76%</td>
<td>90%</td>
</tr>
<tr>
<td>More Heart and Diabetes Checks - Māori</td>
<td>72%</td>
<td>90%</td>
</tr>
<tr>
<td>More Heart and Diabetes Checks - Pacific</td>
<td>77%</td>
<td>90%</td>
</tr>
<tr>
<td>More Heart and Diabetes Checks - Other</td>
<td>77%</td>
<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Total</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Māori</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Pacific</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Asian</td>
<td>98%</td>
<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Other</td>
<td>90%</td>
<td>90%</td>
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#### Priority One - Auckland DHB

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better help for smokers to quit (primary care) - Total</td>
<td>61%</td>
<td>90%</td>
</tr>
<tr>
<td>More Heart and Diabetes Checks - Total</td>
<td>83%</td>
<td>90%</td>
</tr>
<tr>
<td>More Heart and Diabetes Checks - Māori</td>
<td>86%</td>
<td>90%</td>
</tr>
<tr>
<td>More Heart and Diabetes Checks - Pacific</td>
<td>85%</td>
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<tr>
<td>More Heart and Diabetes Checks - Other</td>
<td>83%</td>
<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Total</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Māori</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Pacific</td>
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<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Asian</td>
<td>96%</td>
<td>90%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Other</td>
<td>93%</td>
<td>90%</td>
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### Improving population health - Waitemata DHB

<table>
<thead>
<tr>
<th>Key Conditions</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes annual checks - Total</td>
<td>45.0%</td>
<td>51.0%</td>
</tr>
<tr>
<td>Diabetes annual checks - Māori</td>
<td>60.0%</td>
<td>51.0%</td>
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<tr>
<td>Diabetes annual checks - Pacific</td>
<td>47.0%</td>
<td>51.0%</td>
</tr>
<tr>
<td>Diabetes management - Total</td>
<td>77.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Diabetes management - Māori</td>
<td>67.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Diabetes management - Pacific</td>
<td>61.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Diabetes management - Other</td>
<td>81.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Total</td>
<td>94.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Māori</td>
<td>94.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Pacific</td>
<td>99.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Asian</td>
<td>92.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Other</td>
<td>92.0%</td>
<td>95.0%</td>
</tr>
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## Improve population health - Auckland DHB

<table>
<thead>
<tr>
<th>Key Conditions</th>
<th>Actual</th>
<th>Target</th>
</tr>
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<tr>
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<td>90.0%</td>
</tr>
<tr>
<td>Diabetes annual checks - Pacific</td>
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<td>90.0%</td>
</tr>
<tr>
<td>Diabetes annual checks - Other</td>
<td>59.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Diabetes management - Total</td>
<td>71.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Diabetes management - Māori</td>
<td>61.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Diabetes management - Pacific</td>
<td>56.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Diabetes management - Other</td>
<td>79.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Total</td>
<td>94.0%</td>
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</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Māori</td>
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<tr>
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<td>97.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Asian</td>
<td>93.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Immunisation - fully immunised by 8 months - Other</td>
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<td>95.0%</td>
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### Service Delivery - Waitemata DHB

<table>
<thead>
<tr>
<th>Enrolment</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO enrolment - Total</td>
<td>94%</td>
<td>95%</td>
</tr>
<tr>
<td>PHO enrolment - Māori</td>
<td>80%</td>
<td>95%</td>
</tr>
<tr>
<td>PHO enrolment - Pacific</td>
<td>99%</td>
<td>95%</td>
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<tr>
<td>PHO enrolment - Asian</td>
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<td>95%</td>
</tr>
<tr>
<td>PHO enrolment - Other</td>
<td>100%</td>
<td>95%</td>
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### Service Delivery - Auckland DHB

<table>
<thead>
<tr>
<th>Enrolment</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO enrolment - Total</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>PHO enrolment - Māori</td>
<td>80%</td>
<td>95%</td>
</tr>
<tr>
<td>PHO enrolment - Pacific</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>PHO enrolment - Asian</td>
<td>71%</td>
<td>95%</td>
</tr>
<tr>
<td>PHO enrolment - Other</td>
<td>100%</td>
<td>95%</td>
</tr>
</tbody>
</table>

## How to read

- **Indicator Title**
- **Actual**
- **Target**
- **Improvement against previous quarter**
- **DHB performance achieving or above the target will display as a solid green line.**

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 19/03/14

61 of 92
Immunisation Q2 2013/14

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

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

The quarter two results were:
- Auckland DHB 94%, (Māori 91%, Pacific 93%), ↑2% for Māori from quarter one
- Waitemata DHB 92%, (Māori 87%, Pacific 94%), ↑2% overall and ↑5% for Māori from quarter one.

Immediate actions
- Working with Waitemata DHB PHOs and practices with overdue vaccination episodes to improve timeliness.
- Targeted support for practices with low coverage rates to encourage newborn enrolment, precalls and recalls and identify overdue infants for immunisation. This includes ongoing targeted support for practices with high Māori enrolments and low coverage rates.
- Work with PHOs to up-skill PHO advisors’ immunisation capacity.
- NIR sourced, PHO/clinic level coverage is monitored monthly in both Auckland and Waitemata DHBs.
- Maternity services across Auckland and Waitemata DHBs provide early identification of Māori newborns with no GP to flag these infants for early OIS referral. The OIS team work to locate the family, offer immunisation and enroll them with a GP and other WellChild services.

Plan
- Immunisation week 2014 is from April 28 to May 2 and focuses on promoting infant immunisation to reach 95 percent of all 8 month olds.
- Work with primary care partners and the Māori health team to develop a 6-month Milestone Project to improve timeliness of the three and five month immunisation events and reduce the equity gap for Māori.
- Extend opportunistic immunisations through the in-patient services of both Starship and Waitakere paediatric hospitals.
- Develop early indicators of change in practice performance and provide systematic early intervention support to practices identified.
- Work with PHOs and the NIR/OIS to develop and utilise identifiable data through Datamart reports.
- Introduce the Immunisation Schedule change, including the rotavirus vaccine from July 1.
Please note the immunisation coverage for two year olds is reported in the final section of this report under the PHO Performance Programme (PPP).

**More Heart and Diabetes Checks Q2 2013/14**

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

The ‘More Heart and Diabetes Checks’ result is produced by the PHO Performance Programme (PPP) and are as reported in the Ministry of Health (MoH) DHB performance tables. The quarter two denominators are 137,529 for Waitemata DHB and 153,340 for Auckland DHB. The denominator increased from quarter four 2012/13 for both DHBs, 1038 for Waitemata DHB and 1074 for Auckland DHB. The quarter two results were:
Auckland DHB 83.3% (127,727 people assessed).
- Total coverage ↑3.3% from quarter one.
- Coverage for Māori ↑2.2% (to 80.4%) and for Pacific ↑3.1% (to 85.4%) which again has Auckland DHB leading nationally.

Waitemata DHB 74.7% (96,483 people assessed).
- Total coverage ↑4% from quarter one.
- Coverage for Māori ↑4.1% (to 71.5%) and for Pacific ↑5.3% (to 76.7%).

An additional 12,197 more people are recorded as having had an assessment in quarter two than quarter one (5889 for Auckland DHB and 6308 for Waitemata DHB). The impact of the rolling cohort means that people moving in and out of the age bands, and people assessed more than five years ago are adding to the number of required assessments.

Auckland PHO has improved from 78% to 81% since December. This was supported by Auckland PHO working with practices to do community assessments, phlebotomy in practices and liaising with the Long Term Conditions Quality Coordinators for support.

Alliance Health + PHO staff has ‘buddied’ with practices to support them to achieve targets. The PHO is providing phlebotomy training and practices are paid for phlebotomy. In addition weekly target meetings are held and incentive payments for practices are paid to help achieve the target. As a result performance has improved from 82% to 84%.

National Hauora Coalition has significantly improved from 69% to 84%. This was supported by non face-to-face assessments being done, improved data collection and a strong push by clinical staff from the PHO to assist low performing large practices.

The result for Procare practices across Auckland and Waitemata DHBs has also improved since December (76% to 77% for Auckland DHB and 76% to 78% for Waitemata DHB)\(^1\). The improvements are supported by training nurses in phlebotomy, providing further nursing support for practices, making improvements in data systems with Dr info reports circulated to practices, incentive payments (including a payment for reaching target) for all assessments completed.

Waitemata PHO has improved from 69% -72%. Waitemata PHO is paying per risk assessment and working on improving data systems. However they are not asking practices to do phlebotomy at this stage.

Auckland DHB is expected to reach the 90% target; Waitemata DHB is unlikely to reach it at the current rate.

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

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1 Please note this does not include risk assessments done in “the Edge” or “My practice” practice management systems.
Better Help for Smokers to Quit – Primary Care Q2 2013/14

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

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

The final quarter two results were:

- Auckland DHB 60.5%, ↑9.4% from the previous quarter; and
- Waitemata DHB 55.2%, ↑8.3% from the previous quarter.

Results for the Māori and Pacific populations are not available.

PHOs report monthly to the DHBs on their performance against this target. More frequent reporting is not possible. However, it can be seen from the results above that there has been...
a significant increase in the last quarter. The DHBs are working with the PHOs to ensure progress continues to be made.

The sub-target of ‘90% of pregnant women are offered advice and support to quit smoking at confirmation of pregnancy with an LMC’ is not yet being nationally reported. Work is underway to ensure this target can be reported upon.

Alliance Health + PHO has been supporting their practices to provide advice and support to quit and is now close to reaching the Health Target. Procare has made reaching the ‘better help for smokers to quit’ Health Target one of their main priorities and is implementing ‘Mission Smokefree’. They have formed a project team with additional resources to assist practices and phone patients that miss receiving advice from their GP. This project is providing a good month by month improvement in their Health Target result.

The other PHOs are also putting additional resources into contacting patients that have not received advice and support to quit from their GP. Waitemata and Auckland DHBs are also contracting additional funding to the PHOs to deliver advice and support to quit via texts and phone calls. However, as such a big increase is required to reach the Health Target in the next two quarters (Auckland DHB 40% – Waitemata DHB 45%) it is unlikely that the target of 90% will be reached by June 2014.

All PHOs are prioritising high needs populations in their programmes to support people to quit smoking. They are all achieving a higher rate of advice and support to quit to their high needs populations, than other populations.
3. Objectives set in our annual plan and other key primary care projects

Diabetes annual reviews

The diabetes annual review (DAR) targets for 2013/14 are:
- A minimum of 51% of people in Waitemata DHB with diabetes will have a DAR.
- A minimum of 90% of people in Auckland DHB with Diabetes will have a DAR.
- A minimum of 75% of people who have had a DAR will have an HbA1c of <64mmol/mol. HbA1c is a measure of blood glucose, and provides information of the control of the blood glucose over a three month period. Fasting blood glucose will provide information on what a person’s blood glucose is at the time of the test.

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

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

<table>
<thead>
<tr>
<th>Waitemata DHB</th>
<th>Auckland DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitemata VDR population is 26,535.</td>
<td>Auckland VDR population is 23,649.</td>
</tr>
<tr>
<td>45% of the total population have had a DAR.</td>
<td>67% of the total population have had a DAR.</td>
</tr>
<tr>
<td>77% of the total population have an HbA1c of &lt;64 mmol/mol.</td>
<td>71% of the total population have an HbA1c of &lt;64 mmol/mol.</td>
</tr>
<tr>
<td>The DHB has seen a one percent increase in DAR over the last quarter.</td>
<td>All four PHOs continue to implement their DCIP plans. The PHOs have been focused on ensuring people have their annual review. This includes meeting their PHO Performance Programme targets. The annual review includes a plan of care for the next year noting what medical and self care activities will be worked on. This approach encourages general practice to work to improve diabetes control.</td>
</tr>
<tr>
<td>Services for the management of people with complex health needs related to diabetes continue in general practice through the Diabetes Care Improvement Packages. Both PHOs have services to assist general practice to initiate insulin. Additional education and support for people needing in-depth nutrition and self management assistance is also available.</td>
<td></td>
</tr>
</tbody>
</table>
Primary mental health

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

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

Waitemata DHB

Work is ongoing with the Waitemata PHOs, to ensure the stepped care model is fully implemented, and the target population prioritised. A steering group has been established, including PHOs, secondary services, and mental health funding/planning team, to oversee implementation of stepped care across primary and secondary services. Gaps have been identified at the interface between primary and secondary services, and work is underway to address this.

The table below shows volumes for Primary Mental Health Options by provider. Services provided include extended GP consultations and medication reviews, brief Intervention counselling, alcohol brief Intervention counselling, group therapy, e-therapy, and other psychological interventions. HealthWest additionally provides youth workers and other youth focused psycho-social interventions.

2013/14 Q2 volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Waitemata PHO</th>
<th>Procare</th>
<th>HealthWest</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>363</td>
<td>113</td>
<td>224</td>
<td>700</td>
</tr>
<tr>
<td>Māori</td>
<td>65</td>
<td>15</td>
<td>202</td>
<td>282</td>
</tr>
<tr>
<td>Pacific</td>
<td>16</td>
<td>5</td>
<td>79</td>
<td>100</td>
</tr>
<tr>
<td>Asian</td>
<td>35</td>
<td>11</td>
<td>17</td>
<td>63</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>35</td>
<td>35</td>
<td>88</td>
</tr>
<tr>
<td>Q2 Total</td>
<td>497</td>
<td>179</td>
<td>557</td>
<td>1233</td>
</tr>
<tr>
<td>Q2 Expected Total</td>
<td>407</td>
<td>432</td>
<td>382</td>
<td>1221</td>
</tr>
</tbody>
</table>

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

Auckland DHB

2013/14 Q2 volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>APHO</th>
<th>ProCare</th>
<th>AH+</th>
<th>NHC</th>
<th>Youthline</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>163</td>
<td>631</td>
<td>0</td>
<td>101</td>
<td>18</td>
<td>913</td>
</tr>
<tr>
<td>Māori</td>
<td>47</td>
<td>0</td>
<td>3</td>
<td>23</td>
<td>1</td>
<td>74</td>
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<tr>
<td>Pacific Island</td>
<td>15</td>
<td>0</td>
<td>19</td>
<td>13</td>
<td>1</td>
<td>48</td>
</tr>
<tr>
<td>Asian</td>
<td>33</td>
<td>87</td>
<td>0</td>
<td>44</td>
<td>6</td>
<td>170</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>12</td>
<td>1</td>
<td>11</td>
<td>7</td>
<td>37</td>
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<td><strong>Q2 Total</strong></td>
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<td>730</td>
<td>23</td>
<td>192</td>
<td>33</td>
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<tr>
<td><strong>Q2 Expected Total</strong></td>
<td>105</td>
<td>385</td>
<td>89</td>
<td>86</td>
<td>38</td>
<td>703</td>
</tr>
</tbody>
</table>

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

Regional after hours and urgent care

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

- As of November 1, two new A&M clinics are now providing free after hours care for children under six years old from 6pm till 8am. The new clinics are Shore Care in Takapuna and White Cross Ascot in Remuera. This means that all of the A&Ms part of the Network are now providing free after hours care for children under six.
- The Network now obtains greater detail from the A&Ms and the telephone triage service regarding patient access and what the funding is being used for.
- All of the Auckland Metro PHOs are now contributing equally to the Network at $1.42 per enrolled person.
- A workshop was held on February 12 to continue the development of a business case for the 2014/15 year.
- The most recent A&M utilisation data received from the Network include attendances until September 2013. This is for patients who are eligible to receive the after hours subsidy. The total medical A&M attendances for after hours (6pm – 8am) for September 5, 2012 to September 4, 2013
are below.
  - North (Shorecare Takapuna) 9,521 attendances. This is a 1% ↑ from the same period the year prior.
  - West (White Cross Henderson) 13,794 attendances. This is an 11.9% ↑ from the same period the year prior.
  - Central (White Cross Ascot Remuera) 5,789 attendances. This is 4.8% ↓ from the same period the year prior.
• A further utilisation update for the October – December 2013 period is expected to be available for the next CPHAC meeting.
Access to Diagnostics-Radiology

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

- The regional wait time targets for routine community referred radiology are 85% of x-ray and CT, and 75% of MRI and ultrasound requests provided within 6 weeks. The table shows the percentage of patients who waited less than six weeks for their imaging to be done in December. This includes a signed-off report back to their GP. The figures highlighted in red show diagnostic investigations that did not meet the target.
- The three DHBs did not meet the target for MRI imaging in December. However there is currently a shortage of hospital MRI scanners and both Auckland and Waitemata DHBs have new MRI scanners going in within the next six months. Counties Manukau DHB is renegotiating contracts with local private providers for additional capacity.
- There is a well recognised nationwide shortage of sonographers which restricts ultrasound capacity in both public and private sectors. All three DHBs need to supplement capacity through private provided ultrasounds. Auckland and Counties Manukau have longer-standing arrangements with private providers which help them with the 6-week ultrasound wait target. Waitemata has funded additional ultrasounds through local private providers for the last six months and wait times have improved.

Wait times for accepted routine community referred radiology are presented below. The regional targets are CT and X-ray 85%, MRI and US 75%.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Month: Sept 2013</th>
<th>CT</th>
<th>X-ray</th>
<th>MRI</th>
<th>Ultrasound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitemata</td>
<td>% Validated within the 6 week indicator</td>
<td>93%</td>
<td>96%</td>
<td>39%</td>
<td>87%</td>
</tr>
<tr>
<td>Auckland</td>
<td>% Validated within the 6 week indicator</td>
<td>88%</td>
<td>91%</td>
<td>67%</td>
<td>76%</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>% Validated within the 6 week indicator</td>
<td>83%</td>
<td>98%</td>
<td>25%</td>
<td>88%</td>
</tr>
</tbody>
</table>
Primary Options for Acute Care (POAC)

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

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

- The numbers of Auckland and Counties Manukau DHB POAC referrals (July – December 2013) are currently below the target (see table below).
- GP referrals have reduced and the lower volumes can be attributed to:
  - quality improvement processes
  - implementation of new and revised clinical pathways and policies
  - improved access to diagnostics across the region. This has resulted in reduced referrals to POAC for radiology requests. There is a risk however that these referrals to POAC will increase again as practices exceed their individual budget for Access to Diagnostics.
- Training and education in Auckland and Middlemore hospitals will continue and has resulted in a significant increase in POAC referrals from the hospitals.
- Waitemata DHB volumes and budget will require monitoring for the next six months to avoid over run.
- St John transport expanded their service to include transporting patients to the GP/medical home in quarter one. The volumes for quarter two were lower than anticipated. Planned education sessions with St John paramedics are planned for February and March to increase awareness.
- The average cost per referral was lower across the whole region compared with the same time last year.
- The number of POAC referrals from the Auckland regional hospitals to support discharge continues to steadily grow.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Target number of POAC referrals</th>
<th>Actual number of POAC referrals</th>
<th>Difference between target and actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>3018</td>
<td>2149</td>
<td>-869</td>
</tr>
<tr>
<td>Waitemata</td>
<td>3258</td>
<td>3833</td>
<td>575</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>6156</td>
<td>4006</td>
<td>-2150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,432</strong></td>
<td><strong>9,988</strong></td>
<td><strong>-2444</strong></td>
</tr>
</tbody>
</table>
e-Referrals

| Increase uptake of e-Referrals by general practitioners and implement referral templates for remaining procedures |
| GP referrals using the regional eReferral system continue to increase in number, with monthly totals in excess of 10,000 across the Auckland region. The most recent estimate for Waitemata DHB shows 59% of referrals submitted electronically (↑8% from previous report). |
| An upgrade by the eReferral system vendor planned for December 2013 was unable to be completed for technical reasons and has been rescheduled for March 1. This upgrade will extend the eReferral capability to the remaining services including older adults and allied health. Mental health will soon follow. Electronic triage of referrals will be enabled by this upgrade. Services in the three DHBs will implement this according to the capabilities of each service, and the availability of support from the Central Referrals Office in each DHB. This will enable quicker and safer processing of referrals, and facilitate rapid messaging to GPs. This will provide particular value to services such as paediatrics in Waitemata DHB (where services are based at different locations), and other services where messaging to GPs can add value to shared care and avert outpatient clinic appointments. |
| Further initiatives to improve the functionality and value from the eReferral system include: |
| • Redesign and refinement of some forms, for example colonoscopy, to better support nationally agreed criteria for access to colonoscopy and to simplify form completion for GPs. Service-specific form design is undertaken on a regional basis and with input from both primary and secondary care. This is often a complex process which requires some compromise between conflicting requirements. |
| • Implementation of a pathway to provide direct access to MRI scans for patients in the Waitemata DHB area with spinal problems, if appropriate criteria are met. This pathway will provide for review of MRI results and appropriate referral for further specialist treatment |
| • Working with Orion (the system vendor for Concerto) to evaluate a product under development by them for its suitability for use as an eReferral platform between secondary care services |

Localities

| Earlier in 2013 the Locality Establishment Governance Group (LEGG) approved the boundaries of localities as those of local board areas. Tāmaki, West Rodney and West Auckland were identified by the LEGG as the three focus areas across Auckland and Waitemata DHBs. |
| Tāmaki | • Mental health has been selected as the priority for the Tāmaki locality. |
| | • A successful workshop was held in November where the community and wider stakeholders developed a vision for what Mental Health will look like in Tāmaki. |
| | • ProCare took over the management of the project in early December to cover maternity leave of the Auckland DHB project lead. The Localities Community Engagement manager also left the Auckland DHB in early December. Handover |

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 19/03/14
from both parties to the ProCare Project Manager took place during December.

- Key community contacts were engaged individually throughout December and a community meeting was set up in early January to reflect on Workshop 1 findings and planning for Workshop 2.
- Project governance and accountability structure was re-defined and agreed by the project sponsors and wider stakeholders and project steering group in late December.

### West Rodney

- Focus has been on engaging with West Rodney health providers, NGOs and communities to understand what health services could be improved in the area. This included hosting a local health provider workshop, local NGO workshop, speaking with local community members at key community events, and attending a number of additional face-to-face meetings with key stakeholders.
- The result of the engagement to date has identified a number of key themes consistent across all groups. These include ‘promoting and connecting local health services’ and ‘improving access to services’. Focus for quarter three will be the scoping and initiating of these workstreams.
- In December a comprehensive West Rodney profile was published. The purpose of this profile is to describe the health needs, service use, and population characteristics of the West Rodney area. The report attempts to describe 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 to support locality planning for the area. A copy of the report can be found at [www.waitematadhb.govt.nz/PlanningConsulting.aspx](http://www.waitematadhb.govt.nz/PlanningConsulting.aspx)
- A communications sub-committee has also been formed to develop a communications and engagement strategy for our localities development. This includes further engagement with West Rodney Māori communities led by Te Rūnanga o Ngāti Whātua and the development of a localities website on Health Point.

### West Auckland

- The focus continues to be the two clinical workstreams: diabetes and child health. There is currently no clinical director in post for West Auckland but the secondary specialists involved in the workstreams are providing governance and leadership for the integration work.
- The West Auckland Diabetes working group continue to support three priorities with a focus in New Lynn initially;
  1. **The implementation of the Quality Improvement Team (QIT).** Recruitment has been problematic and the roles are being re-advertised in early 2014. Once in post, the team will be focusing on 10 practices across West Auckland with high numbers of Māori and Pacific patients.
  2. **The development of an integrated diabetes model of care.** Two clinics and lunchtime educational sessions have been held in Health New Lynn. Practice GPs and nurses are invited to attend the consultation with the specialist. A small evaluation will occur after the third clinic in 2014.
  3. **Facilitation of network development to support improved diabetes care.** Without a clinical director in post there has been little interaction with the surrounding GP practices although they are invited to the lunchtime educational sessions. Some of the DHB services operating out of Totara Health Services are continuing to use the clusters as
their referral mechanism. These linkages will hopefully be strengthened through the QIT workplan. There has also been some work by an independent facilitator with a subset of New Lynn cluster practices to look at a number of diabetes performance initiatives which is to be progressed next year. This will work in parallel to the QIT.

- The child health working group is focusing on two key areas: Asthma at Whānau House and Cellulitis at Totara Health. This involves reviewing and agreeing clinical guidelines, and a shared care model between primary and secondary care. Work is beginning to see how the shared care plan tool can support this work.

Greater Auckland Integrated Health Network

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

**Work Stream 1: Better management of high risk individuals**

a) Develop a predictive risk algorithm (to identify patients with a high risk of admission to hospital).
   - Patients at Risk of Readmission (PARR) tool based on secondary data: Enhanced transmission of PARR lists from DHBs to PHOs.
   - Predictive risk tool based on combined primary and secondary care data: Undertook ethics, privacy and security analysis to meet the requirements of the Regional Privacy Advisory Group, in order to be able to proceed with data collection.
   - Regional data sharing framework: Commenced Phase 1 (scoping) to develop a proposal for a metro- Auckland data sharing framework. This will support implementation of the combined predictive risk tool, as part of a broader infrastructure that includes several defined uses of data sharing.

b) Enhanced integrated care for patients at high risk of admission
   - Pilot projects to enhance integrated care for patients at high risk of admission are in development and early implementation stages at Counties Manukau Health and Waitemata DHB.
   - Updated the high risk individual toolkit to include findings of the literature review about the effectiveness of identification methods and the associated interventions.
   - Commenced development of a high risk individual regional pathway – with a development group, and a first draft of the pathway.

c) Evaluation
   - The National Institute of Health Innovation has completed their evaluation methodology. Commenced planning for Phase 1 - a “current state analysis”.
Work Stream 2: Better response to acute events in the community

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

b) St John
   - The extension to the St John transport initiative to include the medical home (own GP) was launched in September. This initiative was initially implemented in December 2011, allowing St John to transport low acuity patients to an A&M facility as an alternative to a hospital emergency department (ED). Since then, on average 50 – 60 patients are transported each week to an A&M reducing low acuity attendances to ED. The extension to the medical home gives St John more transport options and a greater choice to patients. Initial uptake has been low, highlighting the need for further communication and a stronger focus on implementation.

c) Metrics
   - A metrics framework has been reviewed and has initially been applied to the Mangere locality to test its utility. This has highlighted data sharing issues to enable better understanding of urgent care processes.

d) Model of Care
   - While the UK capacity assessment tool has some limitations for application in New Zealand, it was agreed to pilot the tool in two practices (at no cost) as an opportunity to inform further work in this area. This web based tool enables analysis of practice performance on a number of key factors for managing access and urgent care in order to understand primary care capacity.
   - Developed a draft model of care for home-visiting housebound patients in the urgent event. This highlighted the need for a literature review to be completed quarter three.
   - Extension of referrals to POAC from St John, HML and ARC.

e) IV service for aged residential care residents in the Auckland district
   - A review of the pilot was completed which showed a limited uptake of the service (nine referrals received in three months). A number of factors were identified for improvement including a review of the Community Acquired Pneumonia regional pathway, which has commenced. An audit of the last 100 patients admitted to hospital from an ARC facility has also been carried out to identify areas of further work. Further analysis of this audit will inform recommendations for expansion of the service.

Work Stream 3: Enablers of better care

Pathways
a) Development
   - 35 pathways have been completed and uploaded to the Healthpoint website www.healthpointpathways.co.nz/northern/ Additional
Pathways in this quarter included paediatric acute respiratory illness, paediatric eczema, and type 2 diabetes.

- Prioritised the next 20 pathways for development. Highest priority was congestive heart failure, followed by palliative care, asthma in children, acute chest pain and atrial fibrillation.

b) Implementation

- Implementation focused on paediatric pathways, including development and distribution of skin resources, and roll-out of the sore throat pathway as part of the national rheumatic fever prevention initiative.

c) Evaluation

- Commenced two-yearly review of dyspepsia, iron deficiency, DVT.

4. Primary Care Nursing

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

**Waitemata DHB**

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

**Auckland DHB**

- Four new graduate nurses started in February 2014 with three supported by the MOH VLCA funding. One graduate in the September 2013 intake continues in a general practice setting supported by the Auckland DHB NETP Programme.

**Combined Auckland and Waitemata DHB Primary Health Care Nursing Reference Group**

- This group is now well established and includes nursing leaders across the Primary Health Care sector including representation from PHOs, NGOs, School Nursing, District Nursing, Public Health Nursing, University Schools of Nursing and Plunket. The group is currently working on developing a Primary Health Care Nursing strategy and is chaired by the Primary Health Care Nursing Director.
5. **Primary care operational issues**

**PHO Performance Programme**

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

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

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

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

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

The purpose of the PPP report is to provide information on how a PHO performs against the nationally consistent indicators.

The graphs below show performance at quarter two 2013/14, compared to target and historical performance (quarter two 2012/13).
The graph below shows ‘Cervical Screening Coverage’ across Auckland and Waitemata DHB PHOs. All PHOs met this target in quarter two, except ProCare Auckland DHB’s high needs population which was slightly under target.

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

The graph below shows ‘Diabetes Detection’ target for Auckland and Waitemata DHB PHOs. All are now meeting or exceeding the target of 90%, but ProCare’s performance for Auckland DHB residents has reduced since last year.
The graph below shows ‘Diabetes follow-up after Detection’ across Auckland and Waitemata DHB PHOs. All PHOs are meeting this target, although targets vary considerably by PHO.

The graph below shows that with the exception of NHC, all PHOs met the ‘Smoking Status Ever Recorded’ target for quarter two. NHC did not meet the high needs population target this quarter by 5%, however their performance has improved over the last year.
The graph below shows ‘Influenza Vaccination Coverage’ across Auckland and Waitemata DHB PHOs. ProCare and NHC did not meet this target for their high needs populations. However performance for all PHOs has improved on last year.

The graph below shows that with the exception of NHC high needs population, all PHOs met the ‘Immunisation Coverage for 2 year olds’ target for quarter two, NHC were 5% below the target set for their high needs population.
Integrated Performance and Incentive Framework

Further to previous updates the Expert Advisory Group has produced a report that sets out a preferred approach, structure and initial set of measures for the framework.

The Integrated Performance and Incentive Framework (IPIF) is intended to support the health system in addressing equity, safety, quality, access and cost of services. It sets high level directions for improved effectiveness and productivity of heath care for the whole population, while monitoring progress towards better services and creating an environment that supports constructive, collaborative, professionally driven quality improvement in front line services. The framework seeks balance between local responsibility and discretion that is needed for innovation and quality improvement, and accountability for performance in meeting sector wide national health goals.

A copy of the report can be found at [ww.hiirc.org.nz/page/45527/](https://www.hiirc.org.nz/page/45527/)

The next step is for the Ministry to continue its co-development work with the sector to jointly develop a way forward. This Report forms the basis for this next stage of work. To this end a small sector group will begin to work with the Ministry to develop a joint implementation plan.

PHO enrollment data

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

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

Recommendation:

That the report be received.

Prepared by: Dr Debbie Holdsworth (Director Funding WDHB/ADHB), Simon Bowen (Director Health Outcomes WDHB/ADHB), Wendy Bennett (Manager Planning and Health Intelligence), Tim Wood (Funding and Development Manager Primary Care WDHB/ADHB), Marty Rogers (Maori Health Gain Manager), Ruth Bijl (Funding and Development Manager Child, Youth and Women’s Health)

Glossary

DHB - District Health Board
NIR - National Immunisation Register
PHO - Primary Health Organisation

1. Summary

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

2. Summary of activities in common

2.1 Collaboration in Planning, Funding, and Outcomes

The collaboration in Planning, Funding and Outcomes across Auckland and Waitemata DHBs is progressing steadily. A Planning, Funding and Outcomes Committee has been established and terms of reference agreed. A draft structure has been developed for phase 2 of the restructure of the planning and funding teams from both DHBs. Consultation documents are currently being finalised prior to undertaking consultation. It is intended that following consultation a proposed structure will be presented to Auckland and Waitemata DHB boards in June. A new Programme Director has been appointed to support the transition. 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 – draft 1 are now in their final stages of development. These will be presented to Special Board meetings for final sign off on 10 March (WDHB) and 12 March (ADHB) before submission to the National Health Board on 14 March. There has been significant development of both plans since these were presented to the respective Boards for review last month. Financial sections of both plans are now included, Module 1 (Statement of Intent) has been further developed and Module 2: priority areas have been substantially improved and refined. However further work will be required
to ensure both plans are of high quality and meet all requirements and this will continue until submission date as well as for the next draft.

Two ‘Challenge’ sessions were held recently – enabling authors/those accountable to review their sections with senior management as well as our MoU partners. Feedback gained during these sessions focused on the need to ensure activity was affordable, appropriate, met the Minister’s and Ministry of Health’s expectations and addressed the inequalities for particular populations within priority areas. Further engagement is planned with both MoU partners and primary care over the coming months to further refine and develop the Plans.

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 Primary Care

Community Pharmacy – Commerce Commission Report

The Commerce Commission has warned all New Zealand District Health Boards (DHBs) and pharmacies nationwide that “no discounting” clauses in the 2012 Community Pharmacy Services Agreement (CPSA) are likely to have breached section 27 of the Commerce Act 1986. The Pharmacy Guild has also been warned for its role in advocating for the inclusion of the clauses in the CPSA. Copies of the warning letters can be found at http://www.comcom.govt.nz/business-competition/competition-enforcement-responses/commerce-act-enforcement-response-register/

The CPSA is a standard form agreement between each DHB and each community pharmacy for the provision of pharmaceutical services to the public. The Commission believes that two of the clauses in the 2012 agreement had the effect of prohibiting pharmacies from waiving, or discounting, the $5 pharmaceutical co-payment paid by patients for the dispensing of each prescription item.

On receiving notice of the Commerce Commission investigation, the DHBs took action and removed the restrictive clause from the agreements at the start of 2013. Consequently the Commerce Commission issued a warning letter to DHBs, The Pharmacy Guild, and Community Pharmacies.

The Commerce Commission Chair Dr Berry has stated that removing this clause was also an excellent outcome for consumers who stand to benefit from pharmacies being able to compete on prescription charges. Dr Berry further notes:

1. “Once the no discounting clause was removed, two pharmacies in lower socio-economic areas in Christchurch and Auckland advertised discounting again and noticed an increase in the number of prescriptions being dispensed.”

2. “The outcome of this investigation sends a number of important messages to the parties involved. Government agencies must consider the effects on competition when entering into procurement contracts.”

3. “Pharmacies and other health providers must also remember that they are in competition with each other despite the collegial nature of their professions. And professional associations, such as the Guild, are also subject to the Act and need to give attention to complying with the competition laws.”
**Primary Care Patient Safety Initiative**

Counties Manukau DHB has been working with Dr Neil Houston to develop a primary care patient safety initiative. The Auckland and Waitemata DHBs have been invited to have general practices from our areas to be involved in the first cohort of practices. There will be five WDHB and four ADHB general practices participating.

Dr Neil Houston, a GP and international expert, leads the successful Scottish primary care patent safety programme. Dr Houston’s APAC conference workshop on patent safety in Primary Care generated a high degree of interest among the delegates to lead quality improvement to improve patent safety and population outcomes.

A series of workshops, the first of which was held on 4\textsuperscript{th} March 2014, have been set up for the coming year with a focus on:

1. Building capability at a general practice, PHO, and Locality level in quality improvement methods with a focus on Patient Safety.
2. Develop systems, processes, and tools to identify, monitor and prevent potentially harmful episodes to patients.
3. Provide an opportunity for General Practices to collaborate to learn from each other’s experience.

Four areas have been identified, where patient safety improvement can be realised, that will be the initial focus of attention:

1. Medication reconciliation following discharge.
2. Results handling systems.
3. Prescribing and monitoring of Warfarin.
4. Prescribing and monitoring of Methotrexate and Azathioprine.

Practices will be required to establish a team of 2-3 patient safety champions who will attend learning sessions, attend facilitated practice meetings to reflect on data, identify areas of change, implement and drive change, use structured case review with a sample of patients to identify and reduce patient safety incidents, reflect on how to best establish a patient safety culture within the practice, involve patients in co-design of practice systems and be involved in the evaluation.

Practices will receive training in quality improvement skills and tools and support for system redesign.

### 2.4 Child and Youth

#### 2.4.1 Child Health

**Immunisation**

Positive performance against the national health target for immunisation continues. The quarter two results were:

- Auckland DHB 94% (Maori 91%, Pacific 93%), an increase of 2% for Maori from the previous quarter; against the target of 90 % of eight months olds will have their primary course of immunisation on time by July 2014
• Waitemata DHB 92% (Maori 87%, Pacific 94%), an increase of 2% overall and 5% for Maori from the previous quarter; against the target of 95 percent of eight month olds will have their primary course of immunisation on time by July 2014.

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

• Providing targeted support for practices with low coverage rates to encourage newborn enrolment, precalls and recalls and identify overdue infants for immunisation. This includes ongoing targeted support for practices with high Māori enrolments and low coverage rates.
• Working with PHOs to up-skill PHO advisors’ immunisation capacity.
• Monitoring NIR sourced, PHO/clinic level coverage monthly in both Auckland and Waitemata DHBs.
• Identifying Māori newborns with no GP to flag these infants for early OIS referral through maternity services across Auckland and Waitemata DHBs. The OIS team work to locate the family, offer immunisation and enrol them with a GP and other WellChild services.

Other planned activity includes:

• Working with primary care partners and the Maori health team to develop a 6-month Milestone Project to improve timeliness of the 3 and 5 month immunisation events and reduce the equity gap for Maori.
• Extending opportunistic immunisations through the in-patient services of both Starship and Waitakere paediatric hospitals.
• Developing early indicators of change in practice performance and provision of systematic early intervention support to identify practices.
• Working with PHOs and the NIR/OIS to develop and utilise identifiable data through Datamart reports.
• Introducing the Immunisation Schedule change, including the rotavirus vaccine from 1 July 2014.
• Preparation for Immunisation week 2014 April 28th – May 2nd, focus on promoting infant immunisation to reach 95 percent of all 8 month olds.

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 are effective from 1 July 2014.

Rotavirus vaccine funded
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 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.

**Measles**
As of 28 February, there have been 62 confirmed measles cases reported in New Zealand: 44 in Auckland, 15 in Bay of Plenty/Lakes, and 3 in Wellington. Most of the patients are linked to international travel (particularly to the Philippines). Eight patients have required hospitalisation. Three recent cases in Auckland had no apparent links to international travel or contact with reported measles cases and were therefore initially classed as sporadic community cases. Genotyping and more recent information have indicated there may be direct links to other cases; however this cannot yet be confirmed. There is a large outbreak among students at Westlake Boys High School, linked to overseas travel.

There continues to be enhanced surveillance for measles, and ongoing efforts by local public health services in tracing cases and contacts.

The Ministry has developed resources to remind health professionals, patients and travellers of the importance of being immunised before overseas travel and to be alert for measles symptoms, especially on return from overseas. The resources are available at [www.health.govt.nz/measles](http://www.health.govt.nz/measles). These resources are currently being circulated by public health units to primary care, emergency departments and travel health clinics.

**Well Child Tamariki Ora (WCTO) Quality Improvement Framework (QIF)**
The Ministry of Health launched a WCTO QIF towards the end of 2013. DHBs were tasked with working with providers to develop a local response to implement the framework. The framework has three dimensions: access, outcomes and quality. The two DHBS held a combined workshop which identified a number of additional priority areas for focused efforts:

- Early enrolment with a GP (access)
- Maori and Pacific access/utilisation of core WCTO checks in the first year of life (access)
- Oral health enrolments (access)
- Children participate in early childhood education (access)
- Breast feeding at 3 months (as there is a significant drop between 6 weeks and 3 months) (outcome).

These areas were identified out of a list of 27 indicators in part because targets were not being met in these areas. They were also selected because providers collectively agreed that they were both achievable aims and health gains could be delivered through them. These are additional to activities already underway in areas such as immunisation. An implementation plan has been prepared and the draft is currently with the Ministry of Health.

**WCTO Service Specification**
The Ministry of Health consulted in the WCTO service specification. Considerable feedback was provided collectively by the three metro Auckland DHBs. Significant practical implementation issues were discussed with the Ministry. The Ministry communicated that they found the DHB feedback useful in the specifications development.

**B4 School Check**
The B4 School Check (B4SC) programme has been in place for nearly five years. Over that time the Ministry has increased targets. There is now a 90% target. Both Auckland and Waitemata have explored a variety of service delivery models. The current model in WDHB is Plunket
delivered across all aspects of the programme. Since shifting to this model, significant improvements towards achieving the target have been evident. Quality dimensions also appear positive. Current performance year to date is 52% total population, 50% high deprivation. To be on track coverage should be at 52% to reach the 90% target.

The ADHB programme sits within a PHO alliance, with programme delivery contracted through ProCare. The model was intended to be primary care led. In practice there is now a very significant outreach component (~40%) suggesting that primary care may not have brought into the model whole-heartedly. Outreach models are expensive to maintain. Of greater concern is performance. Current year to date performance is 42% total population, 41% high deprivation. This is the lowest in the country. The alliance is working on a number of remedial actions including additional management support, additional administrative support, increased nursing for outreach and additional focus on nursing clinical leadership.

Child Youth Mortality Review Group
Funding from the Ministry of Health for the Child Youth Mortality Review Groups for both DHBs has decreased. We are currently developing an option paper which will explore whether any efficiencies can be made, such as by working more closely across the two DHBs. If not, a proposal for additional funding to support this work may be required.

Regional Child Health Network
The Northern Regional Child Health Network has been finalising the Child Health section of the Northern Region Health Plan. Priority areas for the overall plan include child health. Within the child health section there will be an ongoing focus on: Rheumatic Fever, Skin sepsis, respiratory illness, unintentional injury, SUDI. Consideration is also being given to developing a range of regionally consistent key messages for health professionals and the wider community.

Children’s Action Plan
The two most recent Child Health Stakeholder Advisory Group (CHSAG) meetings – an intersectoral regional group - have focused on issues around the development of the Children’s Action Plan. The particular focus has been on activity already underway with the vulnerable pregnant women’s groups in both WDHB and ADHB. These multidisciplinary groups consider the social complexities pregnant women are living with and aim to put supports in place for both the pregnant woman and key members of the care team, particularly LMCs. Consideration is being giving to how these groups can be strengthened and how transitions from maternity care can best be managed so women, babies and families and whanau do not lose supports which enable the best care for the baby beyond the maternity period.

Youth
A school based health services (SBHS) quality framework prepared by the Ministry of Health was launched at Otahuhu College by the Ministers of Health and Education on 21 February 2014. Both Ministers and the school Principal spoke highly of the service provided in Otahuhu College. The SBHS is a nurse led service supported by general practitioners and other visiting health providers. The nursing and GP service are funded by ADHB. ADHB also funds Procare through the Youth Alliance to provide nursing support and supervision, GP leadership and primary mental health services across the model. The Youth Alliance Leadership Team most recently decided to pilot a visiting psychologist in schools programme across the ADHB network of SBHSs.

Meetings are currently underway with WDHB schools regarding new or renewed agreements for nurse led SBHS. For some schools this will result in a considerable increase in resources,
such as in Massey High School where approximately three full time equivalent (FTE) nurses will be able to be employed at the school to deliver comprehensive primary healthcare services including wellness checks for all Year 9 students. HealthWest will continue to be an important part of the SBHS model across the district.

2.5 Maori Health Gain

Performance against National Maori Health Targets is varied across both DHBs, however work with each of the funding streams and community based providers is continuing and the identification of possible strategies to affect positive change is ongoing. Whilst performance against the smoking target within the hospital setting is good, Primary Care continues to lag behind. The Primary Care team has been working with each of the PHOs to address this issue.

Enrolment across both DHBs in PHOs whilst not at the national target of 95%, is at 79% (96% non-Maori) Waitemata and 81% (96% non-Maori) Auckland. The roll out of the Ethnicity Data Audit Tool is expected to identify anomalies which could account for between 2-12% differences in practice register databases. Once data quality has been addressed, specific and targeted strategies can be developed to reduce the disparity in enrolment.

Child Health

Immunisation:
Performance across both DHBs is not consistent; however with the introduction of a single provider focusing on the Outreach Immunisation Service, a consistent and steady increase can be seen. Work is also being done with community based providers and PHOs to identify other strategies to support continued movement towards target. The December result had Waitemata at 87% and Auckland at 91%.

Older People

A Kaumatua Action plan is currently being developed. The issues of aging for Maori, whilst the same as for other ethnicities, engenders a different social and cultural response.

Work is also underway to support the uptake of the 65+Influenza programme and includes the development of Maori nursing capacity in this area and Kaumatua supported interventions.

Whanau Ora

The development of a policy tool for the DHBs has been completed and is currently going through a national endorsement process before being presented for local implementation. The focus of the tool is to assist the DHB in understanding its role in contributing to Whanau Ora Outcomes. This has included work on the development of an Integrated Contract for all Maori providers, thus allowing them to develop a service model more in line with “Whanau Ora” expectations and outcomes.

The interface with the new Whanau Ora commissioning agency and the DHB is yet to be fully understood, however it is expected that in the initial roll out of this kaupapa they will be focussed on the wider determinants of health, and the interaction with health services will be more at an individual whanau level and the development of Maori leadership capacity.

Family Violence

The impact of family violence on the health outcomes for Tamariki Maori is well documented. Whilst there is an internal (hospital based) response to identifying, through assessment, women and children who have suffered abuse, there are very few community based options.
In acknowledgment of this a business case is being developed to provide a community based option for Maori women and their children in the Auckland and Waitemata districts.