Community and Public Health Advisory Committees Meeting

Wednesday, 26th November 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
Aas 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  STRATEGIC DISCUSSION: The Auckland Plan - Working with Auckland Council to Create “The World’s Most Liveable City” ................................................................. 7

1 AGENDA ORDER AND TIMING

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<th>NAME</th>
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<td>Elsie Ho</td>
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<td>Dr Tim Jelleyman</td>
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* absent
* attended part of the meeting only
# absent on Board business

11th June meeting cancelled due to power cut
## REGISTER OF INTERESTS

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<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
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<tr>
<td>Lester Levy</td>
<td>Chair - Auckland District Health Board</td>
<td>20/08/14</td>
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<td>Chairman - Auckland Transport</td>
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<td>Deputy Chair - Health Benefits Limited</td>
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<td>Independent Chairman - Tonkin &amp; Taylor</td>
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<td>Chief Executive - New Zealand Leadership Institute</td>
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<tr>
<td>Max Abbott</td>
<td>Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology</td>
<td>19/03/14</td>
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<td>Patron - Raeburn House</td>
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<td>Advisor - Health Workforce New Zealand</td>
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<td>Board Member - AUT Millennium Ownership Trust</td>
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<td>Chair - Social Services Online Trust</td>
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<td>Board Member - The Rotary National Science and Technology Trust</td>
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<tr>
<td>Jo Agnew</td>
<td>Professional Teaching Fellow - School of Nursing, Auckland University</td>
<td>01/03/14</td>
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<td>Trustee Starship Foundation</td>
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<td>Casual Staff Nurse - ADHB</td>
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<td>Peter Aitken</td>
<td>Pharmacist</td>
<td>15/05/13</td>
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<td>Shareholder/Director, Consultant - Pharmacy Care Systems Ltd</td>
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<td>Judith Bassett</td>
<td>Nil</td>
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<td>Pat Booth</td>
<td>Consulting Editor – Fairfax Suburban Papers in Auckland</td>
<td>24/06/09</td>
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<tr>
<td>Chris Chambers</td>
<td>Employee - Auckland District Health Board (wife employed by Starship Trauma Service)</td>
<td>20/04/11</td>
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<td></td>
<td>Clinical Senior Lecturer- Anaesthesia Auckland Clinical School</td>
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<td>Associate - Epsom Anaesthetic Group</td>
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<td>Sandra Coney</td>
<td>Elected Member - Chair: Waitakere Ranges Local Board, Auckland Council</td>
<td>12/12/13</td>
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<td>Member - Henderson - Massey and Rodney Local Boards, Auckland Council</td>
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<td>Director - Trusts Community Foundation Ltd</td>
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<td>Lee Mathias</td>
<td>Chair - Counties Manukau District Health Board</td>
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<td>Director – Health Innovation Hub</td>
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<td>Managing Director - Lee Mathias Ltd</td>
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<td>Advisory Chair - Company of Women Ltd</td>
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<td>Robyn Northey</td>
<td>Project management, service review, planning etc - Self-employed Contractor</td>
<td>18/07/12</td>
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<td>Board member - Hope Foundation Northern Region</td>
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<td>Trustee - A+ Charitable Trust</td>
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### Register of Interests continued...

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<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Christine Rankin</td>
<td>Member - Upper Harbour Local Board, Auckland Council</td>
<td>17/05/13</td>
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<td>Director - The Transformational Leadership Company</td>
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<td>CEO - Conservative Party</td>
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<tr>
<td>Allison Roe</td>
<td>Member - Devonport-Takapuna Local Board, Auckland Council</td>
<td>02/07/14</td>
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<td>Chairperson - Matakana Coast Trail Trust</td>
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<td>Gwen Tepania-Palmer</td>
<td>Chairperson - Ngatihine Health Trust, Bay of Islands</td>
<td>10/04/13</td>
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<td>Life Member - National Council Maori Nurses</td>
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<td>Alumni - Massey University MBA</td>
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<td>Director - Manaia Health PHO, Whangarei</td>
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<td>Committee Member - Lottery Northland Community Committee</td>
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<td>Elsie Ho</td>
<td>Associate Professor - School of Population Health, University of Auckland</td>
<td>03/09/14</td>
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<td>Member - Waitemata DHB Asian Mental Health and Addiction Governance Group</td>
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<td>Member - Problem Gambling Foundation of New Zealand Advisory Board</td>
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<td>Rev Featunai Liuaana</td>
<td>To be advised.</td>
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<td>Dr Tim Jelleyman</td>
<td>Member - Active Clinic Network for Greater Auckland Integrated Health Network</td>
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<td>Chair - Child Health Network, Northern Regional Health Plan</td>
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<td>Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland</td>
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<td>Member-Board of Kaipara Medical Centre</td>
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Strategic Discussion: The Auckland Plan – Working with Auckland Council to Create “The World’s Most Liveable City”

Recommendation:

That the Committee receives this background paper to support a facilitated discussion about how Auckland Council and the District Health Boards can work together for health gain.

Prepared by: Candace Bagnall for Simon Bowen (Director Health Outcomes WDHB/ADHB), Dr William Rainger (Service Manager ARPHS), Dr Julia Peters (Clinical Director ARPHS), Dr Michael Hale (obesity project clinical leader)

Glossary

ARPHS - Auckland Regional Public Health Service
CCO - Council Controlled Organisation
DHB - District Health Board
ECE - Early Childhood Education
HAT - Healthy Auckland Together
MoH - Ministry of Health

1. Executive Summary

1.1 Local government has a well-established role in maintaining and improving the health of the citizens it represents. This role is clearly articulated in the Auckland Plan (Auckland Council, 2012), a 30-year, aspirational plan aiming to create Auckland as “the world’s most liveable city”.

1.2 This paper has been written in collaboration with Auckland Council colleagues, and provides background for a structured discussion on how the DHBs can engage more effectively with Auckland Council, with the shared objective of improving the health and wellbeing of the people of Auckland. It covers

(a) The Auckland Plan and its potential for health gain (and our working relationships with Council)
(b) Examples of health sector engagement with Auckland Council including the Unitary Plan, and working together to reduce obesogenic environments
(c) Working together to reach health-related targets outlined in the Auckland Plan (see Appendix Two).

2. Introduction: “the world’s most liveable city”

2.1 The Auckland Plan was developed by Auckland Council following its establishment on 1 November 2010 (see Figure 1 for overview of planning documents and where the Auckland Plan fits). The plan:
sets a vision and strategic direction for Auckland and its communities that integrates social, economic, environmental, and cultural objectives - the vision is that Auckland will be the world’s most liveable city

Identifies six transformation shifts in thinking and acting, essential to achieve this vision all will impact on health outcomes, especially “dramatically accelerate the prospects of Auckland’s children and young people”, “substantially raise living standards for all Aucklanders with a focus on those most in need” and “significantly lift Maori social and economic well-being”

describes Auckland’s role in New Zealand

puts people at the heart of the plan and recognises that the health and well-being, education and safety of Aucklanders is critical to a better future for Auckland and New Zealand

outlines a high-level development strategy to give direction and enable coherent, coordinated decision-making by Auckland Council and other parties - this designates The Southern Initiative as one of the two-placed-based priorities in the Plan\(^1\)

identifies the existing and future location of residential, business, rural production and industrial activities

identifies the existing and future location of critical infrastructure facilities (such as transport, water supply, wastewater and storm water disposal), other network utilities, open space, and social infrastructure

identifies nationally and regionally important recreational and open space areas, ecological areas that should be protected from development, environmental constraints on development, and landscapes and areas of historic heritage value

identifies the policies, priorities, land allocations, programmes and investments to implement the strategic direction\(^2\).

2.2 The Auckland Plan provides a visionary context for the next 30 years of development in Auckland. The implementation of this and other plans such as the Unitary Plan by Council and its CCOs will significantly impact on health outcomes through for example,

- improving housing supply, choice, quality and affordability
- improving public transport and encouraging active transport
- promoting physical activity through sports and recreation, parks and reserves, and swimming pools
- delivering and maintaining quality infrastructure
- addressing environmental sustainability,
- commitment to enable Māori aspirations and lift Māori social and economic well-being, and
- empowering communities through supporting community leadership and a range of local community development activities
- promoting inclusion and removing barriers to opportunity and participation for disadvantaged communities.

2.3 In recognition of the importance of the Auckland Plan in addressing health determinants, ARPHS and the three DHBs in Auckland collaborated on a substantial written and oral

\(^1\) Covers the local board areas: Mangere-Otahuhu, Otara-Papatoetoe, Manurewa and Papakura

\(^2\) Material on the Auckland Plan was retrieved from http://theplan.theaucklandplan.govt.nz/a-plan-for-all-aucklander/ on 31 October 2014.
response during Council’s consultation process, and succeeded in increasing strategic opportunities for health gain. A summary of successful, partially successful and unsuccessful recommendations from this submission can be found in Appendix Three of this paper. It is important to note that the Auckland Plan is not legally binding on Council, but the Unitary Plan and other Council planning documents are, under various pieces of legislation such as the Resource Management Act. Ongoing input from the health sector is necessary to ensure that health-related aspirations expressed in the Auckland Plan are reflected in these plans.

2.4 Further collaborative submissions have been made on a range of Council planning documents, notably the Unitary Plan, which is undergoing an intensive and more detailed consultation with stakeholders, including the health sector (led by ARPHS).

2.5 ARPHS has since facilitated joint DHB collaboration with Auckland Council through the Auckland Intersectoral Health Group and related project work. An example of this approach is Healthy Auckland Together (HAT), a collaboration of DHBs and other health sector agencies, and Auckland Council, working together to address high rates of overweight and obesity across the Auckland region (see case study at 5).

2.6 Council’s Long-term Plan provides information about what is planned over a ten-year timeframe to achieve the vision outlined in the Auckland Plan. The new Long-term Plan and budget for 2015-2025 are currently being developed and will shortly be consulted on. (The first long-term plan 2012-2022 was largely based on inherited budgets and projects from the former eight councils.) This provides an opportunity for the health sector to have input to implementation from a health perspective.

Figure 1: Overview of key planning documents of Auckland Council
3. **Auckland Plan Targets**

3.1 The Auckland Plan identifies thirteen strategic directions of direct relevance to health gain, with associated targets, priorities, measures and indicators, as identified in the table at Appendix Two. The 74 targets and associated measures were developed through a comprehensive consultation process which included central government agencies.

3.2 There is significant overlap between these targets and priorities, and those of the health sector. As well as incorporating health priorities such as increasing rates of B4School checks, and childhood immunisation, there are targets and priorities for early learning, education, youth employment, economic development, housing affordability, public transport, community development, water quality and access to sports and recreational facilities, all of which contribute to the health of populations.

3.3 The objectives of the Auckland Plan will be delivered through a number of strategies and action plans, which are underpinned by a monitoring framework. It is intended that Council reviews the targets regularly to ascertain whether they remain relevant. They will be rated for progress and achievability every three years, providing an opportunity for stakeholders including the health sector, to provide input to the review process.

3.4 A Review Committee will be established which will:

- Provide broad representation across the relevant disciplines and policy areas relevant to the strategic directions outlined in the Auckland Plan
- Contribute to the discussion of key influences and drivers affecting results
- Advise on the appropriateness of targets and measures and make recommendations for any changes to the monitoring framework.¹

4. **Mechanisms for collaboration**

4.1 Health sector engagement with Auckland Council occurs at different levels, and some mechanisms are still in development. This is partly a timing issue. With Auckland Council now having completed the Auckland Plan and undergoing consultation on other major planning exercises post-amalgamation, there are opportunities for Council to develop new ways of working with key stakeholders, including the health sector.

4.2 At an operational level, these relationships are well-established. They tend to be based on longstanding common service roles and objectives for example in regulatory issues to do with alcohol-related harm, tobacco control, and environmental health. These working relationships have required minimal change since amalgamation.

4.3 As previously mentioned, the health sector has also been actively engaged during planning processes with submissions being made in response to consultation opportunities provided by Council.

4.4 Chief executives of both Council and the three DHBs met in September this year to discuss issues of mutual concern, and will continue to meet regularly. They agreed to an initial focus

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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 26/11/14
4.5 Further opportunities for strengthening collaboration include:

(a) **Formalising mechanisms of engagement**

In the medium term, the development of a formal relationship between senior Council and DHB managers would provide opportunities for strengthening partnerships at an operational and strategic policy level, with annual or bi-annual meetings or workshops to focus on identified areas of common concern.

(b) **More effective co-ordination focused on agreed priorities**

The Auckland Intersectoral Health Group (AIHG) provides a regular opportunity for the DHBs to work with Council on agreed priorities. These have been identified as follows:

- Reducing population obesity levels through shared Council and health sector regional planning, to increase physical activity and promote healthy nutrition
- Promoting a healthy workforce, noting that together the Council and the DHBs have a sizeable percentage of the Auckland workforce and could usefully share learnings and resources
- Reducing the prevalence of tobacco smoking across the region, with a particular focus on the Southern Initiative
- Reducing alcohol-related harm through Council’s Local Alcohol Policy
- Strengthening community development through local area plans and Council’s Thriving Communities Action Plan.

It would be possible to formalise the role of AIHG and increase its mandate as a mechanism for DHBs to engage with Council at a strategic level.

(c) **Healthy Families New Zealand**

Healthy Families New Zealand (HFNZ) services are being established, funded by the Ministry of Health, and Auckland Council is part of the successful collaborative provider in Counties Manukau, and is also supporting the Waitakere lead provider, Sport Waitakere.

HFNZ will establish community-based health promotion services which have the same set of priorities as AIHG (see (b) above). This new initiative provides an opportunity for the DHBs, ARPHS and Council to leverage this investment to work with health and other agencies to strengthen ‘prevention systems’ across the region.

(d) **Including an explicit health focus in Council planning processes**

The health sector has already advocated through its collective submission on the Unitary Plan, managed by ARPHS, for the Council to consider the inclusion of a health objective being added to high-level planning documents such as the Regional Policy Statement. This would reflect obligations under the Health Act and the Council’s responsibilities under its Spatial Planning mandate, and focus on enabling improved health, wellbeing and safety for all Aucklanders, and reducing health and social inequalities.

(e) **Representation on/input to the Auckland Plan Review Committee**

As described at 3.4, the health sector needs to work with Council on monitoring and adapting targets and measures likely to impact on population health gain. At this stage the Review Committee has not been established, but the review process will be undertaken in early 2015 and this will provide an opportunity for DHB input.

(f) **Sharing information and expertise**

Another opportunity would be for ARPHS to provide Council with expert advice on how to incorporate social and health impact assessment into the range of assessments required of residential developers, especially in the Special Housing Areas and to advise on the further development of the Auckland Design Manual.
4.6 With the establishment of 21 local boards and the new shared-governance structure in Auckland, health services have the opportunity to become involved in planning of social services and engagement with Council at a local level.

4.7 Mechanisms for strategic relationships have been slower to establish. While there are various social sector/Auckland Council groups meeting; for example, the Auckland Joint Officials Group (AJOG), senior DHB representatives rarely attend. Meetings are usually attended by Ministry of Health officials – usually by video link from Wellington.

5. Case Study – Healthy Auckland Together

5.1 Auckland Regional Public Health Service has been leading a regional obesity prevention project as discussed and supported by CPHAC in October 2013 (see Appendix One for project overview diagram). The project has brought together Auckland Council (including Auckland Transport) and health sector representatives to work collaboratively on reducing obesogenic environments, improving nutrition and increasing physical activity in Auckland.

5.2 Agreement has been reached on four initial priorities:
- Increasing physical activity through environmental change
- Children and young people’s settings
- Healthy nutrition environments policies
- Supporting Healthy Families New Zealand.

5.3 The first of these priorities will require close collaboration between Council and the health sector, as Council and Auckland Transport are responsible for many aspects of the physical environment that impact on the amount of physical activity that takes place in communities, and providing access to good quality food.

5.4 Collaborative activities are likely to include:
- Health sector engagement with Council on local and regional planning processes
- Shared communications on common priorities, including promoting examples of good practice
- Promotion of workplace wellness programmes
- Information sharing.

5.5 A number of Auckland Plan targets and measures (see Appendix Two for all health-related targets and progress against these) are directly aligned with those of Healthy Auckland Together, as follows:

<table>
<thead>
<tr>
<th>Strategic direction</th>
<th>Targets</th>
<th>Priorities</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Direction 1:</strong> Create a strong, inclusive and equitable society that ensures opportunity for all Aucklanders</td>
<td>1.9 There will be no gaps in life expectancy between European, Maori, Pacific and Asian ethnicities by 2040.</td>
<td>Improve the education, health and safety of Aucklanders, with a focus on those most in need.</td>
<td>Statistics NZ life expectancy tables.</td>
</tr>
<tr>
<td><strong>Strategic Direction 5:</strong> Promote individual and community</td>
<td>5.1 Increase the number of school-aged children participating in organised</td>
<td>Provide quality opportunities for all Aucklanders to</td>
<td>Numbers of school children and hours of</td>
</tr>
</tbody>
</table>

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 26/11/14
## Strategic direction

### Wellbeing through participation and excellence in recreation and sport

**Targets**

- sport and informal physical activities by 2040.

**Priorities**

- participate in recreation and sport.

**Measures**

- participation from schools and sports clubs.

### Strategic Direction 12: Plan, deliver and maintain quality infrastructure to make Auckland liveable and resilient

**Targets**

- Increase the number of Aucklanders actively participating in recreation and sport every week from 79% to 90% by 2040.

**Priorities**

- Prioritise and optimise our recreation and sport facilities and public open space use and the capability of recreation and sport organisations.

**Measures**

- Numbers of Aucklanders actively participating in recreation and sport.

### Strategic Direction 13: Create better connections and accessibility within Auckland, across New Zealand and to the world.

**Targets**

- Increase the number of Council sports fields that are useable throughout the year from 80% to 90% by 2020.

**Priorities**

- Protect, enable, align, integrate and provide social and community infrastructure for present and future generations.

**Measures**

- Number of sports fields with all-weather turf.

### The Southern Initiative

**Targets**

- No further increase in the prevalence of obesity in the area by 2020, and then an absolute decrease of at least 1% per annum until 2040.

**Priorities**

- Integrate transport planning and investment with land use development.

**Measures**

- The number of people living within 400m of QTN and 800m of RTN.

- Prevalence of obesity, by age (children and 15+) and ethnicity (NZHS, MoH).

## Workshop Questions

1. How best for DHBs to engage with Council, at
   (a) Governance level
   (b) CE/senior management level?
   (c) Operational/ day to day service delivery/specific projects/monitoring?

2. What are the main opportunities and challenges for working together to promote health gain and reduce inequalities?

3. Where, within current resources, is it likely to be most constructive to focus our collective efforts?
APPENDIX ONE: Framework for regional obesity prevention project

Healthy Auckland Together Framework (draft)

**Vision**
A social and physical environment where people living in Auckland are able to eat well, live physically active lives, and maintain a healthy body weight within their communities.

- **Goal 1.** Improve nutrition
- **Goal 2.** Increase physical activity
- **Goal 3.** Reduce obesity

**Approaches**
- Collaboration (what we do together)
- Advocacy and profile raising (what we say together)
- Monitoring progress (what we measure together)

**Initial key priorities**
- Healthy nutrition environments policies
- Children and young people’s settings
- Support Healthy Families NZ
- Increasing physical activity through environmental change

**Overall target**
- 10% increase in numbers of Aucklanders meeting physical activity guidelines by 2025

**Collaborative Action Plan**
## APPENDIX TWO: Auckland Council strategic directions impacting on health and progress against targets at November 2014

<table>
<thead>
<tr>
<th>Strategic direction</th>
<th>Targets</th>
<th>Priorities</th>
<th>Measures</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Direction 1:</strong> Create a strong, inclusive and equitable society that ensures opportunity for all Aucklanders</td>
<td>1.1 Ensure that by 2017, all pre-school children receive all well checks, including the B4school check, and are up-to-date with childhood immunisation.</td>
<td>Put children and young people first.</td>
<td>Percentage of two-year-olds who are up to date with immunisations Percentage of pre-school children who receive the B4 School Check (MoH data)</td>
<td><strong>Green</strong> – above 90% across all three DHBs 75% ADHB 68% WDHB 80% CMDHB (at July 2013)</td>
</tr>
<tr>
<td></td>
<td>1.6 Increase residents’ perception of safety in their neighbourhood from 68% in 2010 to 80% by 2030.</td>
<td></td>
<td>Perceptions of safety by age, sex and location (AC QoL survey).</td>
<td><strong>Red</strong> – perceptions of safety in homes, neighbourhoods after dark, and city centre all decreased since 2010</td>
</tr>
<tr>
<td></td>
<td>1.7 Ensure that the incidence of trauma from road crashes caused by alcohol, speeding or lack of restraints will be in line with nationally set targets by 2020.</td>
<td></td>
<td>Number of fatal and serious incidents (FSI) by incident category (Auckland Transport, using NZTA Crash Analysis System database).</td>
<td><strong>Red</strong> – over 5 years to 2014, FSI levels have decreased across most categories except pedestrians and cyclists which have increased since 2009.</td>
</tr>
<tr>
<td></td>
<td>1.8 Decrease the number of child hospitalisations due to injury by 20% by 2025.</td>
<td></td>
<td>To be established⁵.</td>
<td><strong>Black</strong> – Falls were the leading cause of injury admissions during 2006-2010, followed by inanimate mechanical forces and transport injuries.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>1.9 There will be no gaps in life expectancy between European, Maori, Pacific and Asian ethnicities by 2040.</td>
<td>Improve the education, health and safety of Aucklanders, with a focus on those most in need.</td>
<td>(Statistics NZ life expectancy tables.)</td>
<td><strong>Black</strong> – no regional ethnicity data currently available. General population life expectancy has increased in Auckland over the last 20 years.</td>
<td></td>
</tr>
<tr>
<td>1.10 By 2020 the number of breaches of the Domestic Violence Act (1995) will have stabilised and by 2040 will have fallen by 40%</td>
<td>Number of recorded breaches of the Act: (NZ Police statistics).</td>
<td><strong>Green</strong> – Recorded breaches in Auckland have decreased from 1417 in 2000 to 1007 in 2013.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.11 All parks and reserves, children’s play areas and other public space identified in bylaws will be smokefree by 2025.</td>
<td>Level of public awareness of smoke-free public places; number of smokers observed; prevalence of smoke-free signage in smoke-free public places.</td>
<td><strong>Black</strong> – Monitoring will take place from 2014 and a policy review is planned for 2016.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.12 Increase the proportion of residents who rate a sense of community in their neighbourhood as important from 71% in 2010 to 85% by 2025.</td>
<td>Strengthen communities.</td>
<td>Proportion of residents who feel that a sense of community in their local neighbourhood is important. (Quality of Life survey.)</td>
<td><strong>Green</strong> – almost 75% of Auckland respondents agreed this was important compared with 71% in 2010.</td>
<td></td>
</tr>
<tr>
<td><strong>Strategic Direction 5:</strong> Promote individual and community wellbeing through participation and excellence in recreation and sport</td>
<td>5.1 Increase the number of school-aged children participating in organised sport and informal physical activities by 2040.</td>
<td>Provide quality opportunities for all Aucklanders to participate in recreation and sport.</td>
<td>Numbers of school children and hours of participation from schools and sports clubs. (Sport NZ Young People’s Survey to be undertaken every 5 years.)</td>
<td><strong>Black</strong> – survey undertaken in 2011, second one not due until 2015. Fewer than 10% of young people spent no time on sport and recreation activities when ‘mucking around’.</td>
</tr>
<tr>
<td>Strategic direction</td>
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<td>Priorities</td>
<td>Measures</td>
<td>Progress</td>
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<tr>
<td>5.2 Increase the number of Aucklanders actively participating in recreation and sport every week from 79% to 90% by 2040.</td>
<td>Prioritise and optimise our recreation and sport facilities and public open space use and the capability of recreation and sport organisations.</td>
<td>Numbers of Aucklanders actively participating in recreation and sport. (2007/08 Active NZ survey)</td>
<td>Black – in 2008 the average proportion of Aucklanders actively participating in recreation and sport on a weekly basis was 77.6%. There was a wide variation in levels across Auckland.</td>
<td></td>
</tr>
<tr>
<td>5.6 Increase the number of Council sports fields that are useable throughout the year from 80% to 90% by 2020.</td>
<td>Number of sports fields with all-weather turf. (Auckland Council)</td>
<td>Green – The number of synthetic pitches increased from 1 in 2010/11 to 10.25 in 2013/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Strategic Direction 11:</strong> House all Aucklanders in secure, healthy homes they can afford</td>
<td>Improve housing affordability and the supply of affordable housing.</td>
<td>Monitor household expenditure on housing. (Statistics NZ Household Economic Survey – customised order 3-yearly.</td>
<td>Black – Approx. 209,000 households spent over 30% of net income on housing costs in 2013, compared with 141,000 households in 2010.</td>
<td></td>
</tr>
<tr>
<td>11.1 Reduce the proportion of households which spend more than 30% of their income on housing costs from the average of 27% in 2011 to 20% in 2030.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>11.3 Reduce the proportion of people living in households requiring at least one extra bedroom from 15.7% in 2006 to 10% by 2020.</td>
<td>Number of people in households requiring at least one additional bedroom (Census using Canadian Crowding Index).</td>
<td>Black – in 2013, 15% (203.817 people) of the usual resident population in Auckland were in this situation compared with 15.7% in 2006.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.4 End rough sleeping (primary homelessness) in Auckland by 2020.</td>
<td>The number of new contacts made by the Auckland City Mission with homeless people in Auckland.</td>
<td>Red – since 2009, the number of new contacts has increased from 81 to 189, plus 1954 outreach contacts in 2013.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic direction</td>
<td>Targets</td>
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<tr>
<td>11.6 Reduce preventable housing-related hospitalisations by 35% by 2020.</td>
<td>Improve the quality of existing and new housing.</td>
<td>Rates of hospitalisations for rheumatic fever, TB and respiratory-related conditions.</td>
<td>Black – information not available at time of writing.</td>
<td></td>
</tr>
</tbody>
</table>

**Strategic Direction 12:**
Plan, deliver and maintain quality infrastructure to make Auckland liveable and resilient

| 12.5 Maintain and extend an integrated network of quality open spaces across the region that meet community needs and provide a diverse range of recreational opportunities by 2040. | Protect, enable, align, integrate and provide social and community infrastructure for present and future generations. | Reporting by Auckland Council | Black – not available at time of writing. |

| 12.6 Health services and facilities of all care types are aligned to meet need across Auckland (ie population and its characteristics, growth and locations, accessibility and co-location) by 2040. | | To be established. | Black – not available at time of writing. |

**Strategic Direction 13:**
Create better connections and accessibility within Auckland, across New Zealand and to the world.

| 13.3 Reduce road crash fatalities and serious injuries from 506 (2010) to no more than 410 in 2020. | Number of road deaths and serious injuries per annum. (NZ Police, Traffic Crash reports) | Red – the number of ‘fatal and serious injuries (FSI) in Auckland reduced by 21% between 2001 ad 2013. However the number of FSI increased from 452 in 2011 to 479 in 2013. |

<p>| 13.5 Increase the proportion of people living within walking distance of frequent public transport stops from 14% (2011) to 32% by 2040. | Integrate transport planning and investment with land use development. | The number of people living within 400m of a quality transit network (QTN) and 800m of a rapid transit network (RTN). | Black – number of people estimated to be 14% in 2011. Current data not available at time of writing. |</p>
<table>
<thead>
<tr>
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<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Southern Initiative</td>
<td>By 2020, 95% of children (8 months) are immunised.</td>
<td></td>
<td>Rates of immunisation</td>
<td><strong>Green</strong> – 92% of two-year-olds were immunised in Counties Manukau in 2012, and 93% in 2014.</td>
</tr>
<tr>
<td></td>
<td>By 2025 the percentage of residents 15 years and over who smoke will fall to below 3%.</td>
<td></td>
<td>Census data</td>
<td><strong>Green</strong> – at 2013 Census, regular smokers were down 3% since 2006.</td>
</tr>
<tr>
<td></td>
<td>No further increase in the prevalence of obesity in the area by 2020, and then an absolute decrease of at least 1% per annum until 2040.</td>
<td></td>
<td>Prevalence of obesity, by age (children and 15+) and ethnicity (NNZHS, MoH).</td>
<td><strong>Black</strong> – information not available at time of writing</td>
</tr>
</tbody>
</table>

**KEY**
Green = tracking towards target
Red = tracking away from end target
Black = No baseline or new data since baseline was established
APPENDIX THREE: Analysis of impact of health sector recommendations to the Auckland Plan

Overview

ARPHS, in collaboration with the three district health boards in Auckland, made a submission on the Auckland Plan in October 2011. Overall, a total of 40 successful or partially successful recommendations were made, and 14 recommendations were not successful.

Some of the overarching areas outlined as having potential for significant public health gain in its submission:

- Placing children and youth in the centre of all policies.
- Decreasing the life expectancy and health outcome gaps between Māori and Pacifica and other New Zealanders.
- Reducing disparities in socioeconomic conditions, as these strongly influence health outcomes.
- Acknowledging alcohol and tobacco as two major contributors to avoidable premature deaths, ill health and injury. Alcohol is also one of the main causative factors in some crime, safety and family violence which also influence health outcomes.
- Controlling the rapid growth of obesity, and conditions where unhealthy nutrition and lack of physical activity contribute such as diabetes, cardiovascular disease (CVD) and cancer.

Successful recommendations

Recommendations were successful in the following areas:

- Development of a Regional Smokefree Policy.
- Smoking prevalence monitoring.
- High level targets for the numbers of Aucklanders participating in regularly exercise.
- Inclusion of green space in Auckland Design Compendium (Auckland Design Manual)
- Better short term air quality improvement targets.
- Giving more detailed consideration to areas where there are vulnerable populations or ‘captured’ populations who should be protected from ongoing exposures to poor air quality.
- High level aims to reduce the levels of discharges and contaminants wherever possible, rather than simply managing these.
- Decreasing the time period before which revised wet weather overflow targets are to be achieved.
- Developing a target to monitor progress in implementing Council’s housing objectives.
- Development of potential mechanisms to improve the quality of rental housing.
- A commitment to improve access to health services as one of the issues considered when planning housing developments.
- Amendment of proposed principles for transport planning and delivery by including consideration of the needs of the transport disadvantaged/those with least access.
- Including further details regarding how Council intends to engage children and young people.
- Demand responsive and community transport models for rural area public transport.
- Ensuring that Council facilitates the re-development of critical social infrastructure on key sites.
- Active engagement with migrant communities and employers to help migrants integrate into their new home.
• Ensuring the inaugural Auckland Plan explicitly and transparently confronts the trade-offs between differing elements of the “vision” and “transformational shifts”\(^6\) in its decision making, and that in making those trade-offs that Council prioritises issues of inequalities and fairness.

The Auckland Plan includes many new commitments to improve health outcomes. Of particular note, these include a commitment to investigate a warrant of fitness on rental housing in the Auckland region.

“Auckland Council, with other parties, will explore the possibility of legislative, regulatory or voluntary measures, such as a ‘warrant of fitness’ scheme, in order to improve the quality of private rental housing.”

**Partially successful recommendations**

- Use of the Unitary plan to restrict the location of gambling, alcohol and fast food outlets.
- Greater emphasis on alcohol and tobacco issues in the Auckland Plan
- The inclusion of an additional environmental design principle to ensure that noise is appropriately addressed in urban design.
- Consideration to the potential conflicts between a substantially increased City Centre resident population and the City Centre’s role as an entertainment centre.
- Ensuring that the health implications from proposed changes to on-site wastewater and water supply systems are considered.
- Reduce the proposed overcrowding target to no more than 5% overcrowded houses by 2040.
- Prioritization of walking and cycling networks and pedestrians in town centres as well as specific actions.
- Further consideration of how social, economic, environmental and cultural wellbeing, access and affordability are optimised by all Council’s transport investments.
- Instituting a programme of reviews of public transport services in differing areas across the region, with priority being given to areas experiencing high levels of socioeconomic deprivation to “provide better, more convenient access to educational institutions, employment and social services”.
- Ensuring that design assessments specifically consider the needs of children.
- Strengthening the monitoring and evaluation framework in collaboration with key strategic partners, including health.
- Commitment to future work with the DHBs and ARPHS to further develop and refine the proposed health-related measures in the monitoring and evaluation framework.
- Specific reference to the spatial distribution of children and young people and the proportion of Aucklanders living with disability in the section on population growth and demographic change.
- Reference to the needs of people with disabilities as one of the groups’ whose needs will be specifically addressed and Include the needs of people with disabilities as the subject of a separate directive in the Auckland’s Peoples chapter of the inaugural Auckland Plan.
- Contributing to enabling Māori aspirations by formally integrating Māori conceptual models (e.g. Whānau Ora) and frameworks throughout the Auckland Plan and not just in isolation in Chapter Two.
- Extending the initiatives proposed in the Southern initiative area to other areas with high levels of socio-economic deprivation in subsequent phases of the inaugural Auckland Plan.

\(^6\) Draft Auckland Plan page 24.
• Equitable access for urban dwellers to open green spaces in order to protect overall health and wellbeing, especially in the context of increased urbanisation.
• Addressing potential social consequences that can flow from poor urban design if it leads to the creation of areas of concentrated socio-economic deprivation.
• Exploration and implementation of new funding models that Council does not create the perverse outcome of increasing health and social inequalities from its decisions.

Unsuccessful recommendations

ARPHS has had unsuccessful recommendations in the following areas:

• Greater focus on participation in goals for sports.
• Consideration of public health risks due to water conservation.
• Public health issues associated with water conservation mandated by environmental design principle.
• Ensuring that the issue of alcohol use and its associated harm be addressed before the City Centre Master Plan is finalised.
• Specific reference to the biosecurity threat that Auckland’s ‘gateway’ status to New Zealand creates.
• Ensuring that all water supplied by Watercare Services is fluoridated.
• Ensuring that proposed housing policies don’t lead to geographically based concentrations of socio-economic deprivation.
• Commitment to continue current programmes that provide some home insulation funding.
• Reviewing and incorporate where valuable, pre-existing child, social and health assessment techniques in its proposed child impact assessment for all Council activities.
• Undertaking a social impact assessment for each new major project.
• That Council involves DHBs early in the area spatial planning processes for future developments.
• Inclusion of DHBs and primary and community health care organisations as agencies involved in delivering infrastructure in Auckland.
• That Council note additional capital intentions information provided.
• Further details of proposed actions in the implementation actions.
2.1  **Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 15\textsuperscript{th} October 2014**

**Recommendation:**

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 15\textsuperscript{th} October 2014 (including the public excluded minutes) be approved.

Note: the public excluded minutes of the above meeting are included under separate cover. It is suggested that, unless there are any issues which require discussion, approval of the public excluded minutes could be incorporated in the above resolution, without moving into public excluded session.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 15 October 2014

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

PART I – Items considered in Public Meeting

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair) (present until 2.50p.m)
Max Abbott (WDHB Board member)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren Flaunty (Committee Deputy Chair) (WDHB Board member)
Lee Mathias (ADHB Board member)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Allison Roe (WDHB Board member)
Elsie Ho (Co-opted member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT:

Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Naida Glavish (ADHB and WDHB Chief Advisor, Tikanga)
Tim Wood (ADHB and WDHB, Deputy Director Funding)
Stuart Jenkins (ADHB and WDHB, Clinical Director Primary Care)
Ruth Bijl (ADHB and WDHB, Funding and Development Manager, Women and Children Services)
Jean McQueen (ADHB and WDHB, Primary Care Nursing Director)
Catherine McNamara (WDHB, General Physician/Diabetologist)
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 Womens Health Council
Tracy McIntyre, Waitakere Health Link
Kirsten Turnbull, Health Link North
Craig Murray, Waitakere PHO
Charlotte Harris, Auckland PHO
Jude Sprott, Procare
Kate Moodabe, Total Healthcare PHO
APOLOGIES: An apology was received from Lester Levy for early departure.

KARAKIA: Pat Booth led the meeting in the karakia.

WELCOME: The Committee Chair welcomed all those present.

DISCLOSURE OF INTERESTS
With regard to the Interests Register, Lee Mathias advised that she has been appointed a Director of the Health Innovation Hub, a Director of healthAlliance and a Director of healthAlliance FPSC.

There were no declarations of interest relating to the agenda.

BRIEFING FROM THE BOARD CHAIR RE LETTER FROM THE NEW MINISTER OF HEALTH
Lester Levy advised that the new Minister of Health, the Hon. Dr Jonathan Coleman, had written to the DHB Chairs. The letter from the Minister indicated some initial priorities that he would like DHBs to focus on. These included: the importance of keeping to budgets and continuing to manage prudently; the importance of continuing the momentum with health targets and continuing to improve performance (from October there will also be the new indicator concerning faster cancer treatment); and the strong focus on helping vulnerable children and interagency cooperation and collaboration to achieve that.

The Board Chair noted that there was not a massive shift of direction but perhaps some added emphasis on some areas. He hoped that appointments would be made soon to the key positions of Director General of Health and Chair of the National Health Board. As signals are received on direction, the Board Chair will send out notes to Board members.

PRESENTATION AND DISCUSSION: QUALITY OUTSIDE OF THE HOSPITAL
Simon Bowen introduced this topic. He noted that a lot of attention had been given in recent years to quality in hospitals, but it is also important to consider quality in areas such as community mental health services, aged residential care, the PHOs and general practices. This item provides an initial opportunity to consider quality arrangements in primary care. It is intended to bring back more detailed work in the future.

Simon Bowen introduced the presenters for this item: Dr Penny Andrew (Clinical Lead Quality WDHB), Dr Alan Moffit (Clinical Director Procare, representing the Auckland Metro Clinical Governance Forum), Jane Lees (Nurse Director, Community and Long Term Conditions, ADHB), and Andrew Jones (Quality Improvement Specialist, WDHB).

Quality in Primary Care
Penny Andrew provided a presentation on Quality in Primary Care. She began with Quality Assurance - regulation. This included:
- Certification and standards (mandatory standards apply to hospitals and rest homes but not primary care)
• Accreditation (incentives for accreditation, not mandatory)
• Contract management (including “back to back” contracts with PHOs with provisions that have to be passed on to primary care providers)
• Performance management and Incentives
• Professional regulation (however there are a large number of health practitioners not covered by this)
• Accountability - Health and Disability Commissioner and Coroners

She commented on why quality assurance alone is insufficient and on the importance of culture and quality improvement.

Penny Andrew then gave two examples of quality improvement projects: Safety in Practice in Primary Care and Reducing Harm from Falls in Rest Homes.

Andrew Jones spoke on the Safety in Practice initiative.

Safety in Practice in Primary Care is a greater Auckland collaboration led by Counties Manukau DHB. It involves:
• Working with PHO Facilitators to develop quality improvement skills in general practices and to improve management of high risk areas of practices.
• Working with four general practices in the Waitemata DHB area, five in the Auckland DHB area and thirteen in the Counties Manukau DHB area.
• Clinical areas focused on are medicine reconciliation following hospital discharge; laboratory result handling; and prescribing and monitoring of Warfarin. Many of the practices are also testing a Trigger Tool for use in the general practice setting.

Andrew Jones commented that looking at specific clinical areas has helped identify other areas for improvement within practices.

Collaboration with Age Related Residential Care (ARRC) – Improving Quality Care

Jane Lees (Nurse Director, Community and Long Term Conditions, ADHB) provided this presentation. Matters covered included:
• The importance of reducing falls in ARRC including Ministry and Regional targets to reduce falls with harm; the major impact of falls on patients including loss of confidence, lower quality of life and increased mortality; and the financial impact of falls - $6.8M to ADHB for Direct Care and 20 beds permanently occupied in hospital.
• The cluster model (hub and spoke) approach being used, grouping the facilities into geographically based groups, with each group hosted by a member of ARRC. The purpose of this approach is to facilitate discussions on data collection and categorisation methods; sharing of improvement ideas and strategies; providing a “safe” environment; and aggregating and disseminating information.
• This approach had received constant positive feedback about meeting and getting to engage with other facilities. Progress had been made in understanding potential pressure injuries during the patient transfer process and achieving better relationships between facilities in transfers. The facilities had also started sharing interventions.
• A website has been developed www.qualitycare4olderpeople.org.nz where facilities can find stories and resources relating to ARRC; enter falls and pressure injuries data; benchmark against other sites; share information, tools and methods between sites; and access training information.
• Standardised resources have been created for any facility to use including for Assessments and Careplans and Information Packages, for example brochures.
• Through cluster groups, a “Yellow Envelope” has been developed to ensure that all important information relating to the care of the resident is transferred between the hospital and facilities when a patient is transferred. All facilities are using these, with positive feedback from them and hospital emergency departments.
• An audit of the yellow envelope had identified that vital information regarding clinical needs is often missing. The cluster hosts are working together to develop a transfer of care document that supports the individualised needs of a resident.
• Next steps include implementation of the dementia care pathway; alternative use of ARRC beds including rehabilitation and intermediate care; Inter-Rai; medication safety initiatives; out of hours support; and telemedicine.

Quality Overview – Primary Care

Dr Alan Moffitt (Clinical Director Procare) provided this presentation on behalf of the Auckland Metro Clinical Governance Forum. He introduced the context as:
• The Ministry of Health National Service Framework
• The operational performance framework
• PHO Head Agreement (negotiated nationally)
• Back to back agreements (DHB to PHO to the Provider)
• Integrated performance incentive framework. The core part of the framework is District Alliances which determine indicators. This is a whole system approach with the Alliance having to meet targets if it wishes to progress. If you do reach “break through” there is more autonomy and some financial incentives as reward.
• Professional bodies (including the Medical Council and Nursing Council) and regulation
• The Royal NZ College of General Practitioners (RNZCGP)
• The PHOs’ own quality frameworks and plans

The presentation was very extensive and is available on request from the Waitemata DHB Board Secretary. The scope included:
• The Auckland Metro Clinical Governance Committee’s wide ranging clinical oversight role.
• The IPIF whole of system national indicators and how the system is structured. IPIF System Level Measures are Healthy Start, Healthy Child, Healthy Adolescent, Healthy Adult and Healthy Aging. For each there are indicators.
• Current IPIF indicators relating to Primary Care are for More Heart and Diabetes Checks; Better Help for Smokers to Quit; Immunisation Coverage Rates and Cervical Cancer Screening.
• Examples of new IPIF measures that might be introduced for Healthy Start.
• PHO Quality Frameworks/Plans – each have a Clinical Quality Plan; some also have a Quality Framework. The process across Auckland PHOs is fairly standard.
• Risk registers and the range of tools that enable practices to identify people at risk.
• Back to back agreements are more standardised now. They include compulsory clauses, IPIF requirements and Foundation Standards. Some PHOs extend this to require reporting or to enforce minimum standards.
• Foundation Standards include minimum legal, regulatory and professional standards for safe, quality general practice. This will be the base level to gain access to the Integrated Performance Incentive Framework. There will be no IPIF funding paid if the Foundation Standard is not met by June 2015.
• Cornerstone is a RNZCGP programme designed for and by general practices. It involves self-assessment and external peer review against a series of Practices Standards.
The Medical Council Maintenance of Professional Standards programme (MOPS) is administered for GPs by the RNZCGP. It involves 150 credits over three years.

For Nursing there is a Professional Development and Recognition Programme.

PHO complaint management and incident reporting, Health and Safety – this differs by PHO. There is a practice requirement within Cornerstone. Some PHOs have centralised reporting and databases.

Patient Satisfaction Surveys – this is a requirement of Cornerstone, a minimum of every three years. Probably about half the practices across Auckland are Cornerstone accredited. There tends to be fairly good positive feedback from patients about primary care. The Health Quality and Safety Commission has done some work looking at patient experience and how that can be measured better.

The Patient Dashboard is important to improving performance.

Clinical Audit Tools – most PHOs are using tools like Dr Info.

Safety in Practice Collaboration (discussed in the earlier presentation on Quality in Primary Care).

Business continuity planning is important, as all were recently reminded with power outages and Ebola. Disaster planning readiness requires a refresh.

A reminder that there are a large number of external DHB providers that are not PHOs.

Matters covered in discussion and response to questions on the presentations included:

- It was noted that most of the proposed new IPIF measures for Healthy Start look extremely challenging. However one of the indicators is the percentage of new born fully breast fed at six weeks, when it is clear that the literature, supported by the Prime Minister’s Science Advisor, is that breast feeding for six months should be the objective. It was noted that there is a risk of achieving something less than ideal. The approach appears to be to set something feasible and when that is achieved to move on to something better.

- In answer to a question about the sustainability of the primary care model, Allan Moffitt said that he is very concerned about the whole system. The burden of demand from the aging population is hitting us now and will get worse and the workforce will not grow quickly enough to deal with that.

- In answer to a question, Allan Moffitt commented that access to services is the key thing to look at; if people can’t access services then results can’t improve. He also agreed that the health sector needed to be open to the possibility of developing ideas from other areas, such as adapting engineering applications to surgery.

The Committee Chair thanked the Panel for informative and insightful presentations. Given the environment that we operate in each of the different areas covered is important. Changes to health and safety legislation are important and it is important to give greater focus and emphasis to the issue of the aging population and the demands that will bring. She would also like Asian, Pacific and Maori health providers to be able to come and present to the Committee and share their perspectives on quality. Also very important in this respect are strong information systems, and making sure that ethnicity data is being picked up, analysed and used. Quality is a top priority for the Committee.

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 3rd September 2014 (agenda pages 7-16)

Resolution (Moved Judith Bassett/Seconded Max Abbott)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 3rd September 2014 be approved.

Carried

Matters Arising (agenda page 17)

No issues were raised.

3 DECISION ITEMS

There were no decision items.

4. INFORMATION ITEMS

4.1 Auckland DHB Child and Youth Mental Health and Addiction Direction 2013-2023 – Progress Update (agenda pages 18-24)

Hillary Carlile (Project Manager), Tim Wood (Chair of Child and Youth Mental Health and Addictions Direction Implementation Governance Group, Acting Funding and Development Manager Mental Health and Addictions), Michelle Atkinson (Youth Voice, ADHB Consumer Leader) and Kirsty Fong (Youth Voice, ADHB Consumer Leader) were present for this item.

Tim Wood introduced the report. Michelle Atkinson and Kirsty Fong provided a six slide presentation illustrating visually some of the key content in the report.

Matters covered in discussion and response to questions included:

- Tim Wood advised that they are still in the early stages of developing performance measures for the Direction. One of the big challenges is understanding what is happening and working out how to influence projects and people to get more responsiveness to youth and to achieve a re-orientation at Auckland DHB about how people think about services. Over time they are hoping to get consistent reporting. A scorecard is being developed which will have reporting measures for key priority projects.
- On the question of progress being made, Michelle Atkinson commented that it had been considered important first to set things up clearly in view of the large number of existing projects. She considered that what had been developed in the Communications area (described on pages 21-22 of the agenda) would help provide the Direction with a lot of traction.
- A request was made that the youth representatives come back in a year’s time to brief the Committee on progress.
In answer to a question, Tim Wood advised that the Governance Group is quite focused. It was considered important that those young people sitting on that weren’t given the burden of being expected to represent young people generally. That was the reason for the separate stakeholder reference group.

Tim Wood advised that the Direction had started as an Auckland DHB project and there is a keenness to keep it going as such, however they will be tracking what does work and considering how that might be applied at Waitemata DHB.

Hilary Carlile advised that in the pre-work that they had done, they had delved into detail, documenting models from overseas. They had definitely been influenced by best practice and informed by the success of other models. With the Stakeholder Reference Group, this was a fluid thing, utilised when they had something specific that they really needed input on. They bring in relevant people in each case, depending on the topic.

The importance of working in conjunction with initiatives of the Auckland Councils and local boards, for example on psychoactive substances, was noted. Hilary Carlile advised that the Council has been “hooked into” the Direction.

The point was made that some young people already access a wide range of support services very successfully. Michelle Atkinson responded that while that is true, there are so many young people who do not, often those lacking in family and other support around them. With Mental Health Services, young people who are extremely unwell may get entry to services within one day, but others needing help can wait a very long time. By the time they receive help they may be very unwell.

Lee Mathias mentioned the Red Flag Project which she had just recently heard about. This involves monitoring Facebook interactions. She will pass information on to Tim Wood as soon as she gets it.

The Committee Chair thanked Michelle Atkinson and Kirsty Fong for the energy and passion that they brought to the Direction and to Tim Wood and Hilary Carlile for all the work put into this. She commented that it is important to remember that this is a developmental process. The establishment and implementation phases will come. She wished all those involved well.

It was confirmed that there would be a further progress report in one year’s time.

Resolution (Moved Robyn Northey/Seconded Lee Mathias)

That the report be received.

Carried

4.2 Non Traumatic Lower Limb Amputations with Diabetes (agenda pages 25-32)

Dr Mazin Ghafel (Public Health Physician), Dr Tom Robinson (Public Health Physician) and Stephanie Muncaster (Programme Manager) were present for this report (together with Tim Wood). Dr Catherine McNamara (WDHB, General Physician/Diabetologist) was also present and assisted the Committee in its deliberations.

Mazin Ghafel summarised the main points in the report (as highlighted in the Executive Summary on pages 25-26 of the agenda).
Matters covered in discussion and response to questions included:

- In answer to a question, Tom Robinson advised that there are a number of things that DHBs can do better relating to diabetes, including encouraging people to stop smoking and to control their sugar intake better. While the smoking rate is dropping, there had been no big improvement with regard to control of sugar intake. The other thing that can reduce the likelihood of amputations is the availability of podiatry services. Waitemata DHB had introduced a podiatry service for diabetes in 2009 and Auckland DHB had introduced a service recently.

- Unfortunately data relating to diabetes is not very good.

- There is an increasing prevalence of diabetes related both to an aging population and also growing levels of obesity. More people are also diagnosed with pre-diabetes than previously.

Dr Catherine McNamara, a diabetes specialist, was introduced to the meeting. In answer to a question she advised that approximately one quarter of the population is pre-diabetic. Lifestyle measures can prevent progression to full diabetes. A diabetic epidemic is upon us and both early intervention and prevention programmes are really important. A major problem is that people do not self-manage effectively. Education is very important. Many diabetes patients do need to go on insulin.

Simon Bowen commented that diabetes is one of the areas that have been focussed on for some time. It has been identified by the Alliance as the number one priority.

Tim Wood commented that there has been a lot of investment in addressing diabetes, but they don’t have a good measure of how effective that has been. That needs to be addressed. It is also important to de-stigmatise diabetes.

There was a discussion of the need for better information on diabetes. This included:

- The need to consider whether there could be better systems to code diabetes patients.

- Max Abbott advised that in Sweden there is a national register which covers all medical conditions. This had great value for research as people can be tracked over time. However New Zealand has a different culture and there would likely be resistance to such a proposal.

- Dr Ghazel advised that a few years previously coding of patients entering hospitals for diabetes had stopped.

- Simon Bowen suggested that while we don’t have information on diabetes patients available from a central source, the DHBs are able to work with G.Ps to obtain source data.

- There was strong support for a co-ordinated approach to ensuring that full data relating to diabetes is collated.

- It was agreed that Auckland and Waitemata DHB management be requested to work together on the issue of achieving effective co-ordination and availability of data relating to diabetes patients.

Other matters discussed included:

- The importance of highlighting the availability of podiatry services for people with diabetes.

- The need to make sure that those people with diabetes are educated about foot care.
• It was suggested that as the Auckland DHB Podiatry Service had just started this provided a good opportunity to review the effectiveness of podiatry and ease of access. Tim Wood advised that patients for this service are referred by G.Ps and the service is free to referred patients. The cost of providing this service includes an educational programme for the podiatrists.

• In answer to a question, Catherine McNamara advised that the symptoms of chronic foot problems caused by diabetes begin with loss of feeling and of circulation. Often that means they people are not aware of when they hurt a foot. This could worsen into ulcers, the foot becoming gangrenous and amputation.

• A more detailed paper on Diabetes is going to be brought to CPHAC from the Alliance Workstream.

The presenters were thanked.

The report was received.

5. STANDARD MONTHLY REPORTS

5.1 Planning, Funding and Outcomes Update (agenda pages 33-39)

Simon Bowen (Director Health Outcomes ADHB/WDHB) and Debbie Holdsworth (Director Funding ADHB/WDHB) introduced the report. Matters highlighted or updated included:

• The progress towards finalising the Annual Reports.

• Progress with transition to the joint Planning and Funding service for the two DHBs.

• The information in the report on preparing consumer information for different ethnicities (page 34 of the agenda).

• The Alliance agreement has been formally signed by all parties.

• The new Minister of Health is visiting the two DHBs on 16 October. Part of that visit is meeting with the PHOs.

• The recent Auckland Power shut down had spotlighted the impact on Aged Related Residential Care facilities and helped define emergency planning needs for such events.

• The excellent results for B4 School Checks with Plunket as provider (page 36 of the agenda).

• The sections of the report on Maori Health and Pacific Health.

The Committee Chair noted the presentation that had been made by the Ministry to Ailsa Claire of a certificate recognising the Auckland DHB achievement of the More heart and diabetes checks health target, one of only two DHBs to do so, and that a similar presentation is being organised to recognise Waitemata DHB’s achievement in leading the country in the better help for smokers to quit health target. These were very pleasing results.

In answer to a question relating to development of a health literacy framework for an ethnically diverse population (page 34 of the agenda), Tim Wood advised that a key question being considered is how do we know that people understand. Part of the framework involves ensuring information available is consistent and that those pamphlets that need translation get translated.
Resolution (Moved Jo Agnew/Seconded Peter Aitken)

That the report be received.

Carried

6.  General Business

There was no general business.

7.  Resolution to Exclude the Public

Resolution (Moved Jo Agnew/Seconded Peter Aitken)

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

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

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Co-opted member appointment</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (j)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]</td>
</tr>
</tbody>
</table>

Carried

4.17p.m - 4.22p.m – Public excluded session.

4.22p.m – the meeting resumed in open meeting.

The Committee Chair thanked those present.

The meeting concluded at 4.17p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARD'S COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 15 OCTOBER 2014

__________________________________________ CHAIR
# Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 17th November 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 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 04/02/15</td>
<td></td>
</tr>
<tr>
<td>CPHAC 03/09/14</td>
<td>4.2</td>
<td>Food Quality – quality of food provided in schools under Kids Can to be looked at.</td>
<td>William Rainger</td>
<td></td>
<td>To be looked at as part of Action Plan.</td>
</tr>
<tr>
<td>CPHAC 03/09/14</td>
<td>5.1</td>
<td>Migrants – information on number of migrants last year to the Auckland Region by ethnicity to be obtained and provided to CPHAC members.</td>
<td>Simon Bowen</td>
<td>CPHAC 26/11/14</td>
<td>An updated Health Needs Assessment is going to the Auckland and Waitemata DHB Boards in December 2014. This will include information on migrant numbers.</td>
</tr>
<tr>
<td>CPHAC 03/09/14</td>
<td>5.1</td>
<td>Health Information for Asian Migrants – information on what services are available at Auckland DHB to help Asian migrants to be provided to CPHAC members.</td>
<td>Samantha Bennett</td>
<td>CPHAC 26/11/14</td>
<td>Refer report 4.2 on this agenda.</td>
</tr>
<tr>
<td>CPHAC 15/10/14</td>
<td>4.2</td>
<td>Diabetes – Availability of Data – that Auckland and Waitemata DHB management work together on the issue of achieving co-ordination and availability of data relating to diabetes patients.</td>
<td>Tim Wood</td>
<td>CPHAC by April 2015</td>
<td>Progression of this to be covered in report to come from the Alliance on Diabetes.</td>
</tr>
</tbody>
</table>
3.1 2015/16 Annual Plan Approach

Recommendation:

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

That the Board:

a) Approve the approach to annual planning for 2015/16, including the longer term direction and timetable.

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

Prepared by: Simon Bowen (Director – Health Outcomes), Wendy Bennett (Planning and Health Intelligence Manager)

Glossary:

ACS - Acute Coronary Syndrome
DHB - District Health Board
HBSS - Home Based Support Services
HSGs - Healthcare Service Groups
NHB - National Health Board
SOI - Statement of Intent
SPE - Statement of Performance Expectation

1. Background

DHBs are required to have a finalised Annual Plan by 28 June 2015.

We are also required to contribute to the development of the revised Northern Region Health Plan which is being co-ordinated by the Northern Regional Alliance (NRA) on our behalf. Instructions regarding the plans are released each year by the National Health Board in a suite of policy and guideline documents, known as the Planning Package. An early draft of these documents was released by the NHB in early October, although much of the detail was still pending at that time. DHBs were given the opportunity to provide feedback on this draft to the NHB. The final pack will be released late November/early December 2013.

2. Planning guidance – updates and changes

2013/14 changes to the Crown Entities Act (CE Amendment Act 2013) meant that the Statement of Intent (SoI) – which was previously a subset of several sections of the Annual Plan – has now become a high level, strategic document with a four year focus. While the Minister may, on occasion, require a more frequent SoI, in general this now only needs to be tabled at least once every three years from 2014/15.

Given the review and subsequent restructure of the 2013/14 Annual Report based on feedback from Audit NZ, we would like to revisit the SoI for 2015/16 for both Auckland and Waitemata DHBs. In the
2014/15 Annual Plans, we had indicated that we would be doing this for Auckland DHB only, due to the ongoing development of Auckland DHB strategy work at that time. However, it would clearly be advantageous to update both SoIs to ensure that subsequent Annual Reports better meet audit requirements as well as being more acceptable to the Board and the public. For Waitemata DHB we would want to ensure the SoI continues the emphasis on meeting the Board priorities of best care for everyone and improving patient experience/relieving suffering of those entrusted to our care. These priorities need to be well articulated throughout our plan.

Early indications from the National Health Board suggest that the requirements for the 2015/16 year will be very similar to the last planning round, although a proportion of the detail of some of the components has yet to be finalised. A few other items of note:

- There continues to be emphasis on system integration, with an expectation to explore new and different models of care and increase focus on how to bend the acute demand curve including early intervention and integrated services focused on the patient and provided closer to home. DHBs are expected to use their Alliance Leadership Team (ALT) and any Service Level Alliance Teams to jointly develop the 2015/16 Annual Plan with their primary care partners to strengthen clinical integration. DHBs are expected to outline how they will achieve increased primary/secondary integration during 2015/16, describing quarterly milestones to measure progress. In the 2015/16 year DHBs are expected to develop an alliancing arrangement that follows the principles of partnership and joint service development and implementation with appropriate stakeholders for More Heart and Diabetes Checks, Long-term Conditions, Diabetes Care Improvement Packages, pre-hospital activity to meet the Shorter Stays in Emergency Department Health Target – Primary Care component, Better Help for Smokers to Quit – Primary Care component, Whānau Ora services, Rising to the Challenge, Health of Older People and Maternal and Child Health.

- The lists of planning priorities for Regional Service and Annual Plans have been agreed by the Minister and are mainly a continuation of existing priorities for both. The key change from the 2014/15 planning priorities is the inclusion of Healthy Families NZ and the Integrated Performance and Incentive Framework

- The Health Sector Forum (a Ministry of Health instituted forum, which provides an opportunity for sector organisations to discuss and align their work programmes) is again leading a process to prioritise the initiatives of the national health entities for 2015/16 (including Health Benefits Limited, National Health IT Board, Health Quality and Safety Commission, National Health Committee, Pharmac, Health Workforce New Zealand and Health Promotion Agency). Finalised priorities and actions for inclusion in 2015/16 Annual Plans will be shared with the sector as soon as possible

- There are a small number of new performance measures for 2015/16 and some changes/potential changes to existing ones. These are:
  - Mental health relapse prevention plan measure may be reinstated, PRIMHD file load success measure removed
  - Reporting on the use of InterRAI will be incorporated in wrap around services for older people reporting
  - Immunisation coverage at 5 years and HPV immunisation coverage to be added
  - Cancer multidisciplinary meeting reporting will now include a requirement for financial information, other cancer measures under review
  - Review of Ambulatory Sensitive Hospitalisation (ASH) methodology
  - Delivery of Whānau ora – more explicit deliverables included in the Access to Care indicator
  - Review of Improving Consumer Experience measure
There may also be further review of other measures.
DHBs are required to demonstrate engagement with PHO partners, including a letter of support for the Annual Plan as well as demonstrating that the Māori Health Plan is developed jointly with PHOs and that PHOs have actions in place necessary to effect the change they must achieve to implement the DHB Māori Health Plan.

3. Proposed approach to Waitemata and Auckland Annual Planning

The proposed approach to the annual plan is largely based on that employed last year. We will again focus on aligning the two plans as far as possible. The timetable of key activities required to complete the plan has been developed based on the draft guidance provided by the National Health Board to date.

Ongoing discussions will be required throughout the process with the National Health Board, NRA, PHOs, MoU partners and other DHBs to ensure the requirements are being met in a way that is appropriate for all stakeholders. To encourage broad discussions and wide input into the planning process, we will again be holding both a Waitemata and an Auckland DHB Planning Day early in 2015:

- WDHB Planning Day: 15 January 2015
- ADHB Planning Day: 22 January 2015

Auckland and Waitemata DHBs will continue to have their own Annual Plans although these will be aligned in format and layout. The majority of the content will be consistent, while retaining distinct strategic content for each DHB. The financial component of the Plan would be specified for each DHB within each Annual Plan, making clear how each DHB’s finances map to objectives in the Plan. Some shared financial content may be possible, such as the financial assumptions for the financial year in question and any high level expectations from the Minister of Health and the Government such as savings targets or efficiency gains. Essentially the documents will follow last year’s process and format, but with further alignment where possible.

The Ministry of Health is again developing a Planning workshop in Wellington in early December to which PHO representative will be invited. PHOs and other stakeholders will be invited to the two DHB Planning days. In addition, specific engagement is planned to occur outside of the DHB Planning days at the PHO Alliance meetings and the PHO CEO forum.

4. Sign Off Process and Timelines

Draft 1 of the Annual Plan will be presented to the February board meetings of both ADHB and WDHB (18 February and 25 February 2015 respectively) for consideration, with approval sought for final sign off of the document via Audit and Finance on 11 March for ADHB and via special board meeting in early/mid-March for WDHB. The final draft will be presented for consideration to CPHAC on 29 April, with sign-off of the final Annual Plan likely to be via either Board or special meetings early in May. Endorsement of the Annual Plan will also sought at these critical stages from our MoU and other partners: Te Runanga o Ngati Whatua, Te Whānau o Waipareira Trust and designated primary care partners.

The final Annual Plan and Maori Health Plan will require the signatures of the following:

- Board Chair
- One other Board member from each Board (for the Statement of Intent only)
- The two CEOs
- The Chair of Te Runanga o Ngati Whatua
- The Chair of Te Whānau o Waipareira Trust (Waitemata DHB)
Demonstration of engagement with and approval of each PHO throughout will be provided, including their letters of support.

As in past years, it is proposed that any amendment or last minute changes to the Annual Plan, Statement of Performance Expectations and Statement of Intent be delegated to the Board Chair and the respective CEOs. This provision allows flexibility to accommodate late information.

Regular oversight of the Annual Plan, the Statement of Performance Expectations and Statement of Intent while under development is the responsibility of the Director – Health Outcomes and the Director - Funding.

**Provisional Timeframe**

*Note this timetable focuses on the non-financial elements of the planning process and does not include the budgeting process deadlines and milestones.*

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| October 2014        | • Release of draft Planning Package by NHB  
                      • Provide input to National Health Board pre-planning round activity/feedback on draft Planning Package  
                      • Commence planning and process work for 2015/16 planning round                                                                                                    | Director Health Outcomes  
                      DHB Planners                                                                                                                                                    |
| November 2014       | • Brief key stakeholders and contributors i.e. Boards, Executive Teams, primary care, Planning and Funding, provider arms etc  
                      • Planning Package and Funding Envelope released late November                                                                                                   | Executive Team  
                      DHB Planners                                                                                                                                                    |
| December 2014       | • Staff provided with clear instructions about the expectations and process for 2015/16 planning. Objective templates available to staff (key contributors)  
                      • Prioritisation work, consideration of asset development and capital works and service changes  
                      • Organisational priorities and high-level drivers clear to staff  
                      • Minister’s Letter of Expectations released  
                      • ADHB Board meeting: Approach approved  
                      • WDHB Board meeting: Approach approved                                                                                                                           | Executive Team  
                      DHB Planners                                                                                                                                                    |
| 10 December - 17 December | • Contributors prepare planning content  
                           • WDHB Planning Day  
                           • ADHB Planning Day                                                                                                                                               | Contributors                                                                                                                             |
| January 2015        | • Planners develop annual plans to meet requirements in the planning package  
                      • First draft provided for consideration:  
                          o ADHB Board  
                          o WDHB Board                                                                                                                                                  | DHB Planners                                                                                                                             |
| February 2015       | • ADHB A&F meeting: sign off ADHB Annual Plan  
                      • Special Board meeting: sign off of WDHB Annual Plan  
                      • First draft of the Annual Plan due with the NHB for review (date TBC)                                                                                     | DHB Planners  
                      Director – Health Outcomes                                                                                                                                      |
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015</td>
<td>• First draft of the Statement of Intent/Statement of Performance Expectations due with the NHB (and ideally with Audit NZ) for review</td>
<td>Director - Funding</td>
</tr>
</tbody>
</table>
| 29 April 2015| • Feedback received from NHB (date TBC)  
• Amendments made to the plan, SPE and SOI as required  
• CPHACs meeting: second draft provided for consideration                                                                                       | DHB Planners Chief Financial Officers |
| Early May 2015| • Board meetings or possibly special meeting/s for final sign off both ADHB and WDHB Annual Plans, SolS and SPEs  
• Final board, PHO and MoU partners-approved Annual Plan due with the NHB (date TBA)                                                                 | DHB Planners Chief Financial Officers |
| On or before 28 June | Final Annual Plans, MHPs and RSPs signed by Minister/signed Sol/SPE extract to Bills Office                                                                                           | DHB Planners Chief Financial Officers |
| July 2015    | • Statement of Intent submitted to House of Representatives and posted on our respective websites  
• Documents made widely available to staff and others                                                                                                                                             | DHB Planners                          |

5. **Risks, Opportunities and Mitigations**

<table>
<thead>
<tr>
<th>Risk area</th>
<th>Specifically</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreeing the right format, approach and content for Annual Plans</td>
<td>While the 2014/15 ADHB and WDHB Annual Plans were developed by the same team, ensuring that format, approach and content were better aligned than in previous years, there is still opportunity to further align information where it makes sense to, while accurately representing each separate entity and their constituent population and financial situation.</td>
<td>It will be important to work closely with restructured teams to ensure that content is identical or very similar wherever it can be, while retaining local content appropriately.</td>
</tr>
</tbody>
</table>
| Impact of the collaboration process and the embedding of new tier 4&5 roles within Planning and Funding | Many teams within the collaborative Planning and Funding team are still developing and there are some gaps in resource that still need to be resolved. Some roles at levels 4 and 5 are still to be filled and some newly appointed employees are still orientating.  
Staff may be distracted during this process and embedding of new roles and responsibilities will still be occurring at the time key planning activity occurs. | Early advice to staff and regular communication that keeps everyone up to date with planning expectations for 2015/16 throughout a time of continuing transition.  
Clear roles and responsibilities identified early in the process and contingency plans identified where authorship likely to change over course of planning |
### Risk area

<table>
<thead>
<tr>
<th>Risk area</th>
<th>Specifically</th>
<th>Mitigation</th>
</tr>
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<tbody>
<tr>
<td>Too many stakeholders/delays in sign-off</td>
<td>Each DHB Annual Plan involves between 55 and 70 contributing authors. In turn, each author must liaise with a great many staff within and across teams in order to arrive at a sensible and tested suite of objectives. While efficiencies have been gained through the merging of some teams, the workload has still increased as there is now one Planning Team across the two DHBs. The Planning Team must ensure sign off of both Annual Plans, Statements of Intent and Statements of Performance Expectations by two Boards as well as engagement across two sets of executive teams, clinical leads, PHOs and other stakeholders who will all need to participate in the planning process. This introduces risk in achieving sign off at critical steps.</td>
<td>Responsible authors identified at the start of the process and their role clear in December. Ensuring enough resource is available to complete the work. Clear roles and responsibilities identified early in the process.</td>
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</table>

### 6. Conclusion

2015/16 will present some challenges as we develop Annual Plans, Statements of Intent and Statements of Performance Expectations for both DHBs. Key to our success is gaining endorsement from both DHB Boards for the proposed planning process for both DHBs and agreeing a clear plan regarding service and priority areas. We will also need to make sure that all key stakeholders are informed about the approach and have an opportunity to provide input into the planning process, ensuring activity continues to run smoothly as the collaborative Planning and Funding roles and responsibilities are embedded.
4.1 Mental Health and Addictions Update 2014/15 Actions

Recommendation

That the report be received.

Prepared by: Jean-Marie Bush (Mental Health and Addictions, Portfolio Manager, Waitemata and Auckland DHBs), Cate Wallace (Mental Health and Addictions, Portfolio Manager, Waitemata and Auckland DHBs), Lee Reygate (Mental Health and Addictions, Portfolio Manager, Waitemata and Auckland DHBs) and Manu Fotu (Suicide Prevention and Mental Health and Addictions, Portfolio Manager, Waitemata and Auckland DHBs)

Approved/Endorsed by: Tim Wood (Deputy Director Funding, Development and Funding Manager Primary Healthcare Waitemata and Auckland DHBs)

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AP</td>
<td>Annual Plan</td>
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<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
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<tr>
<td>CADS</td>
<td>Community Alcohol and Drug Service</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
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<tr>
<td>DAP</td>
<td>District Annual Plan</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>EOI</td>
<td>Expression of Interest</td>
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<tr>
<td>HONOS</td>
<td>Health of the Nation Scale</td>
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<tr>
<td>IFHC</td>
<td>Integrated Family Health Centre</td>
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<tr>
<td>IY</td>
<td>Incredible Years (Intensive Parenting Programme)</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<tr>
<td>NRA</td>
<td>Northern Regional Authority</td>
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<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
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<tr>
<td>QPR</td>
<td>Question, Persuade and Refer (Suicide detection training)</td>
</tr>
<tr>
<td>SDP</td>
<td>Service Development Plan (Rising to the Challenge)</td>
</tr>
<tr>
<td>SPAP</td>
<td>Suicide Prevention Action Plan</td>
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<tr>
<td>SST</td>
<td>Social Sector Trial</td>
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<tr>
<td>Triple P</td>
<td>Positive Parenting Programme</td>
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<tr>
<td>WSN</td>
<td>Waitemata Stakeholder Network</td>
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<tr>
<td>WHOQoL</td>
<td>World Health Organisation Quality of Life Scale</td>
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1. Executive Summary

This report provides a summary of key initiatives and achievements in the Mental Health and Addictions portfolio for Auckland and Waitemata DHBs. The report describes the strategic direction and Government priorities that underpin the 14/15 DAP actions. These actions focus service development, implementation of new services, and activities of reconfiguring and realigning existing services to ensure the best and most efficient use of resources.
The Ministry of Health Guidance to DHBs for the 14/15 Annual Planning required the Mental Health (Service Development Plan) to include the following:

- Two actions against each of the four key objective areas in Rising to the Challenge - Service Development Plan (SDP)
- Actions that contribute to the government work programmes of Welfare Reforms and Drivers of Crime
- Actions to deliver on Regional Mental Health priorities including the Perinatal Infant Mental Health Services (Healthy Beginnings), Regional High and Complex Needs Initiative and Eating Disorders Service.
- Implementation of the New Zealand Suicide Prevention Action Plan (2013 to 2016), specifically actions related to training, development of a district suicide prevention and postvention plan, and inter-agency collaboration in prevention and postvention work.

2. Introduction

Mental Health and Addictions Strategic Directions

There are a number of key mental health and addictions plans and strategies that articulate Government priorities and guide the development, implementation and quality of mental health and addictions services. These include:

2.1 Rising to the Challenge – The Mental Health and Addictions Service Development Plan 2012-2017

This plan sets the national direction for mental health and addiction service delivery across the health sector until 2017. The priority actions are aimed at achieving system wide change to improve outcomes for people using primary and secondary services, and their families and whānau. There are four overarching goals of the plan:

- Actively using our current resources more effectively
- Building infrastructure for integration between primary and specialist services
- Cementing and building on gains in resilience and recovery for all populations
- Delivering increased access to all populations

Each year all DHBs are expected to actively work on at least two actions for each of the four goals. These actions are reported quarterly to the Ministry of Health, and are also reflected in District Annual Plan actions.

2.2 Blueprint II Improving mental health and wellbeing for all New Zealanders: How things need to be

This provides a 10 year strategy to improve the mental health and well-being of all New Zealanders. The strategy is underpinned by the principle of intervening early, and calls for full implementation of a stepped-care approach.

Stepped Care is defined as “an integrated and seamless approach to health care delivery that involves intervening in the least intrusive way, from self-care right across the primary, DHB and Non-Government Organisations (NGO) continuum, in order to get the best possible outcomes, enabling entry and exit at any point based on need”. This system of delivering and monitoring treatments is designed so that the treatment that is most effective and least resource intensive is delivered first and enables people to move to a different level of care as their needs change. This model is
intended to help provide the most effective mental health and/or Alcohol and Drug care for the greatest number of people.

2.3 Welfare Reforms
The government has a well-established programme of work to focus on getting people off benefits and into work. Employment is a central part of recovery for people with mental health problems; is generally good for mental health and the evidence on how best to support people with mental illness into jobs is well established. Te Pou, the New Zealand Centre of Mental Health Research report that people with mental health conditions:

- fall out of work at twice the rate than people with other health conditions following the onset of symptoms
- make up 40 per cent of new and existing beneficiaries and;
- once a person has been out of work for more than six months the risk of developing a mental health condition increases.

2.4 Drivers of Crime
In 2009 the Government agreed that “Addressing the Drivers of Crime” be established as a whole of Government priority. There are four key areas in this strategy:

- Antenatal, maternity, and early parenting support
- Programmes to address behavioural problems in young children.
- Reducing the harm caused by alcohol.
- Alternative approaches to managing low-level offenders, and offering pathways out of offending.

One of the health-led deliverables is funding effective positive parenting advice and support interventions delivered through primary care settings (i.e. schools, Primary Health Organisations (PHOs), Non-Government Organisations (NGOs), Well Child services and/or Iwi providers). A second health-led deliverable is enhancing resource sharing and collaboration across Ministries and local organisations to reduce youth drug and alcohol use through the Social Sector Trials.

Actions and achievements against Drivers of Crime initiatives including the Triple P Parenting Programme and the Ranui Social Sector Trial are discussed in further detail below.

2.5 Regional Activity
Key areas of activity in the Northern Region are reflected in the Regional Mental Health Plan, and in local District Annual Plans (DAPs). Both DHBs have DAP actions to participate in regional work for Infant and Perinatal Mental Health, High and Complex Needs, Eating Disorders Service, Maori Workforce development and Youth Forensics. Funder led activity currently focuses on the first two areas.

2.6 Healthy Beginnings
Regional work for Infant and Perinatal Mental Health is guided by this strategy. In January 2012 the Ministry of Health published “Healthy Beginnings – Developing perinatal and infant mental health services in New Zealand”. This publication was developed as a guide to DHBs and describes the continuum of care and the service linkages required to effectively address the mental health and alcohol and other drug (AOD) needs of mothers and infants. “Healthy Beginnings” stresses the need for a comprehensive continuum of perinatal and infant mental health and addiction services including:
• Health promotion
• Screening and assessment
• Community based treatment services (primary care and specialist)
• Access to respite and inpatient services for those most in need
• Consultation and liaison services within the health system and with other agencies.

“Healthy Beginnings” also highlights key issues for DHBs to address when developing coordinated effective Perinatal Infant Mental Health Services including:

• The need for strong collaboration between mental health, maternity and child and family health services
• Effective linkages between health and other services that address families overlapping social and relational issues, including services funded by the Ministry of Social Development
• Developing perinatal and infant mental health and AOD services that are able to address mental health and AOD issues and address issues in relation to the parent infant relationship
• Ensuring services for Maori are based on whanau ora and that Maori families are supported to achieve their maximum health and wellbeing
• Recognition of the need for the capacity and capability of the workforce to be developed and grown before the full continuum of services can be made available throughout the country.

“Healthy Beginnings” has informed the development and implementation of the Perinatal and Infant Mental Health Project, described in more detail below.

2.7 National Suicide Prevention Action Plan

In June 2006 the Government released the New Zealand Suicide Prevention Strategy 2006–2016 (replacing the 1998 New Zealand Youth Suicide Prevention Strategy, and expanding the scope to cover suicide prevention across all ages). The strategy provides a high-level framework for reducing the rates of suicide and suicidal behaviour in New Zealand (Ministry of Health, 2006). Subsequently, the New Zealand Suicide Prevention Action Plan 2008–2012 was developed to translate the goals of this Strategy into action.

In May 2013 the Government released the New Zealand Suicide Prevention Action Plan (SPAP) 2013–2016, focusing on the following key areas:

• Support families, whanau, hapu, iwi and communities to prevent suicide
• Support families, whanau, hapu, iwi and communities after a suicide
• Improve services and support for people at high risk of suicide who are receiving government services
• Use social media to prevent suicide
• Strengthen the infrastructure for suicide prevention.

Suicide prevention and postvention activities are now included in the National Services Coverage Schedule expectations and in the DHB Annual Planning requirements. By January 2015, DHBs are expected to have provided the Ministry of Health with evidence of how they are developing district suicide prevention and postvention plans and facilitating integrated cross-agency collaboration in respect of local responses to suspected suicide clusters/contagion (Postvention).
3. Achievements and Progress

3.1 Actively using our resources more effectively (Rising to the Challenge SDP)
Specialist clinical services in both DHBs are actively engaged in a number of initiatives to use resources more effectively, using a range of recognised techniques such as Lean Thinking, Six Sigma, and Productive Ward. The national mental health KPI project benchmark against a number of productivity indicators (e.g. percentage of staff time spend in direct face to face time with service users).

The Stepped Care model also requires actively using our resources more effectively, by ensuring that treatment that is most effective, yet least resource intensive, is delivered first. E-therapies, primary mental health options, brief interventions and NGO supports, are some examples of these.

Support Hours Implementation
In the mental health NGO sector a major piece of collaborative work across both DHBs has been to reconfigure a range of different service specifications, into one service line of Support Hours. Historically there were a number of contracted service specifications to deliver community support services. The differentiation across these service specifications created barriers to flexibility in service delivery and the ability to flex support for people in a responsive way. Pooling all these services into one line of support hours enabled more flexible and responsive services, tailored to meet the needs of service users at any point in time. The service specification in Waitemata DHB also gave some increased flexibility for NGOs to deliver support to people in primary care.

In addition the model and payment methodology was moved from an FTE input based model to an output model, based on purchase of direct delivery of support hours. The methodology was based on buying “productive hours” with the expectation that 80% of productive time be spent in face to face delivery (including travel time). Table 1 is a snapshot of the 13/14 Q4 data for Waitemata DHB NGOs that shows an average of 68.8% face to face (target is 80%). Auckland DHB NGOs have only been using the report template since Q1 (2014/15) so reliable data for them isn’t available yet.

Table 1: Q4 Snapshot of Waitemata NGO Face to Face Percentage of Contact Time

<table>
<thead>
<tr>
<th>Face to face contact time</th>
<th>Peer Support Hours</th>
<th>Support Hours</th>
<th>Clinical Support Hours</th>
<th>Total Support Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>80.00%</td>
<td>Support hours face to face</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70.00%</td>
<td>Support hours face to face</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60.00%</td>
<td>Support hours face to face</td>
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<td></td>
<td></td>
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<tr>
<td>50.00%</td>
<td>Support hours face to face</td>
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<td></td>
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<tr>
<td>40.00%</td>
<td>Support hours face to face</td>
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<td></td>
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<tr>
<td>30.00%</td>
<td>Support hours face to face</td>
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<td></td>
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<tr>
<td>20.00%</td>
<td>Support hours face to face</td>
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<td></td>
<td></td>
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<tr>
<td>10.00%</td>
<td>Support hours face to face</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0.00%</td>
<td>Support hours face to face</td>
<td></td>
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</table>
Auckland DHB has completed the reconfiguration. Waitemata DHB has one mainstream contract still to reconfigure, and three Kaupapa Maori services yet to reconfigure. All four providers are in discussion about this and are keen to reconfigure.

Over the course of the implementation of this model there has been some divergence in the Auckland and Waitemata service specifications and reporting requirements. The joint mental health funding team are seeking to re-align these over the coming six months.

Counties Manukau DHB are also now implementing this model. There is an agreement with Navigate (the Northern region NGO representative group) that a regional review of the model will be undertaken. The NRA will provide support to the review.

3.2 Building Infrastructure for Integration between primary and specialist services/Stepped Care

“Rising to the Challenge” - The Mental Health and Addictions Service Plan 2012-2017, requires a shared system response across primary and secondary services, with both agreeing on how they will work together to provide seamless and effective services for people experiencing mental health and addiction issues. Stepped Care is the foundation model to achieve this integration across the services.

Auckland and Waitmata DHBs both have Annual Plan actions to achieve this integration, by building system and clinical integration with primary care, secondary and NGO services. These are also prioritised actions for 2014/15 in the national Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 for both DHBs.

Three projects are underway to address infrastructure issues and integration:

1. Maungakiekie-Tamaki Locality Project (Auckland DHB)
2. New Lynn/Totara House Integrated Family Health Centre (Auckland DHB and Waitmata DHB)
3. Whanau House (Waitmata DHB)

It is anticipated that Mental Health and Addictions NGOs will participate in pilots in all three of these projects. NGO support services are well placed to provide complementary services in primary care, and assist in addressing social determinants of health (e.g. family issues, finances, housing and employment) which can adversely effect mental health status. These pilots will help inform understanding of whether applying more of this NGO resource to the primary care/early intervention part of the pathway improves outcomes, and helps reduces exacerbation of mental health problems and need for specialist secondary services.

3.2.1 Maungakiekie-Tamaki Locality Project (Auckland DHB)

As part of the primary care localities approach extensive consultation was undertaken with the Maungakiekie-Tamaki community. This engagement resulted in a series of workshops and over 100 meetings with a variety of stakeholders concerned with the mental health of the Tamaki community.

Thirty two proposed projects were identified through this engagement and these were subsequently grouped into three high level work streams. These are:

1. Building mental health capability in primary care - providing greater mental health support for General Practice.
2. **Effective navigation between primary care and the community through care navigators and peer support** - providing a care navigation/peer support service that would act to support linkage between primary care and the community.

3. **A physical, virtual and mobile community wellness hub** - the development of a community that would support overall community wellness and access to health and social services.

**Progress to Date**

Pro-Care Networks Ltd are providing the project lead, who reports to the Alliance Leadership team. A project working group is in place, made up of a diverse range of expertise from Auckland DHB Mental Health Services, Mental Health Planning and Funding, Mental Health NGOs, Community leaders, PHOs, Nursing, Consumers and Population Health. This group is defining the model/s, scoping the programme of work, developing an implementation plan and will deliver on an agreed series of projects that integrate across the three streams. Working group members are also participating in the three work streams, with the work streams feeding back into the working group.

The project group will develop proposals to submit to the Alliance Leadership team, to pilot initiatives identified through a co-design process. These pilots would then need to be carefully evaluated, to inform further roll-out, shared learnings and funding sustainability.

The Tamaki community is a dis-advantaged community with overall poor health and social determinant issues. Given the high investment of the community by engaging with this consultation process, it is important that the DHB ensures that there are positive and sustainable outcomes delivered in response to this process.

**3.2.2 New Lynn/Totara Health Integrated Family Health Centre (Auckland DHB and Waitemata DHB)**

In 2013, Procare Health Limited and Waitemata DHB came together to plan steps to improve the integration and responsiveness of the Mental Health Services with a focus on primary care. Agreement was reached to develop and demonstrate a pilot “stepped model of care” using Totara Health as the pilot site. Totara Health quickly came on board as part of the project team, as did Auckland DHB. New Lynn has a shared border between the two DHBs, and so is an ideal site for a joint project. The objectives of the pilot were to:

- Integrate primary care services with Procare primary mental health services (Procare Psychological Services), DHB secondary mental health and addiction services, NGO and community services
- Demonstrate how mental health providers and services can be joined up to provide more effective care for clients
- Support Totara Health staff to manage the mental well-being of their clients more effectively
- Reduce levels of illness, through early treatment and prevention
- Demonstrate how a closer working relationship between primary and secondary care can be achieved, along with how this positively impacts client outcomes
- Provide a replicable model that can be rolled out across the DHBs

**Progress to Date**

The Integrated Family Health Practice in New Lynn continues to host the project. Malcolm Stewart (Clinical Psychologist) from Procare Health Ltd is the clinical lead for the project. Waitemata DHB Mental Health Services have established a role to enable specialist psychiatrist support for this model. DHB Community Mental Health Primary Care Liaison nurses are based some of the time in Totara Health. This allows for timely intervention and support for clients both exiting and entering
secondary care, and at the interface between the two. Four key components are being integrated in order to deliver the clinical care required:

- GP assessment processes
- Coordination/guidance processes
- Primary/Secondary stepped care pathways
- Community Resources

The integration of each of these components in a trial is expected to be implemented by the end of this year. A process to identify mental health and addictions NGO partners in the pilot is under discussion.

As this is a pilot project, the model developed from this may be replicated in other sites. In order for the model to be sustainable and replicable, the project steering group will need to ensure the model and pathway is well documented and that outcomes are clearly identified and evaluated.

### 3.2.3 Whanau House

Te Whanau O Waipareira Trust, have provided space at Whanau House, to West Auckland secondary mental health services. We are in early discussion with them, about a pilot using some of their community mental health and addiction support services to complement the clinical service delivery.

### 3.2.4 Raeburn House Re-configuration

In July 2014 the Waitemata Board approved the recommendation from the Audit and Finance Committee to transfer the Raeburn House Agreement from the provider arm to planning and funding, and approved the reconfiguration of the service to align with primary mental health services.

Consultation has occurred with Raeburn House, Waitemata PHO and Procare Health on the reconfigured services to be delivered by Raeburn House. The result of this consultation has been strong support for the reconfigured Raeburn House service to deliver flexible group programme and health service navigation. The group programme will align with Primary Mental Health Initiatives (PMHI) and, by freeing up PHO primary mental health resources, allow greater access to these services. Health Navigation will support GPs, clinical services and the public to find the mental health and addiction services they require. Navigation support will be provided by a directory, telephone, internet and a smartphone application. The detail of these services is currently being negotiated with Raeburn House.

### 3.3 Welfare Reforms and Social Outcomes Indicators

#### 3.3.1 Auckland DHB and Waitemata DHB Employment Workgroup

Being in employment is a significant contributor to good mental health. The Employment Workgroup is an Auckland DHB/Waitemata DHB Collaboration project established in late 2013. The group is working to meet the Waitemata 2014/15 DAP outcome to establish mental health employment specialists, and the ADHB 2014/15 DAP outcome to map and improve service access and pathways across the various Ministry of Social Development and health employment contracts.

The Employment Workgroup has engaged a project manager funded equally by the Waitemata Stakeholder Network (WSN) and ADHB (provider arm and funder). The plan is in the early stages of development and is utilising the social outcomes data on employment (see Tables 2 and 3 below) to develop baseline data.
3.3.2 Social Outcomes Indicator Workgroup

The National Adult Key Performance Indicator (KPI) forum agreed in 2013 that all DHBs would collect social indicator data to compliment clinical indicators (e.g. HONOS). Social outcomes reported are employment, housing, PHO enrolment, and psychological interventions. Auckland DHB and Waitemata DHB are represented on the Social Outcomes Indicator Workgroup. This group, led by the NRA and Platform Trust (the national mental health NGO peak body), was established to develop a set of social outcomes indicators and a reporting framework to guide the national collection of this data. Currently this group is investigating a potential project with the Auckland University of Technology (AUT) to link social outcomes data with the World Health Organisation Quality of Life (WHOQoL) scale.

Waitemata DHB Social Outcomes Indicators

In partnership with the Waitemata Stakeholder Network (WSN) a new reporting format for NGOs was introduced in 2012/2013 to record the delivery of Support Hours services and record some of the major social determinants of health (social outcomes) for users of all NGO services. This data is recorded on a quarterly basis and allows changes to be tracked over time.

Currently the mental health provider arm is updating its collection of social outcomes to align with the WSN reporting format.

Table two shows employment status at entry and exit of Waitemata NGO services for service users who exited in Q1 2014/2015 reported through the new template. This employment data highlights that the majority of people enter and exit NGO services without employment and is being used to inform the Auckland DHB and Waitemata DHB Mental Health Employment Project.

Table 2: Waitemata DHB NGO employment data Q1 2013/2014

Auckland DHB Social Outcomes Indicators

The new reporting template introduced in Waitemata DHB for 2013/2014 was introduced to Auckland DHB NGO providers in Q1 2014/2015. NGO providers have been very supportive of the alignment of the two DHBs’ reporting requirements. It will take some time for ADHB NGOs to align
their reporting systems to the new report, and it is anticipated that their data produced for Q1 and Q2 of 2014/2015 will be unreliable.

The Auckland DHB provider arm is also updating its collection of social outcomes to align with the NGO reporting format.

Table three shows employment status at entry and exit of Auckland NGO services for service users who exited in Q1 2014/2015 reported through the new template. As above, this employment data highlights that the majority of people enter and exit NGO services without employment.

**Table 3: Auckland DHB NGO employment data Q4 2013/2014**

![Employment data chart]

### 3.4 Drivers of Crime Initiatives

#### 3.4.1 Multi-level Response to Children’s Conduct and Behaviour Problems Service: Primary Care Triple P

This service is one of the health led deliverables in the government’s “Drivers of Crime” conduct problems work-stream and involves making effective parent programmes available through both primary care and specialist settings.

Severe conduct and behavioural problems in childhood are the most important predictor of later chronic antisocial behaviour, including crime.

- Over 50% of all offending is perpetrated by people who developed behaviour and conduct problems in early childhood, who are on the so called ‘life-course-persistent antisocial pathway’.
- Early onset behavioural problems also predict poor school readiness, low achievement, school failure and substance abuse.

Parent management training programmes are one of the most effective interventions to reduce severe conduct and behavioural problems in young children. Access to these programmes is expected to improve health, education and social outcomes and reduce rates of criminal offending. The Ministry of Social Development’s Advisory Group on Conduct Problems recommended the evidence-based parent management programmes that should be considered for implementation in the New Zealand context. The list includes the Incredible Years BASIC Parent programme (IY-Parent)
and the Triple P – Positive Parent Programme (Triple P), both of which have a significant evidence base and good traction in New Zealand. Triple P is the only programme of evidence-based parenting intervention that has developed a version of the programme tailored specifically for primary care settings.

Waitemata DHB successfully submitted a Request for Proposal to the MoH, to be one of four national pilot sites for this service. The initial pilot period was December 2011 to December 2013. This has since been extended until June 2016.

The aim of the service is to implement evidence-based parent management programmes through both primary care and specialist settings, and to provide additional mental health and AOD support to the most vulnerable parents through specialist settings. There are two parts to the service.

1) The engagement of a primary care/community provider to deliver the Primary Care Triple P evidence based parenting programme and to establish and support a network of other primary care/community providers to be trained to deliver Primary Care Triple P parenting programmes. Waitemata DHB went through a contestable process for this service. Te Whanau O Waipareira Trust were awarded this contract, and continue to deliver the service.

2) The further development and delivery of the Incredible Years evidence based parenting programme, through CAMHS (Child and Adolescent Mental Health Service), with a focus on working alongside Special Education.

**Progress/Achievements**

Te Whanau O Waipareira Trust have established a network of 83 practitioners across Waitemata who have completed the Triple P training. These practitioners come from a range of services including Plunket, Well Child providers, Mental Health NGOs, Familyworks, school social workers, Parents as First Teachers and Women and Family services.

Two nurses are employed by Te Whanau O Waipareira Trust to deliver the service. They provide ongoing support and supervision to the network of practitioners, as well as delivering the Triple P programme. This calendar year (January to September) Triple P interventions have been delivered to 107 family and whanau.

**3.4.2 Ranui Social Sector Trial**

The Ranui Social Sector Trial (SST) is one of 16 trials in New-Zealand. Social Sector Trials are a collaborative initiative between the Ministries of Social Development, Justice, Education, Health and the New Zealand Police. The focus of these trials is to support decision making at the local level, build on existing networks and strengthen the co-ordination between Ministry services, and between Ministry services and communities.

The Ranui SST was initiated on 1 July 2013 and is being led by New Zealand Blue Light (an established NGO closely associated with the New-Zealand Police). An action plan was developed by New-Zealand Blue Light (*Ranui Youth Action Plan: July 2013 – June 2015*) that described the expected outcomes for 12 to 18 year old young people in Ranui. The expected outcomes are to:

- reduce truancy
- reduce youth offending
- reduce drug and alcohol use
- increase engagement in education, training and employment.

Each outcome has an established working group to progress its goals.
The Ranui Drug Strategy Working Group was established to progress the outcome of reducing drug and alcohol use and is chaired by a member of the funding team. Currently the group is working on two projects:

1. Achieving the DAP objective of establishing AOD (Alcohol and Other Drugs) outcome measures for youth as part of the Ranui SST

Data has been collected from 1 January 2014 on the number of Ranui youth seen by services. Table four shows the number of 12-18 year old Ranui residents seen by Alcohol and Other Drug (AOD) services. Services reporting are Odyssey, CADS (Te Atea Marino, Tupu and Altered High) and Waitemata DHB Emergency Departments (North Shore and Waitekere).

Table 4: Ranui Youth seen by NGO and Waitemata DHB Services for Alcohol and Drug Issues

<table>
<thead>
<tr>
<th>12-18 year olds accessing services</th>
<th>Q3 13/14</th>
<th>Q4 13/14</th>
</tr>
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<tbody>
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<td></td>
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Table 5 shows the percentage of enrolled 12 to 18 year olds in the Ranui Medical Centre (part of Procare PHO) with alcohol and substance abuse issues. The Ranui Medical Centre is the only GP practice within Ranui. The Ranui Medical Centre screened 535 in Q3 and 652 in Q4 young people for alcohol related issues, and 530 in Q3 and 644 in Q4 for AOD issues.

Table 5: Ranui Medical Centre AOD screening of enrolled Ranui Youth

<table>
<thead>
<tr>
<th></th>
<th>Q3 13/14</th>
<th>Q4 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate to heavy drinker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuser</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As reported by previous SSTs the collection of meaningful AOD data is problematic. The data required is often collected but only extractable by a manual search. For example the data provided by Waitemata DHB Emergency Departments requires searching for key words in patient notes. Such processes delay reporting and increase the rate of error. Currently data from the New Zealand Police and High Schools is not available. The Police have made changes to their data collection that will allow reporting of AOD related arrests of young people that occur in Ranui.

2. One-off funding of Ranui SST alcohol and drug services

In June 2014 Waitemata DHB received one-off funding ($63,651) from the MOH for 2014/2015 which is to be used to fund alcohol and drug services in the social sector trial communities. Waitemata DHB tasked the Ranui Drug Strategy Working Group with the allocation of this funding to support the achievement of the Ranui SST outcome to reduce drug and alcohol use. Following an Expressions of Interest (EOI) process New Zealand Blue Light was selected as the preferred provider.

The NZ Blue Light proposal is to provide cannabis testing, support and counselling to Ranui youth in high schools. Testing will be voluntary and used with young people wanting support to stop or reduce cannabis use, and as a means to keep people in school who would otherwise be stood down or excluded for cannabis use. New Zealand Blue Light will support the family/whānau of those youth in, or who will potentially access, the programme to support their young person. This support may include cannabis testing of family/whānau member(s) where wanted by them. New Zealand Blue Light will also develop peer support within schools.

Currently Waitemata DHB is developing the service specification with NZ Blue Light and the Ranui SST Lead.

3.5 Regional Activities

3.5.1 Perinatal and Infant Mental Health Project (Healthy Beginnings)

In March 2014 Auckland DHB and Waitemata DHB signed Crown Funding Agreements (CFA) with the Ministry of Health (MoH) to provide a Maternal Mental Health Acute Continuum. These funds followed the release of the ‘Healthy Beginnings’ report in January 2012 and the completion of a Northern Region stocktake of maternity, maternal and infant mental health services by the Northern District Support Agency in 2012. A significant amount of consultation has been undertaken at both a regional and local level. Approximately 400 people were consulted in the development of the model and 250 people from consumer organisations, NGO, primary health, midwifery and other DHB services attended the Model of Care Road Show presentations held across the Region between May-July 2014. To address the breadth of need identified during the consultations for the development of the "Northern Region Perinatal and Infant Mental Health Model of Care Guideline"; a range of DHB and NGO services are in the process of being implemented. These services include:

- Acute responsiveness enhancement to maternal mental health services to provide additional clinical and medical staffing. This will enable greater intensity and frequency of treatment and support than could otherwise be provided including extended hours during weekdays and weekends and increased liaison support to existing services and community support. Auckland DHB have recruited to 1.2 FTE clinical positions and 2 FTE are in appointment process (social worker and occupational therapist) and a 0.6 FTE Senior Medical Officer has been appointed and commenced employment. Waitemata DHB have recruited to 2.65 clinical FTE positions. Recruitment for the SMO position is in process.
• NGO Crisis Respite Beds and Packages of care services The objective of these services is to provide short term, recovery orientated, residential crisis respite and support hours for mothers and infants where the mother is experiencing an acute deterioration in her mental health during pregnancy or in the first 12 months post-partum. The services will be available 7 days per week with 24 hour awake staffing. The respite Service is to be provided in a "home-like" residential setting within the local community that is safe, comfortable and welcoming for mothers and infants and easily accessible by public transport. The support hours’ component of the service is to be provided largely in the service user’s own home, the home of a friend or family member or in a maternity ward or birthing unit.

• Auckland DHB and Waitemata DHB agreed to combine the available funding and have conducted a joint Request for Proposal process to establish one residential respite service to provide beds and clinical and non-clinical support hours across both catchment areas at a location mutually accessible by both DHBs. A collaborative service of six beds increases the financial viability and sustainability of the service for the selected provider; allows the most efficient use of the contracted resources; and ensures that the clinical expertise, collegial support and resources are combined in one site and not duplicated at two different sites. A preferred provider has been selected, and negotiation will be underway when the CEOs have given their approval. Support hours services should commence in March 2015 and respite in May/June 2015.

• Mother and baby acute mental health care inpatient unit to provide hospital based specialist perinatal mental health assessment, treatment and support for three mother and infant dyads where the mother requires more intensive support and treatment than can safely be provided with an individually tailored package of care or by residential crisis respite service. This 24 hour staffed separate unit provides three beds in private rooms, family and whānau rooms, a kitchen and lounge area and observational rooms and is based within the Child and Family unit at Starship Children’s Hospital. The service commenced operating in October 2014.

These services are to work collaboratively and strong linkages will also be developed and maintained between these services and maternal mental health services, crisis mental health services, midwives and other lead maternity carers, Well Child providers, Maori Health advisors, Pacific health providers, General Practice teams and local health and social services for mothers and infants.

3.5.2 High and Complex needs (Regional)
The Regional Services Planning Group sponsored a High and Complex Needs Project in 2013. The project was driven by recognition by the Northern DHBs and the Ministry of Health that there were gaps in the service continuum, for people with high and complex needs, resulting in un-necessarily prolonged admissions to forensic inpatient beds at the Mason Clinic, and adult acute in-patient beds across the region.

The continuum of care recommended by the Project group to meet the needs of these people starts at the top level of inpatient forensic beds, stepping down to non-forensic minimum secure beds, to rehabilitation beds, and then to community based services.

The MoH has already committed to the commissioning of five additional High and Complex beds within the Mason Clinic inpatient forensic services. In addition Waitemata DHB has committed significant funding for the development of community based services for this group of people (see following section (High and Complex Needs – Waitemata DHB).

The most significant current gap for Auckland and Waitemata DHBs is that of minimum secure beds.
Progress to date

- The CEO/CMO group has approved a request to progress to completing a comprehensive options appraisal to develop the business case for establishing minimum secure inpatient beds. They have requested that this business case is completed in the context of all work proposed for the High and Complex Needs project.
- The CEO/CMO group have also requested an update on the proposed model of care, what the pathway includes in terms of packages of care, and their current status.
- Sam Everitt and Dr Lyndy Matthews from the NRA will commence planning work to progress the requests above for discussion at the next High and Complex Needs Sponsor and Steering Group.

High and Complex Needs (Waitemata DHB)
Waitemata District Health Board approved funding of $2 million per annum in July 2014 to develop and implement two High and Complex Needs Long Term Community Residential Services. The people needing these Services are unable to live independently, have serious physical health and/or cognitive and/or behavioural and/or alcohol and other drug problems; require on-going monitoring and clinical treatment; present considerable risk to themselves and/or others; and are likely to require support from mental health services indefinitely. The purpose of these new community based Residential Services is to provide safe, effective, and appropriate accommodation and support for up to 15-16 people whose needs cannot be met by less intensive mainstream adult mental health services and who would otherwise be long-term users of inpatient services, adult acute units and Regional Forensic Psychiatry Services. The new Services will ensure better and safer use of resources so that people receive the right level of care at the right time and in the right place.

The Services will be delivered within Waitemata DHB district and will provide a home-like environment in which residents’ personal care, daily living, physical, psycho-social, spiritual and cultural support needs can be met. Staffing levels and expertise will reflect the requirement to supervise and manage the on-going challenges presented by people with high and complex needs. This will require services to be flexible, provide continuity of care and provide a high level of expertise in complex symptom management. The facilities and grounds will be appropriate for those with multiple disabilities while ensuring the safety of service users/tangata whai i te ora, staff and members of the general public. It is expected that these services will have a rehabilitative function; engage residents in meaningful activities; and support residents to be as independent and self-sufficient as possible, and if suitable, transition into more autonomous supported accommodation. Access to and exit from these Services will be managed by the Local Coordination Service in collaboration with the high and complex needs allocation group. Services will be required to accept all referrals that fit the High and Complex needs criteria where capacity allows.

A Registration of Interest to deliver these Services was advertised in early November 2014. The ROI closes on 5 December 2014 and the panel will meet to shortlist organisations on 19 December 2014. The medium term individualised packages are anticipated to commence in April 2015. The long-term accommodation and support options are anticipated to commence in June 2015.

3.7 Suicide Prevention and Postvention Activities
The New-Zealand Suicide Prevention Action Plan (2013 – 2016) requires a number of actions on the part of DHBs to prevent suicide and provide postvention responses to actual suicides.

Auckland DHB had a dedicated suicide prevention co-ordinator as part of a Ministry of Health pilot scheme. These pilots ended in June 2014. There were well established suicide prevention and postvention activities within Auckland DHB over the last six years including having:
• an established suicide prevention advisory group
• an established inter-sectorial collaboration working group
• a suicide Prevention and Postvention Plan for 2013-2014

As part of the Auckland DHB/Waitemata DHB funding team collaboration framework, a new role was established in the mental health and addictions team, with a focus on suicide prevention and postvention. The new programme manager, Manu Fotu, commenced on the 17th October 2014. Key areas of focus will be:

**Memorandum of Understanding (MoU)**
An MoU between the two DHBs and Coronial Services of New Zealand, Ministry of Health and the Clinical Advisory Services Aotearoa Limited (CASA) will support the implementation of the New Zealand Suicide Prevention Action Plan 2013 – 2016 specifically: Action 11.2 “Establish a function to analyse and share up-to-date provisional coronial data on suicide deaths with agencies working in local areas to help prevent further suicides”. This agreement outlines how Coronial Services of New Zealand will provide coronial information on suspected suicides to assist DHBs to provide a timely and appropriate local response to suspected suicides and describes the DHB responsibilities regarding the collection, use, disclosure and retention or disposal of coronial information.

**Question Persuade Refer (QPR) training**
The Suicide Prevention Action Plan 2013 – 2016 outlines a programme of actions that the government will implement over four years. Action 3.1 stipulates: “training community health and social support service staffs, families, whanau, hapū, iwi and community members to identify and support individuals at risk of suicide and refer them to agencies that can help”. The Ministry of Health proposed a service package to implement Action 3.1 and one component of this package is to allocate a one-off funding for QPR NZ to facilitate QPR Gate Keeper Foundation online training.

The QPR tool is an online, multi-media adult learning programme which can equip participants with skills to recognise that a person may be contemplating suicide and how to ask about suicide risk. QPR presents the steps to Question a person to determine if they have suicidal thoughts or plans followed by instruction in how to Persuade and then to Refer them for further assessment and/or treatment.

The Ministry of Health allocated 400 QPR training licences across Waitemata DHB and Auckland DHB. There were 270 workers registered with the programme at the beginning of October, with a high uptake by Maori providers and mental health providers. As a result of the recent appointment of the Suicide Prevention programme manager, it is envisaged that the remaining available places will be filled through promotional activities by the end of November, with priority to Pacific and Asian workers.

**Waitemata DHB Suicide Prevention Advisory Committee**
A high priority is to establish a Waitemata DHB Suicide Prevention Advisory Committee to support the development of district suicide prevention and postvention plan and to facilitate integrated cross-agency collaboration to respond to suspected suicide clusters/contagion (postvention) activities. Membership of the advisory committee has been confirmed, and an initial meeting is being scheduled. It is anticipated that when the Waitemata group is functioning, and the plan is in place, a combined Auckland and Waitemata advisory group, and inter-sectorial collaboration working group will be formed.
4.2 Asian and Migrant Health Service Information Sources and Pathways in Auckland

Recommendation:

That the report be received.

Prepared by: Samantha Bennett (Asian, Migrant and Refugee Health Gain Manager)
Endorsed by: Dr Debbie Holdsworth (Director Funding WDHB/ADHB), Simon Bowen (Director Health Outcomes ADHB/Waitemata DHB)

Glossary

ARMS - Auckland Regional Migrant Service
ARPFS - Auckland Regional Public Health Service
CAB - Citizens Advice Bureau
CNSST - Chinese New Settlers Service Trust
DHB - District Health Board
GP - General Practitioner
MELAA - Middle Eastern, Latin American and African
MBIE - Ministry of Business, Innovation and Employment
NGO - Non-Government Organisation
PHO - Primary Health Organisation
TANI - The Asian Network Incorporated

1. Executive Summary

Newcomers or new Asian migrants continue to choose the Auckland region as a desirable place to settle based on factors such as lifestyle balance, employment and education. Individuals and families bring with them a cultural context, attitudes and belief system that influence their healthcare behaviour (both help seeking and health seeking) that may impact on access and utilisation of services. It is imperative that settlement support information about the health and disability systems, healthcare services and the need to enrol with a PHO, including the role of primary care as a gateway for accessing appropriate primary and secondary health services, is accurately and clearly communicated and understood to the consumer. Key enablers for uptake of targeted messaging include accessing health system and healthcare information in multiple languages, and delivery of streamlined consistent, clear and concise information by providers across the multiple touch points in the Auckland region.

The Ministry of Business, Innovation and Employment (MBIE) is the lead central Government agency responsible for driving the national Settlement Strategy. Immigration New Zealand – a business unit within MBIE has been funded to lead and coordinate settlement support work since 2004, and in July launched a new settlement information service for new migrants to help them settle and work in New Zealand, with the Citizens Advice Bureau (CAB) contracted to lead the face-to-face settlement information service nationally from September 2014. Seven designated sites will provide information workshops and seminars including Pakuranga, Manurewa, New Lynn, Auckland Central, Mt Albert, Browns Bay and Northcote. Each site will deliver four workshops per year to newcomers. The Asian, Migrant and Refugee Health Gain Manager (ADHB-WDHB) has been and will continue to work with the lead CAB manager of the national contract to ensure accurate and up-to-date information on...
healthcare services including PHO enrolment and role of primary care is delivered within the information sessions and promoted via collateral. The position will also liaise with the other key providers or touch points for healthcare service information to the Asian newsettlers in Auckland to ensure a consistent, streamlined approach. Such providers include:

- DHB services
- Government Agencies i.e. Immigration New Zealand and Ministry of Health websites
- Asian Associations across the respective ethnicities e.g. New Zealand Chinese Association
- PHOs
- Auckland Council
- Universities
- Providers of online health portals e.g. Healthpoint
- Dedicated settlement support providers e.g. Auckland Regional Migrant Services (ARMS)
- Language support lines e.g. New Zealand Office of Ethnic Affairs Language Line, CABs language link
- Targeted Asian NGOs e.g. The Asian Network Incorporated (TANI)
- Asian service providers e.g. Chinese New Settlers Service Trust (CNSST)
- Ethnic specific membership groups and their respective online social media channels e.g. forums, chat and blog sites.

2. Introduction/Background

The term ‘Asian’ is used in New Zealand to describe culturally diverse communities with origins in the Asian continent, from China in the north to Indonesia in the south, and from Afghanistan in the west to Japan in the east. The definition of ‘Asian’ excludes people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia. Migration trends and changes in Auckland’s demographic reveal that Auckland’s Asian ethnic population has seen significant growth since the 2006 census. In 2013, 23.1% of people living in the Auckland region identified with one or more Asian ethnic groups compared with 18.9% in 2006 (SNZ, 2014a). As the Asian migrant population grows rapidly, increasingly it places greater demand on providers who reach out to Asian newcomers to deliver timely settlement support including information on the New Zealand health and disability systems and healthcare services.

Three factors impact on the ability of newcomers such as Asian newsettlers to access health and disability system and healthcare service information:

1. Language proficiency
2. Stage of readiness to seek out information i.e. early and later adopters
3. Awareness of sources or touch points to access healthcare information

Multiple key partners each with their own role and function outreach and promote settlement related support or information dissemination to new Asian populations either at the broader or ethnic specific group level. Key providers include:

- Government Agencies i.e. Immigration New Zealand and Ministry of Health websites, DHBs
- Asian Associations across the respective ethnicities e.g. New Zealand Chinese Association
- Auckland Council
• PHOs
• Universities
• Online portals e.g. Healthpoint
• Dedicated settlement support providers e.g. Auckland Regional Migrant Services (ARMS)
• Language support lines e.g. New Zealand Office of Ethnic Affairs Language Line, CABs language link
• Targeted Asian NGOs e.g. The Asian Network Incorporated (TANI)
• Asian service providers e.g. Chinese New Settlers Service Trust (CNSST)
• DHB services
• Ethnic specific membership groups and their respective online social media channels e.g. forums, chat and blog sites.

The recent addition of CAB as a lead agency providing a settlement information service adds an additional touch point or access point for new migrants who prefer to access information face-to-face rather than online (which often is provided in English by Government providers). The CNSST, TANI, ARMS and some Asian ethnic Associations are also key partners across the migrant sector who deliver settlement support information including promotion of PHO enrolment, registering with a GP and how to access healthcare services. Lastly, the Waitamata DHB’s Asian Health Support Services may opportunistically direct Asian newsettlers domiciled in Auckland to the respective Asian and/or migrant providers to access settlement related information if they are contacted.

Partners deliver health service information on topics such as New Zealand health system eligibility, costs, how to access health advice, types of services available, language support, rights and complaints. Various communication and capacity building methods include social media, orientation/information sessions and workshops, hardcopy and online collateral, and recruiting dedicated newcomer support roles to act as liaisons to new migrants such as the voluntary position based in ARMS. Often healthcare service information is delivered and communicated as an additional topic along with other settlement support areas such as pre-employment, employment rights and education at information sessions/workshops which may dilute key messages based on competing information. Both ARMS and CNSST deliver dedicated sessions on ‘Understanding the New Zealand System’ and healthcare services at regular intervals throughout the year. TANI acts as bridge between the Asian communities and mainstream service providers and is an important access point for up-to-date information to those communities including new migrants.

Barriers to uptake of health service information by new Asian migrants, particularly primary care and PHO enrolment, are due a number of factors including:
• to the individual’s readiness to seek out information
• knowledge of settlement service touch points
• competing information at orientation workshops during early settlement stages which leads to information overload and loss of retention
• access to up-to-date and correct information by partners and providers
• access to information in multiple languages across mixed communication methods i.e. social media, face-to-face workshops and hardcopy collateral.

Increasingly greater demand has been placed on partners and providers across the region to deliver and disseminate health information messaging using a multi-strategy approach where greater coordination regionally is required. ARMS currently has been contracted by MBIE to manage the
regional directions and oversight for settlement support to migrants in the Auckland region. The addition of CAB managing a national contract with the provision of settlement service information as a core activity may provide greater direction for ARMS to ensure delivery of a streamlined approach across the Auckland region.

Furthermore, it is imperative that all partners and providers that share the responsibility of outreach to Asian migrant population direct newcomers to the appropriate information touch points including the respective providers who deliver settlement service information which should also include health system and healthcare service awareness raising of eligibility processes, referral pathways, potential costs and the gatekeeper role primary care plays in access to publically funded or low cost healthcare within the system parameters.

3. Risks/Issues

The impact of multiple sources and shared touch points for the provision of information on the health and disability systems, and healthcare service information, may lead to the following potential risks:

1. ‘Some’ not ‘all’ new Asian settlers access and retain key information based on language barriers, prioritising settlement related information, lack of awareness of touch points, dilution of information at orientation/information sessions leading to lack of understanding of the system, protocols and thus unfamiliarity and low uptake to services

2. Unequitable access to healthcare services across and within Asian ethnic groups compared to other populations, and presenting late to services e.g. Mental health and addiction services

3. Low PHO enrolments across and within Asian ethnic groups

4. Disparate primary care seeking behaviour whereby individuals place unrealistic demands on family doctors to be referred to secondary care without meeting approved referral thresholds. Individuals then become confused when they are asked to pay for secondary care services, when they were under the assumption they were eligible for publically funded or low cost services, leading to mixed messages disseminated within the respective Asian ethnic networks

5. Expectations of tertiary care i.e. Emergency Care to manage non-urgent primary health issues which may impact on treatment plans, undue burden on individuals and their families, and constrained demand on health system resources and workforce

6. Lack of awareness of the right to ask for an interpreter when booking and accessing health services

7. Patterns of health seeking behaviour that is reactive rather than proactive due to individuals who are late adopters and their stage of readiness to access health information and care

8. Compounding misinformation across ethnic groups based on prior experiences in the system and/or specific health services that leads to a growing pattern of service utilisation or under-utilisation consistent within a specific ethnic group placing undue burden on a priority area service.

4. Progress/Achievements/Activity

There are a number of key strategies adopted across Auckland to increase opportunities for new Asian settlers to access healthcare information. They include:
4.1  **Asian and MELAA Health Governance Group (Waitemata DHB – Auckland DHB)**

The Asian and MELAA Health Governance Group has membership across the Planning, Funding and Outcomes team workstream services, DHB services e.g. Auckland DHB Interpreting and Translation Service, Auckland Regional Public Health Service (APRHS), Waitemata DHB Human Resources, Waitemata DHB Child Health Services, and the Northern Regional Alliance. This two-way platform provides opportunities for members to share updates about their respective service changes i.e. contract and procurement changes which may impact on service delivery and/or access to populations, and communicate identified barriers shared by respective services with respect to low uptake by Asian and MELAA groups. The Asian, Migrant and Refugee Health Gain Manager can then communicate service updates to the respective partners and touch points of settlement service information to new Asian migrants, and work with the identified services or populations groups to address the barriers to access and utilisation to improve health gain.

4.2  **Auckland Regional Primary Care Working Group**

Currently the Asian PHO enrolment rate in Waitemata DHB is 77% and Auckland 74%. The Auckland Regional Primary Care Working Group was established with the key intent to identify the barriers to PHO enrolment and lower access to primary health care services for Asian and Middle Eastern, Latin American and African (MELAA) populations, and to develop and implement interventions, evaluation measures and monitoring by engaging key stakeholders across primary and secondary care, settlement support agencies, NGO providers, academia and immigration networks. An Action Plan 14-15 has been developed to address the barriers to PHO enrolments and low uptake of primary health services.

The Working Group is considering establishing a PHO enrolment target aligned to the Action Plan for 14-15. A key initiative of this Group was the development and implementation of a Campaign to the Asian population in 2012 to promote awareness of PHO enrolments in both simplified Chinese and Korean titled the ‘Your Local Family Doctor’ campaign (http://www.yourlocaldoctor.co.nz/). The campaign provided information on why to enrol with a GP, doctors in the area, case studies, useful links, and frequently asked questions. Hardcopy patient collateral was disseminated to PHOs both within the Auckland and Waitemata catchments and provided to TANI for promotion to the Asian communities.

4.3  **Workforce recruitment and retention**

i. In October 2013 Waitemata and Auckland DHBs appointed an Asian, Migrant and Refugee Health Gain Manager in the Planning, Funding and Outcomes team to address the inequalities of Asian, migrant and refugee populations at a strategic health gain level. Oversight across Auckland and Waitemata effectively enables the position to work across workstream services across the two DHBs to increase the health status of the Asian, migrant and refugee populations by addressing inequalities that impact on access and utilisation, working with services to address barriers and low uptake, adopting a collaborative, partnership approach with the DHB and external partners at an intersectoral level where possible, and coordinating and streamlining consistent messaging about healthcare services to the respective migrant touch points.

ii. In July 2014, the Auckland DHB appointed a Community Engagement Manager, Strategy, Participation and Improvement Unit to engage across communities including Asians on the ground in order to connect and link communities to health services, share information about health service access points and identify barriers to uptake. This newly appointed position aims to act as a two-way conduit from the communities and Asian partners to the Asian, Migrant and Refugee Health Gain Manager position and mainstream services to provide updates on identified or potential barriers to service access utilisation.
4.4 Waitemata DHB Asian Health Support Service
The Waitemata DHB funded provider arm service is another key contact point for new Asian migrants in Waitemata to access health service information or direct individuals to sources of information and opportunistically may provide information to Asian individuals domiciled in Auckland on a needs basis.

4.5 Citizens Advice Bureau
CAB Language Link provides settlement support information to newcomers via telephone support by language specific ‘interviewers’ in 26 languages. The Asian, Migrant and Refugee Health Gain Manager is working closely with the Language Link Manager to ensure that the interviewers are providing current, accurate and consistent information about the health and disability systems, healthcare service information, and details about the right to access Auckland DHB Interpreter Services based on levels of English language proficiency. The need to enrol with a PHO and role of primary care as a gatekeeper to publically funded or low cost secondary and tertiary care is covered.

The Manager of this service is also responsible for the implementation of the national settlement information service contract and working with the seven dedicated sites across Auckland (Pakuranga, Manurewa, New Lynn, Auckland Central, Mt Albert, Browns Bay and Northcote) to provide settlement service information. The Asian, Migrant and Refugee Health Gain Manager will work alongside this CAB Manager to ensure that streamlined information is provided about the health and disability systems, and healthcare services to newcomers.

4.6 Auckland Regional Public Health Service
ARPHS has developed an information brochure to new migrants on the New Zealand Health System and disseminated to settlement support and migrant partners. See Appendix 1. Note: the Asian, Migrant and Refugee Health Gain Manager is in the process of updating a detailed factsheet in multiple languages on the health system modelled from Pegasus in Christchurch to be disseminated to settlement support agencies as a support document at new migrant information sessions.

4.7 Auckland DHB Interpreting and Translation Service
Access to interpreters is a key enabler in the reduction of language barriers for newcomers when engaging in healthcare services including primary health. The Asian, Migrant and Refugee Health Gain Manager when engaging with Auckland DHB services reminds the services about supporting Asian patients to access the service where required. The Manager will also work closely with the newly appointed Interpreter Service Coordinator as she outreaches to PHOs and respective GP clinics to promote the use of interpreters and identify barriers to utilisation of the interpreter and translation service.

4.8 Healthpoint
Healthpoint is a central online portal for newcomers to access up-to-date information about healthcare providers, referral expectations, services offered and common treatments. The challenge is this site is provided in English only. The Asian, Migrant and Refugee Health Gain Manager is in the process of consolidating GP lists and languages spoken per region to be disseminated to Asian ethnic communities. Further liaison with Healthpoint is required to work on translating website pages in multiple languages.

4.9 Auckland Regional Migrant Service
ARMS continues to play an important role to newcomer migrants in the Auckland region. The service is contracted by MBIE to adopt a regional coordination role and is responsible for managing local
settlement network meetings, Steering Groups, Stakeholder Groups, communication strategies e.g. Regional newsletters, and scoping emerging needs of newcomers. ARMS run orientation sessions bi-monthly across settlement support topics including the health and disability systems and service information. A Newcomer Supporter role has been retained on a voluntary capacity trained to assist newcomers including directing them to various providers including healthcare services. The ARMS Board has identified new strategic priorities for the next triennium, one of which is to focus back to delivering information to community groups, particularly hard-to-reach groups. The Asian, Migrant and Refugee Health Gain Manager will continue to work in close partnership with this partner to ensure streamlining of consistent messaging about the health system, healthcare services and access to the Auckland DHB Interpreting and Translation Service is delivered regionally across the partners.

4.10 **Chinese New Settlers Service Trust**
CNSST continues to act as pivotal touch point to Asian new settlers providing culturally and linguistically appropriate services including settlement service provision, health and disability system and service information sessions, and collateral dissemination. The Auckland DHB Community Engagement Manager, Asian, Migrant and Refugee Health Gain Manager, and Waitemata DHB Asian Health Support Services all work in close partnership with this provider.

4.11 **The Asian Network Incorporated**
TANI continues to act as key bridge between mainstream health providers and Asian communities. This NGO has strong reach into Asian communities and disseminates health system information via collateral including promotion of the *Your Local Doctor* – PHO enrolment drive to Asian communities at various events. The Auckland DHB Community Engagement Manager and Asian, Migrant and Refugee Health Gain Manager work in close partnership with this provider.

4.12 **Orientation workshops**
A deck of presentation slides on key information about Understanding the New Zealand health system and DHB health services was reviewed by the Asian, Migrant and Refugee Health Gain Manager for the orientation sessions at ARMS and Raeburn House (Waitemata). The Manager will liaise with the CAB Manager of the settlement service information workshops to ensure the same key messages are used for the quarterly information sessions. Similarly, the Waitemata DHB Asian Health Support Services also delivers information sessions to the CNSST when required.

4.13 **Asian ethnic Associations**
Outreach to the Asian ethnic specific Associations and local networks is another important strategy by the Asian, Migrant and Refugee Health Gain Manager. The Manager will continue to liaise with the respective Associations/networks to promote consistent messaging about access to DHB health services and the importance of enrolling with a PHO.

5. **Conclusion**
There is fragmentation of sources of health and disability system information and communication pathways to newcomers in Auckland. This is often shared across multiple partners based on their scope, role and function. The CAB, CNSST, ARMS, TANI and Asian ethnic Associations as well as online Government websites e.g. Immigration New Zealand and MoH are key touch points for new Asian migrants in Auckland. ARMS is contracted to adopt an overarching regional coordination role to settlement support to migrants including Asian new settlers. Effective streamlining of settlement support information across multiple partners is imperative in particular health and disability system, DHB services, and the role of primary care in New Zealand. The Asian, Migrant and Refugee Health Gain Manager will work collaboratively with ARMS to build a strong regional approach across the...
partners to embed a streamlined approach to capacity building and communication strategies pertaining to health system and service information to increase opportunities for improved access and uptake of services. Working closely with the new player in the sector CAB is also critical.

The Asian, Migrant and Refugee Health Gain Manager will collaborate closely with the Auckland DHB Community Engagement Manager for initiatives requiring outreach to the respective Asian community groups and partners to ensure a strong bridging role between DHB services and touch points for settlement related service information initiatives related to healthcare information. Lastly, all partners and providers who act as access points for settlement support information should ensure that accurate, up-to-date, clear and consistent information is provided to newcomers or they are directed to other agencies that can act as repositories of such health system and healthcare information.
A General Practitioner (GP) is a doctor who looks after the health of all the family. This is the most important person for your health in New Zealand. If you are worried about your health you should visit your GP first.

GPs are found in your community at a Medical Centre. Practice Nurses and other health professionals also work there.

GPs will help find specialist services at hospitals and other health services.

Register with a GP - this will make a visit cheaper, talk to the GP receptionist. Tell your GP if you need an interpreter.

A Community Services Card will help with some health costs.

**Sudden but not serious illness**

If you become ill see your GP. If closed go to a private accident & medial clinic— costs apply.

**Dentist**

Free basic dental care is available to children under 18 who are at school or not working. Ask at school to register.

Dental services are not free for adults. Some hospitals offer emergency pain relief treatment.

**Maternity**

You can choose who looks after you when you are pregnant.

This can be a midwife or an obstetrician. Hospitals also have maternity services.

After birth a Wellchild provider for example Plunket will support you and the baby.

**Public Hospitals**

In New Zealand All major towns have a hospital. Your GP will arrange specialist appointments. There will be a wait unless it is an emergency.

You will get a letter with an appointment date and time. It is important that you confirm the appointment.

Hospitals have free interpreting. When you confirm your appointment ask for an interpreter to be booked.

Not all services are provided by the public hospital and a private service may be needed - this will have a cost. Your GP should explain this.

**Emergency**

If you are seriously ill or injured you may need to go to the emergency department (ED) for urgent assessment and treatment.

**Dial 111 for an ambulance – Emergency Only**

Ambulances are for emergencies only.

Examples might be:

- Severe pain
- Someone is unconscious
- Heart attack
- Not breathing properly
- Extremely sick
- A major injury

**Emergency Department (ED) also treat**

- Significant wounds
- Broken bones and dislocated joints
- Accidental poisoning or overdose of medication/drugs
- Other accidental injuries

**Private Accident and Medical Clinic**

These clinics deal with less serious injuries or illnesses.

They will assess and refer you to a hospital ED if they are unable to treat your illness or injury.

These clinics are often open when GPs are closed. There is normally a cost for treatment at these clinics.

**Medicines**

**Chemist/Pharmacist**

The Doctor may give you a form for some medicine; this is a prescription. Take this to a pharmacy. The pharmacist will explain when and how to use the medicine.

**Worried?**

Do not delay finding medical care.
## Costs and Other Support

<table>
<thead>
<tr>
<th>Service</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner (GP)/Family Doctor</td>
<td>Registered Adults: costs apply</td>
</tr>
<tr>
<td></td>
<td>Children under 6: free or low cost</td>
</tr>
<tr>
<td>Public Hospital or Specialist (including Emergency Department)</td>
<td>Free</td>
</tr>
<tr>
<td>Hospital interpreters (request before your appointment date)</td>
<td>Free</td>
</tr>
<tr>
<td>Accident and Medical Clinic</td>
<td>Costs apply</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Adults and children over 6: $5.00</td>
</tr>
<tr>
<td></td>
<td>Children under 6: Free</td>
</tr>
<tr>
<td>Maternity care (midwife, public hospital)</td>
<td>Free</td>
</tr>
<tr>
<td>Tests</td>
<td>Costs may apply - ask your GP</td>
</tr>
<tr>
<td>• Scans (e.g. ultrasound), blood tests, cervical screening</td>
<td>Free</td>
</tr>
<tr>
<td>• Breast screening</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>ACC covered serious accidental injury: Free</td>
</tr>
<tr>
<td>*ACC—Accident Compensation Corporation</td>
<td>Transport or non ACC emergency: $75-85</td>
</tr>
<tr>
<td>Dentist</td>
<td>Children at school (basic care): free</td>
</tr>
<tr>
<td></td>
<td>Adults: costs apply</td>
</tr>
<tr>
<td>Private doctors and hospitals</td>
<td>Costs apply</td>
</tr>
</tbody>
</table>

### Telephone Advice

If you can phone Healthline for free health advice. Healthline has telephone interpreters on request.

**Healthline 0800 611 116**

### Language Support

All Hospitals have interpreters free of charge. You must ask before your appointment so an interpreter can be booked.

Tell your GP if you need language support before your appointment.

### Complaints

You have the right to be treated with respect by health providers. If you have concerns or wish to complain contact the organisation who provided your care or the Health & Disability Commission.

Website: [www.hdc.org.nz/complaints](http://www.hdc.org.nz/complaints)

National Freephone: 0800 112233

### Eligibility

Advice in this leaflet is for Permanent Residents and Citizens of New Zealand only. It is accurate on date of publication.

For more information: [www.moh.govt.nz/eligibility](http://www.moh.govt.nz/eligibility)
5.1 Primary Care Update Quarter 1, 2014/15

Recommendation:

That the report be received.

Prepared by: Tim Wood (Deputy Director, Funding and Development; Manager Primary Care), and Dr Stuart Jenkins (Clinical Director Primary Care)
Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

ALT - Alliance Leadership Team
CMH - Counties Manukau Health
CPSA - Community Pharmacy Services Agreement
CT - Computed Tomography [radiology imaging]
CVD - Cardiovascular Disease
DAR - Diabetes Annual Review
DCIP - Diabetes Care Improvement Package
DE - Developmental Evaluation
DHB - District Health Board
DM - Diabetes Mellitus
EDAT - Ethnicity Data Audit Tool
EOI - Expression of Interest
GP - General Practitioner
IFHC - Integrated Family Health Centre
IPIF - Integrated Performance and Incentive Framework
ISG - Implementation Support Group
JPSG - Joint Project Steering Group
LEGG - Locality Establishment Governance Group
MH - Mental Health
MoH - Ministry of Health
MRI - Magnetic Resonance Imaging [radiology imaging]
NGOs - Non-Government Organisations
NHT - National Health Targets
NZ - New Zealand
PHO - Primary Health Organisation
POAC - Primary Options for Acute Care
Q - Quarter
QIT - Quality Improvement Team
SMOs - Senior Medical Officers
VDR - Virtual Diabetes Register

1. Summary

This report provides an update on primary care activities within the Auckland and Waitemata District Health Board areas during the first quarter of the 2014/15 financial year. The report is presented in the following sections:

- National Health Targets
- Integrated Performance Incentive Framework
- Progress against the 2014/15 Annual Plan Deliverables.
2. National Health Targets

The Primary Care Scorecard (see Figure 1) is a standardised tool that is used by both Auckland and Waitemata District Health Boards (DHBs) to internally review and track their performance against a range of measures including the National Health Targets (NHT). Given the DHBs’ focus on health targets, these are presented first in the scorecard. Where appropriate, indicators are presented with performance by ethnicity.

How to read the Scorecard

For each measure, the green bar reflects how well we are doing against the target for the period presented. The bar will begin to show green when the target has been partially achieved. For most indicators, this is once 60% of the target has been met. If performance is meeting target or better than target the bar will display as a solid green line. For the Health Targets, the scale is more sensitive as any variance is deemed to be significant. The bar will only begin to show green once 80% of the target is achieved. 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.

Figure 1: Auckland & Waitemata DHB Primary Care Scorecard

The Scorecard above (see Figure 1) shows for each measure the actual performance of both DHBs during quarter one 2014/15 against target. This is described in detail as follows:
I. Better Help for Smokers to Quit – Primary Care Health Target Q1, 2014/15

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 Integrated Performance Incentive Framework (IPIF – see Section 2) and are as reported in the Ministry of Health (MoH) DHB performance tables. Both Auckland and Waitemata DHBs have maintained achievement of the primary care ‘better help for smokers to quit’ health target. All of the PHOs continue to have a focus on maintenance and achievement of the target. They have project teams dedicated to ensuring that people who smoke receive advice and help to quit.

The initial quarter one results released by the MoH are as follows; these are also shown in the Scorecard under Health Targets as well as by the bar chart below:

- Auckland DHB 99.8%, ↑0.1% from the previous quarter; and
- Waitemata DHB 99.2%, ↓2.3% from the previous quarter.

All PHOs are prioritising high needs populations in their programmes to support people to quit smoking.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>Needs updating on 20th Nov</td>
<td>Needs updating on 20th Nov</td>
<td>99.8%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>Needs updating on 20th Nov</td>
<td>Needs updating on 20th Nov</td>
<td>99.2%</td>
</tr>
</tbody>
</table>

PHOs report monthly to the DHBs on their performance against this target. More frequent reporting is not possible. The PHOs have now updated their plans for 2014-15 to ensure sustainable achievement of the target. A focus of the plans is on embedding the provision of support to quit as a clinical intervention that is part of ‘usual care’ for general practices.

Auckland and Waitemata DHBs are building on the success of the brief advice ‘better help for smokers to quit’ Health Target, by adding a local target for Cessation Support. Supported quit attempts, rather than brief advice on its own, leads to better quit rates. As the reporting for the
‘better help for smokers to quit’ health target, has been on ‘brief advice’ this has been where the
effect of DHBs, PHOs and GPs has been focussed. For many this has not followed through into
providing ‘support to quit’. By setting a local target for Cessation Support, we aim to reinforce
the importance of providing both advice and support to quit. The Primary Care Team are
currently working with the PHOs to agree on a figure for this target.

II. More Heart and Diabetes Checks Health Target Q1, 2014/15

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

The ‘More Heart and Diabetes Checks’ results are produced by the IPIF (see Section 2) and are as reported by the MoH DHB performance tables. The quarter one denominators are 143,103 for Waitemata DHB and 152,337 for Auckland DHB. The denominator increase between quarter four 2013-14 and quarter one 2014-15 for Waitemata DHB was 1031. The denominator decrease between quarter four 2013-14 and quarter one 2014-15 for Auckland DHB was 557.

The initial quarter one results released by the MoH are as follows; these are also shown in the Scorecard under Health Targets as well as by the bar charts below:

- **Auckland DHB 91.7%** (139,644 people assessed)
  - Total coverage ↓0.2% from quarter Four. This is first in the country.
  - Coverage for Māori ↓ 0.1% (to 88.2%) and for Pacific ↓1.3% (to 89.8%). Auckland DHB is first in the country for Māori coverage and is third in New Zealand for Pacific coverage.

- **Waitemata DHB 89.7%** (128,413 people assessed)
  - Total coverage ↑0.5% from quarter four. This is first in the country.
  - Coverage for Māori ↑0.1% (to 83.5%) and for Pacific ↑0.2% (to 87.6%). Waitemata DHB is fifth in the country for Māori coverage and is fourth in New Zealand for Pacific coverage.
The impact of the rolling cohort means that people are moving in and out of the age bands, and people assessed more than five years ago are adding to the number of required assessments.

The increase in assessments has been achieved through:

- Practice support to run outreach clinics
- Providing funding for phlebotomy and extra nurse resource
- Purchasing a Point of Care testing machine to collect blood results easily
- Tools to identify patients who have not had a risk assessment
- Weekly target meetings at the PHO and practice level
- Virtual assessments through Patient Management Systems and Dr Info queries
- Text to remind and home visits to complete assessments.

The Planning, Funding and Outcomes team continues to meet with the PHOs on a monthly basis to discuss coverage and activities undertaken to maintain the 90% target. Recent meetings have focused on increasing coverage for Maori and Pacific people.

The Ministry of Health have confirmed the bonus funding available to the PHOs who achieved the 2013-14 target of 90%. This funding will be available to four of the five PHOs in the Auckland and Waitemata DHBs from 30 November 2014. Waitemata PHO will not receive bonus payment. The Planning, Funding and Outcomes Unit have yet to confirm the deliverables for the funding. We have contacted the PHOs indicating the funding available and the activities we would like this focused on. This includes increasing assessment rates for Maori and Pacific people, workforce education and management of people with high risk profiles.

**Improving Population Health - Diabetes Annual Reviews (DARs)**

| Q3   | Q4   | Q1   | Q2   | Q3   | Q4   | Q1   | Q2   | Q3   | Q4   | Q1   | 2011/12 | 2012/13 | 2015/14 | 2014/15 |
|------|------|------|------|------|------|------|------|------|------|------|--------|---------|---------|---------|---------|
| ADHB | WDHB | ADHB | WDHB | ADHB | WDHB | ADHB | WDHB | ADHB | WDHB | ADHB |        |         |         |         |         |

The good diabetes management targets for 2013/14 are: 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.

Both DHBs’ performance is shown in the Scorecard under improving Population Health (diabetes) and is described below:

**Auckland DHB**

Auckland VDR population enrolled with general practice is 25,697. This includes:

- 1,783 Maori
- 5,790 Pacific people
- 3,944 Indian people
- 73% of the VDR population have an HbA1c of <64 mmol/mol
- 78% of Maori with diabetes have good management
- 63% of Pacific people have good management
- 71% of Indian People have good management
- there has been a 3% increase in good diabetes control as measured by HbA1c over the last quarter.

All four PHOs continue to implement their DCIP plans. The PHOs have been focused on ensuring people have their annual review and are receiving evidence based care. This includes meeting their PHO Performance Programme targets.

The community podiatry programme for people with diabetes has been rolled out by three of the four PHOs. ProCare Networks Limited will have the referral form installed in the ProXtra system no later than 30 November 2014. This will enable general practice to refer people with moderate and high risk foot conditions to the service.

**Waitemata DHB**

Waitemata VDR population enrolled with general practice is 28,845. This includes:

- 2,064 Maori
- 3,717 Pacific people
- 2,147 Indian people
- 76% of the VDR population have an HbA1c of <64 mmol/mol
- 63% of Maori and Pacific people with diabetes have good management
- 75% of Indian People with diabetes have good management

Services for the management of people with complex health needs related to diabetes continue in general practice through the DCIPs. 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.

**Service Delivery Targets – PHO Enrolment**

PHO enrolment for Auckland DHB is at 92% and Waitemata DHB is at 95% which have remained unchanged from the last quarter of the last financial year. Pacific enrolment is over target for both DHBs – 116% in Auckland DHB and 99% in Waitemata DHB. Māori enrolment rates (Auckland DHB on 85% and Waitemata DHB on 82%) have also remained mostly unchanged for both DHBs.
compared to the last quarter of 2013/14.

Asian enrolment rates are 71% and 80% for Auckland DHB and Waitemata DHB respectively and have remained largely unchanged from quarter four of 2013/14. Also Asian enrolment remains lower than those of other ethnicities for both DHBs.

An Asian Migrant and Refugee project manager role has been recruited to, covering parental leave of the Asian, Migrant and Refugee Manager. This role will work with the Primary Care Team to focus on primary care projects aimed at increasing Asian PHO enrolment. A piece of work is underway to investigate barriers/enablers to Asian PHO enrolments and access to primary care. Oversight is provided from the Auckland Regional Primary Care Working Group focusing on Asian, Middle Eastern, Latin American, African (MELAA) Migrant and Refugee Health.

3. Integrated Performance Incentive Framework

The Integrated Performance and Incentive Framework (IPIF) is a quality improvement programme that will support the health system to address equity, safety, quality, access and cost of services. The IPIF has been developed by clinicians, sector leaders and the Ministry of Health. 2014/15 is Phase One and is a transition year moving from the PHO Performance Programme. The phased implementation approach to IPIF has now been agreed.

The following five PHO performance indicators, focused on the three preventative primary National Health Targets, have been agreed, along with the proposed weightings as shown in the table below:

<table>
<thead>
<tr>
<th>IPIF Indicator</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks (CVD/DM) – National Health Target</td>
<td>25%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit (Tobacco) – National Health Target</td>
<td>25%</td>
</tr>
<tr>
<td>Increased Immunisation - National Health Target – 8 Months</td>
<td>15%</td>
</tr>
<tr>
<td>Increased Immunisation - National Health Target-2 Year Olds</td>
<td>10%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>25%</td>
</tr>
</tbody>
</table>

Each quarterly payment will be calculated on the basis of the PHO’s performance in each quarterly period during the year commencing on 1 July 2014. The DHB will pay the proportion of the quarterly pool for the quarterly target as set out in the table above.

All PHOs are expected to meet and/or maintain performance at the national target by 30 June 2015. Quarterly targets have been set for individual PHOs (as shown in the tables below under each PHO) to enable them to reach the national targets after four quarters.

The 2014/15 targets for Auckland PHO are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 2014/15</th>
<th>Q2 2014/15</th>
<th>Q3 2014/15</th>
<th>Q4 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>87.8%</td>
<td>88.6%</td>
<td>89.3%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>68.2%</td>
<td>75.5%</td>
<td>82.7%</td>
<td>90.0%</td>
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<tr>
<td>Increased Immunisation – 8 Month Olds</td>
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<td>93.7%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
<td>93.8%</td>
<td>94.2%</td>
<td>94.6%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
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</table>
The 2014/15 targets for **ProCare** are:

<table>
<thead>
<tr>
<th>Indicator</th>
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<th>Q3 2014/15</th>
<th>Q4 2014/15</th>
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<td>88.0%</td>
<td>89.0%</td>
<td>90.0%</td>
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<tr>
<td>Better Help for Smokers to Quit</td>
<td>74.4%</td>
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<td>Increased Immunisation - 8 Month Olds</td>
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<td>94.5%</td>
<td>95.0%</td>
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<tr>
<td>Increased Immunisation – 2 Year Olds</td>
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<td>94.9%</td>
<td>95.0%</td>
<td>95.0%</td>
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<tr>
<td>Cervical Screening</td>
<td>79.0%</td>
<td>79.3%</td>
<td>79.7%</td>
<td>80.0%</td>
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</tbody>
</table>

The 2014/15 targets for **Waitemata PHO** are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 2014/15</th>
<th>Q2 2014/15</th>
<th>Q3 2014/15</th>
<th>Q4 2014/15</th>
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<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>80.1%</td>
<td>83.4%</td>
<td>86.7%</td>
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<tr>
<td>Better Help for Smokers to Quit</td>
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<td>73.5%</td>
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<td>Increased Immunisation - 8 Month Olds</td>
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<td>94.4%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Increased Immunisation – 2 Year Olds</td>
<td>93.6%</td>
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<td>94.5%</td>
<td>95.0%</td>
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<tr>
<td>Cervical Screening</td>
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<td>80.0%</td>
<td>80.0%</td>
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</tr>
</tbody>
</table>

The 2014/15 targets for **Alliance Health Plus (hosted by CMDHB)** are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 2014/15</th>
<th>Q2 2014/15</th>
<th>Q3 2014/15</th>
<th>Q4 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>85.6%</td>
<td>87.1%</td>
<td>88.5%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>83.9%</td>
<td>86.0%</td>
<td>88.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Increased Immunisation - 8 Month Olds</td>
<td>92.5%</td>
<td>93.3%</td>
<td>94.2%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Increased Immunisation – 2 Year Olds</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>73.9%</td>
<td>75.9%</td>
<td>78.0%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

The 2014/15 targets for **National Hauora Coalition (hosted by CMDHB)** are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 2014/15</th>
<th>Q2 2014/15</th>
<th>Q3 2014/15</th>
<th>Q4 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>83.8%</td>
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<td>87.9%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>83.1%</td>
<td>85.4%</td>
<td>87.7%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Increased Immunisation - 8 Month Olds</td>
<td>88.9%</td>
<td>90.9%</td>
<td>93.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Increased Immunisation – 2 Year Olds</td>
<td>91.5%</td>
<td>92.6%</td>
<td>93.8%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>73.6%</td>
<td>75.7%</td>
<td>77.9%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

The information on the actual performance during the first quarter of 2014/15 against the above-mentioned IPIF targets is expected to be released by the MoH on 20th November. This information will be added to this report as soon as possible after the receipt of the MoH information.
IPIF Measures, Incentives and Reporting

Recently the DHBs have been advised by the MoH that the IPIF Joint Project Steering Group (JPSG) has proposed the following life stage system level measures for introduction in 2015/16, however this is yet to be confirmed:

- Healthy Start
- Healthy Ageing
- Capability and Capacity

The IPIF measures lie at the heart of an integrated health system. The JPSG advice will be considered by the MoH and once agreed the recommended measures will be incorporated into the DHB annual planning process.

IPIF Indicators by Ethnicity and High Need Populations – Placeholder

It is to be noted that the new IPIF indicators do not require reporting by ethnicity/high needs. The Planning, Funding and Outcomes Unit will work with the PHOs to reinstate ethnicity level reporting.

4. Progress Against the 2014/15 Annual Plan Deliverables

I. Auckland Waitemata District Alliance

The Waitemata and Auckland DHBs, Te Rununga O Ngati Whatua, Te Whanau O Waipareira and PHOs that have provider members with enrolled populations in the Waitemata and Auckland DHB geographic areas have agreed to form a District Alliance. The Alliance has agreed to work together in a collective and cooperative way to plan and deliver health services that support the needs of our communities and localities.

The Alliance Agreement was signed on 10th September 2014. The Agreement includes accountability, the sharing of information and resources so that we are collectively responsible for performance and best use of resources. The Alliance Leadership Team has commenced monthly meetings since July 2014. It is envisaged that the Alliance will build on the work to date and will work to develop a more cohesive, accessible, efficient, effective, safe and sustainable health system for our community through pursuing the following goals:

- Create conditions for patient and whanau determined care through a local approach to empower individuals to make informed decisions about their healthcare e.g. greater flexibility in the way services are provided or in what providers do.
- Increase integration of community, primary care, secondary care health services and social services through local and a whole of system approaches for our future health system.
- Build capability and capacity across the sector by increasing the scope of primary care.
- Support, where appropriate, infrastructure development within primary care.
- Reduce health inequalities through reorientation of the sector so that individuals and communities are supported to improve their own lives.
- Support clinical governance through engagement with clinicians and design of services and change process that enable the achievement of desired outcomes.
• Drive performance through quality improvement, transparent reporting and effective mechanisms for public accountability from the Alliance.

We acknowledge that the Alliance will develop over time, establishing the work programme to jointly achieve the National Health Targets and the goals identified in the Regional Health Plan, District Annual Plan, and the Integrated Performance Incentive Framework.

II. Auckland Waitemata Rural Service Level Alliance

The focus of the Rural Service Level Alliance is to explore the options around retaining and improving services to the rural communities in the Auckland and Waitemata districts. The Alliance will provide a more ‘fit for purpose’ arrangement that promotes and facilitates service planning and integration, supports service development and enables management of funding and financial risk in a shared risk framework.

A rural alliance proposal is being consulted on with the stakeholders. The proposed scope of the Rural Alliance is as follows:

• Provision of a rural lens on DHB service development which means that the DHB will engage with the Rural Alliance Leadership Team to obtain a rural perspective
• Oversee a programme of work to provide advice to the DHBs on opportunities to improve health care services in rural communities.
• Oversee and provide direction in an advisory capacity for service review, including endorsement of advice to the Auckland Waitemata District Alliance and or to the Board of Auckland/Waitemata District Health Board(s).
• Oversee and provide direction in an advisory capacity on any rural health workforce development and planning activity.
• Oversee and provide direction in an advisory capacity for any agreed work programmes with a focus on health care for rural communities.

The key goal of the Rural Alliance is to promote clinical leadership in the health system, producing aligned clinical and financial accountability and supporting patient centred clinically led decision making in health services. It is proposed that the Rural Alliance adopts the goals developed and agreed by the Auckland Waitemata District Alliance (see previous section).

III. Support implementation of Phase 4 of the Community Pharmacy Services Agreement

A meeting to provide information to the Metro Auckland community pharmacies is scheduled on 18 November 2014. This meeting is being run in collaboration with DHB Shared Services and the Ministry of Health. The following topics will be discussed in the meeting:

• Stage 4 payment information in the pharmacy portal
• The latest on the NZ Electronic Prescribing Service
• Medicines Management Action Plans and,
• The proposed CPSA 12 Contract Extension process and timelines.

Pharmaceutical Waste Management
The current agreement with community pharmacies neither addresses the issue of cytotoxic waste management nor does it address the provision of sharps disposal containers for use by patients at home. There is lack of consistency in that it does not link reimbursement to the cost of
disposal. To ensure a safe, effective, accessible, efficient and affordable waste management system is in place the Metro Auckland DHBs have proposed a standardised waste management solution across the region. This proposal has been endorsed by the Metro Auckland Pharmacy Advisory Group, who will provide governance oversight of this initiative. Consultation on this with the community pharmacies commenced on 01 November, 2014.

IV. Complete Review of Health Services on Waiheke Island 31 March 2015

A stocktake of services provided on Waiheke Island and subsequent gap analysis is underway. Close engagement with service providers is being maintained throughout this process. This is also a key focus of the Rural Service Level Alliance.

V. Continue to Support the Regional Primary Options for Acute Care Services

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.

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 DHB performance in quarter one 2014/15 is as follows:

- The total number Auckland Metro POAC referrals (July - Sept 2014) was 6% below the target (see table below). Counties is 36% below target and Auckland is 24% below target while Waitemata is 50% above target volumes for the quarter.
- Overall, the total referrals received increased by 24% compared with 5,020 for the same period in the previous year.
- The average cost per referral remains lower across the whole region compared with the same time last year. This can be attributed to changes in clinical policies and revised provider agreements. In addition, the percentage of lower cost St John pathway patients being referred has kept the average costs down.
- 86% of patients were safely managed in the community and avoided hospital presentation.
- Referral volumes for Cellulitis across all DHBs have reduced compared with the same quarter in 2013.

**POAC referrals** for Metro Auckland DHBs (July – September 2014)

<table>
<thead>
<tr>
<th>POAC referrals</th>
<th>Auckland</th>
<th>Waitemata</th>
<th>Counties</th>
<th>Auckland Metro</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target number of POAC referrals</td>
<td>1511</td>
<td>1630</td>
<td>3080</td>
<td>6221</td>
</tr>
<tr>
<td>Actual number of POAC referrals</td>
<td>1142</td>
<td>2452</td>
<td>2267</td>
<td>5861</td>
</tr>
<tr>
<td>Difference between target and actual</td>
<td>-369</td>
<td>822</td>
<td>-813</td>
<td>-360</td>
</tr>
<tr>
<td>Avg cost per referral (excl. GST), budget $200.00</td>
<td>$189.00</td>
<td>$177.92</td>
<td>$189.67</td>
<td></td>
</tr>
</tbody>
</table>
The Auckland Waitemata DHB primary care team is working with the providers to undertake analysis of current utilisation with a focus on access for the high needs population.

VI. Integrated Models of Care

a) Mental Health stepped care pilots complete with approved roll out plans by 30 June 2015
A draft project implementation plan has been completed in partnership with ProCare, Waitemata DHB and Auckland DHB for establishment and refinement of a collaborative stepped care model to be piloted in the New Lynn Integrated Family Health Care Centre. This will be evaluated to inform the potential to roll out across primary care.

b) The Waitemata DHB Cognitive Impairment Clinical Pathway Evaluated by January 2015
The 9 month Waitemata DHB Cognitive Impairment Clinical Pathway Pilot ended on 31 July 2014. The Department of Geriatric Medicine, University of Auckland is evaluating the Pilot. This includes interviewing patients and family carers; GPs and Practice Nurses; PHO representatives; Alzheimer’s Auckland; and secondary care geriatric services clinicians. The evaluation report is due by 31 January 2015 and will form the basis of recommendations to the DHB Boards for approval regarding rollout of the pathway. In collaboration with the Pilot the Waitemata DHB Cognitive Impairment Clinical Pathway has been uploaded onto the Northern Region Clinical Pathways electronic dynamic format and is currently, along with four other pathways, in proof-of-concept testing.

c) Palliative care model agreed and implementation initiated by 1 April 2015
The Palliative care model of care was approved and finalised in October 2013. A Clinical Governance Group has been in operation since March 2014 and is currently overseeing the work of a sub group. The subgroup is composed of senior medical officers (SMOs) in palliative medicine.

The group has been in place since July 2014. They have been working on one element of the model of care, relating to improving the current SMO resourcing model and therefore improving equity of access to palliative care specialists for patients. The model under development refers to a network approach whereby a central pool of palliative medicine specialists is created who work collaboratively to effectively serve the needs of patients throughout the district.

The group has reviewed the various options of a collaborative model, conducting and documenting a risk benefit analysis on each option. The paper was reviewed by the Clinical Governance Group on the 30th October 2014 and received full endorsement from all members. The paper will be going to the Hospice Governance Group and the DHB Board for approval by December 2014.

VII. Regional After Hours Network (ADHB)

An afterhours business case has been developed and been approved by relevant stakeholders. The development of a procurement process to identify suitable service provider(s) is progressing. Additionally work is being initiated on the development of a quality framework for these services.
VIII. Localities Development

a) Tamaki Locality

The project has gathered momentum over the past few months and there are approximately forty people from diverse backgrounds working across the project teams which have been formed around the three workstreams which are:

- Workstream 1: Enabling better mental health service provision by primary care providers
- Workstream 2: Providing effective linkage between General Practice and the Community
- Workstream 3: Enabling the community to effectively support positive mental health and wellness.

A co-production framework has been agreed and a developmental evaluation (DE) is ongoing. This DE process is guiding the work of the work streams and ensuring that they adhere to the agreed co-production way of working. This evaluation process will also produce a resource for community initiatives that Auckland and Waitemata DHBs can draw on for future community development work.

The project teams are shaping a wide range of projects, the majority of which will begin implementation in January/February 2015

Workstream 1 is developing projects in the following areas:

- The better utilisation of NGOs
- Improving the interface between primary and secondary care
- Contextualising mental illness within a social context for patients
- Psychiatry phone line for GPs
- Mental Health professional development and education for nurses.

Workstream 2 is focusing on developing a point of contact for people to connect with community resources which will support individuals and Whanau to access and understand social supports which keep them well and to understand and access Primary Mental Health and social support. This is being led by the mental health NGOs. This group has set a timeline for the development of this project:

- A range of adult and youth focus groups to be held in mid-November to ascertain what people want from a Navigation service and how it would best fit with the local context.
- Early December: Outline service specification developed
- Before Christmas: Small EOI for MH NGOs operating in Tamaki to develop the pilot
- Late Jan-Early Feb: Implement pilot.

Workstream 3 has well developed plans and is moving ahead at pace. The key projects and developments in this stream are:

- To create an integrated network of wellbeing hubs. This project aims to work with existing hubs to develop an integrated network for both local communities and communities of interest. The possibility of developing a purpose built centre through harnessing the proposed redevelopment of a large part of central Glen Innes by Auckland Council, Tamaki Redevelopment Company and the Local Board is being discussed with the above parties as well as ADHB and Ngati Whatua.

- Trialling new ways of working with families where one stop service provision is provided to families who have health and social needs. Two key project areas have been identified under this project banner:
– Working with ‘High Involvement’ individuals selected from existing initiatives within Tamaki
– Working with ‘Engaged Families’ who are trying to improve their wellness but need some extra support to reach the next stage. This group was supported to develop an EOI that has been submitted to Pasifika Futures for this initiative.

- Developing a wellbeing framework for Tamaki which will include undertaking baseline research in order to gain a robust understanding of current levels of wellbeing and to measure the impact of improvement initiatives. Following our submission to the Local Board they have adopted the proposal to partner with ADHB the development of a wellbeing plan for Tamaki in their three year strategic plan.

b) West Rodney Locality

Project structure
- At the August 2014 Auckland North localities operational group meeting it was confirmed that the Localities Establishment Governance Group (LEGG) will cease and the localities work will be overseen by the Alliance Leadership Team.

Child Oral Health Project
- The project goal is to connect services and inform families/whānau of the importance of oral health and services available to them. The aim is to ultimately improve child oral health outcomes for West Rodney communities.
- The West Rodney preschool oral health survey closed on 30 September 2014. This was a paper-based survey distributed through West Rodney preschools, general practices, Plunket and other local providers. The survey measures parent/caregivers knowledge of good oral health and their knowledge of what dental services are available for them. Given the survey is paper-based there will be some delay in getting all the returned survey data recorded and analysed. It is expected this will be completed during October.
- In terms of health literacy, we continue to work with ARDS to develop a knowledge base to inform an oral health information pamphlet.
- We have developed a spread sheet which identifies where the transportable dental units are scheduled to attend from August 2014 to March 2016. The next stage is to develop this into a simplified resource for the community.

Newborn Enrolment
- Initial work has begun to investigate a Single Newborn Enrolment Process, with members of the Child Health team meeting over the past few months to scope this project. Work continues to finalise a project scope so that we can more formally engage and work with these key stakeholders to develop a suitable model.

Community Engagement
- The South Kaipara Health and Wellbeing Festival event was held in Parakai in September. This was a free family event celebrating and learning about health and wellbeing in South Kaipara, organised by Healthlink North. There was an excellent turnout of health and wellbeing service providers for the community to engage with, and lots of positive feedback following the event has been received. Waitemata DHB and other local health services present at the festival included: Bowel screening pilot, Waitemata DHB South Kaipara Services, Kaipara Medical Centre, Waitemata DHB South Kaipara Services, Te Ha Oranga Helensville, Waitemata DHB Maternity Unit and the Auckland Regional Dental
Service. Healthpoint also had a stall and were able to show people how to use the Healthpoint site to search for health services close to them.

c) West Auckland Locality - Implement West Auckland locality – diabetes and child health pathways in all general practices by 30 June 2015

Child Health Pathway
- Three new child health pathways were launched during the last quarter, and these include Acute Asthma Paediatric; Cough >4 Weeks; and Constipation Paediatric. Overall, utilisation of the health clinical pathways has continued to improve.

The implementation of the Quality Improvement Team (QIT)
- Recruitment was finally successful with a Registered Nurse accepting the position who commenced work in July 2014. Twelve West Auckland practices have been prioritised to work with the QIT to improve diabetes care focusing on Māori and Pacific populations. The practices have been briefed about the project and the nurse’s role through a letter and site visits accompanied by the respective PHOs.
- Data sharing and extract of clinical indicators has been agreed in principle by the PHO’s using their IT auditing tools (Mohio, Medtec Evolution and Dr Info.)

IX. Improving PHO Enrolment especially among high need populations

The Ethnicity Data Audit Tool (EDAT) implementation has started in general practices in the Auckland and Waitemata DHBs. The EDAT provides a resource for assessing the quality of ethnicity data in primary care settings including systems for ethnicity data collection, recording and output. The tool also provides guidance on quality improvement activities including the regular repetition of the EDAT and suggests remedial action for areas identified as requiring improvement. Currently 50 general practices have implemented EDAT (21% of the 240 general practices within Auckland and Waitemata districts) but it is too early to assess whether this audit tool has actually improved ethnicity collection and recording in primary care.

5. Others

I. Primary Mental Health
The Primary Mental Health service specification outlines a stepped care model which is regionally consistent across Waitemata and Auckland DHBs where possible. The service, with the exception of the Prime Minister’s Youth Mental Health Initiative, 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.

Auckland DHB
- The Primary/Secondary Integration Strategic Group and the linked Tāmaki Locality Mental Health Project continue to look at opportunities for increased integration between primary and secondary mental health services (please see section VIII Tamaki Locality under Localities Development)
- The Youth Alliance, led by ProCare PHO, provides primary mental health interventions to youth aged 12 to 19 years.

2014/15 quarter one volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland PHO</th>
<th>ProCare</th>
<th>AH+</th>
<th>NHC</th>
<th>Youth Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>53</td>
<td>1116</td>
<td>25</td>
<td>18</td>
<td>42</td>
</tr>
<tr>
<td>Māori</td>
<td>117</td>
<td>405</td>
<td>11</td>
<td>88</td>
<td>26</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>133</td>
<td>310</td>
<td>136</td>
<td>69</td>
<td>59</td>
</tr>
<tr>
<td>Asian</td>
<td>27</td>
<td>186</td>
<td>18</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>325</td>
<td>38</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Q1 Total</td>
<td>333</td>
<td>2342</td>
<td>228</td>
<td>180</td>
<td>146</td>
</tr>
<tr>
<td>Q1 Target</td>
<td>86</td>
<td>360</td>
<td>106</td>
<td>77</td>
<td>104</td>
</tr>
</tbody>
</table>

Utilisation of services is currently under review. The DHB and the providers are working together to better understand utilisation against the current Agreement.

**Waitemata DHB**

- The Raeburn House service is being reconfigured to support the PHO delivery of primary care interventions. This will support PHOs to deliver increased volumes.
- In previous years Waitemata DHB has funded PHOs by enrolled population. For 2014/15 Waitemata DHB has moved to funding by enrolled Māori/Pacific and Q5 population. Due to the significant changes in PHO funding this will cause, Waitemata DHB has agreed to stagger this funding change over 2014/15.
- HealthWest provide primary mental health interventions to youth aged 10 to 24 years as part of the Waitemata Youth Health Hub.
- 2014/15 quarter one volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Waitemata PHO</th>
<th>ProCare</th>
<th>HealthWest</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>339</td>
<td>450</td>
<td>205</td>
</tr>
<tr>
<td>Māori</td>
<td>45</td>
<td>272</td>
<td>160</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>17</td>
<td>91</td>
<td>43</td>
</tr>
<tr>
<td>Asian</td>
<td>26</td>
<td>46</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>72</td>
<td>21</td>
</tr>
<tr>
<td>Q1 Total</td>
<td>444</td>
<td>931</td>
<td>442</td>
</tr>
<tr>
<td>Q1 Target</td>
<td>320</td>
<td>553</td>
<td>357</td>
</tr>
</tbody>
</table>

- Utilisation of services is currently under review. The DHB and the providers are working together to better understand utilisation against the current Agreement.

**II. Access to Diagnostics - Radiology**

A regional Access to Diagnostics Radiology steering group helps 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 actual vs. regionally agreed target regarding wait time for accepted routine community referred radiology is as follows:

<table>
<thead>
<tr>
<th>DHB</th>
<th>CT Target</th>
<th>CT Actual</th>
<th>CR Target</th>
<th>CR Actual</th>
<th>MRI Target</th>
<th>MRI Actual</th>
<th>US Target</th>
<th>US Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
<td>90%</td>
<td>64%</td>
<td>85%</td>
<td>89%</td>
<td>85%</td>
<td>80%</td>
<td>75%</td>
<td>46%</td>
</tr>
<tr>
<td>CMH</td>
<td>90%</td>
<td>84%</td>
<td>85%</td>
<td>96%</td>
<td>85%</td>
<td>86%</td>
<td>75%</td>
<td>76%</td>
</tr>
<tr>
<td>WDHB</td>
<td>90%</td>
<td>95%</td>
<td>85%</td>
<td>99%</td>
<td>85%</td>
<td>64%</td>
<td>75%</td>
<td>96%</td>
</tr>
</tbody>
</table>

Note: for MRI, Waitemata DHB performance is expected to improve over the next six months as the new MRI scanner becomes fully operational.

For ADHB the 2014/15 YTD expenditure is $73K against the allocated budget of $125K i.e. underspent by $52K. On average 2/3rd of general practices in the Auckland DHB area are referring to this service.

About 43% of all referrals in the Q1 have been submitted through the ProExtra tool. Out of these referrals almost half are of European ethnicity whereas Maori was 8% and Pacific was 16% and a quarter belonged to quintile 5.
5.2 Planning, Funding and Outcomes Update

Recommendation:
That the report be received.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Ruth Bijl (Funding and Development Manager Child, Youth and Women’s Health), Kate Sladden (Funding and Development Manager Health of Older People) and Marty Rogers (Maori Health Gain Manager)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Simon Bowen (Director Health Outcomes)

Glossary

ADHB - Auckland District Health Board
AISA - Approved Information sharing Agreement
ARRC - Age Related Residential Care
B4SC - Before School Check
BPS - Better Public Services
DHB - District Health Board
DSS - Disability Support services
EDAT - Ethnicity Data Audit Tool
HBSS - Home Based Support Services
HCSS - Home and Community Support Services
HOP - Health of Older People
ISPS - Independent Service Providers
LTCF - Long Term Care Facility
LTS-CHC - Long Term Support for Chronic Health Conditions
MSD - Ministry of Social Development
NASC - Needs Assessment Service Coordination
NCSP - National Cervical Screening Programme
NHB - National Health Board
NSU - National Screening Unit
PG - Psychogeriatric
PHO - Primary Health Organisation
VIKI - Vulnerable Kids Information System
WTCO - Well Child/Tamariki Ora

1. Planning

Waitemata DHB Annual Plan is being resubmitted to the National Health Board (NHB) this week, along with our Annual Report which has been given clearance by the auditors and printed. The Statement of Intent and Statement of Performance Expectations will be extracted as separate documents from the Annual Plan and tabled in Parliament along with our Annual Report by 26 November 2014.

Work on the summary Health Needs Assessments for both DHBs is largely complete.
The 2015/16 draft Annual Planning package has been released by the NHB and is available on the NSFL website. The Waitemata DHB Planning Day will be held on 15 January 2015, the ADHB Planning Day on 22 January 2015.

The new Community Engagement Manager will commence in post on 1 December 2014.

2. Women, Children and Youth

2.1 Child Health

Immunisation

Health Target – Immunisation – 95% of 8 month olds fully immunised by Dec 2014.

![Bar chart showing percentage of 8 month olds fully immunised by DHB]

Achieving the immunisation health target is a major challenge. To achieve the target, all eligible infants must receive a series of interventions based on the 6 week, 3 month and 5 month scheduled vaccines. Vaccines need to be spaced and timed to achieve an optimal immune response, amongst other reasons. Results to date against the immunisation health targets have been little short of remarkable as gains of over 20 per cent have been achieved over the last few years. To achieve 95 per cent, a perfect system needs to wrap around the three vaccination events. The system response includes health promotion, engagement of families with primary care, pre-call and re-call systems, outreach services and a strong child health information management system (the National Immunisation Register). Examples of some of the challenges with achieving this target include:

- families for whom there is a delay in the timing of vaccines due to life events (such as holiday seasons) and for whom delivering the schedule in a timely way is difficult to achieve (this is not uncommon, particularly around Christmas)
- families with few resources may have challenges to accessing a family doctor for example, existing debt, lack of transport, no-one to look after the siblings.
- an infant who arrives in the DHB or country under the age of 8 months and therefore is included in the target population but due to the vaccine intervals cannot be vaccinated on time (this is not uncommon in metro Auckland)
- a family that feels uncomfortable about immunisation and considers that ‘splitting’ vaccines is ‘easier’ on the infant, though the evidence does not support this (this is not common but still happens)
an infant who has an illness or condition that means it is not safe to immunise them as their immune system is compromised (this is rare).

Nationally, the single biggest challenge is for those DHBs with high decline rates. Decline rates have decreased significantly along with the increase in immunisation coverage. National decline rates range from 1 – 20%.

At this time, ADHB is on track, Waitemata DHB is not on track, to achieving the target of 95% of 8 month olds fully immunised by December 2014.

Status as at 01 November 2014 is:
- Auckland DHB – 95% (All)
  - 92% Maori
  - 97% Pacific
  - 98% Asian
  - 91% Other
- Waitemata DHB – 92% (All)
  - 88% Maori
  - 95% Pacific
  - 97% Asian
  - 86% Other

Declines in the Waitemata area continue to be a challenge. The decline rate remains steady at around 4 per cent, though it has dropped over the last few years from around 7 per cent. Actions have been discussed with the PHOs to address this, with the current focus on up skilling staff in high decline practices.

The key strategies being pursued to achieve the target are:

Health promotion, with current examples of work under way in these areas including:
- An article promoting on-time immunisation is planned with the North Shore Times and the Western leader newspapers with appropriate local people involved.
- The design for the promotional t-shirts for practice staff agreed and now in production. A slogan competition was run for practice staff to complement national immunisation branding. The winning slogan was “Kids need hugs not bugs. Immunise.”
- Health systems, with current examples of work under way in these areas including:
  - All PHOs nominating a Newborn Enrolment Champion
  - Development of practice level processes to improve acceptance of NIR nominated newborns.
  - Working with PHOs and practices to review processes and improve on-time immunisations leading up to the 6 month milestone.
- Developing a regional immunisation coordination model that will:
  - Introduce additional Immunisation Coordinator roles in the Waitemata DHB region.
  - Include support for pharmacies and other immunisation providers
  - Move clinical assessments for authorised vaccinators to PHO responsibility.
**Children**

The DHB will be taking a more active role in Well Child/Tamariki Ora (WCTO) services. The major provider in the DHB areas is Plunket. Plunket is contracted under a national agreement by the Ministry of Health. Plunket is working to improve systems for Maori and Pacific children in particular. The DHB will broker a relationship with the Kohunga Reo Trust to support them in this. In the New Year, the Ministry will fund a half time position to help drive WCTO quality improvements. This position will be based in Planning and Funding and presents an opportunity to increase the reach and equity of this universal programme.

*The B4 School Check*

Both Auckland and Waitemata DHBs are on track for achieving the Before School Check (B4SC) target. The target to end October is 30% (90% at year end). Both Auckland and Waitemata DHBs are sitting at 31% total population and 32% high needs. Plunket is working hard to deliver an equitable programme and has a targeted strategy to reach Maori and Pacific children. This is delivering positive results.

The ethnicity breakdown in Auckland is:
- 31% Maori
- 32% Pacific
- 31% Other.

The ethnicity breakdown in Waitemata is:
- 33% Maori
- 31% Pacific
- 31% Other

*Children’s Action Plan*

To meet the requirements of the Vulnerable Children’s Act agreements with contracted providers who work with children need to be varied. Letters are being sent to all affected providers informing them of their obligations in relation to having a Child Protection Policy and undertaking staff vetting.

Recent information from the Ministry of Social Development (MSD) on the Children’s Action Plan indicated:
- An outcomes framework and a common assessment tool have been signed off by the Vulnerable Children’s Board – the Tuituia tool used by CYPF.
- CYPFS will continue to provide care and protection to children who have been abused or neglected while the Children’s Teams are expected to provide a coordinated response for children ‘at risk’ of abuse or neglect. Currently, the number of ‘at risk’ children is quantified at 25,000 – 30,000 children nationally.
- MSD is consulting stakeholders on information sharing and an information sharing agreement – the Approved Information Sharing Agreement (AISA) is to be entered into between agencies.
- MSD expect the Vulnerable Kids Information System (ViKI) – to be implemented from July 2015. This is not a national database of all children as tried in the UK, rather a database with relevant information about children who may be at risk.
- MSD proposes a ‘Hub’ – a central, single contact point and triage centre for referrals in from professionals and the community, and referral out to CYPFS, Children’s Teams or other single service providers, e.g. Well Child Tamariki Ora. The Hub to be staffed by “trained professionals”.

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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 26/11/14
2.2 Youth Health

Sexual health review

The Waitemata DHB Sexual Health Service Review commenced in May 2012. The review initially focused on the Auckland Regional Sexual Health service and the service provided to the Waitemata population. The objectives of the service health review included:

- Improved local access, acceptability and coverage
- Strengthened primary and secondary care interface
- Enhanced existing local services in primary care
- Better use of resources.

An initial hui was attended by 54 participants from all stakeholder groups including ten young people from across the Waitemata district. This workshop focussed on engaging all interested parties in an open discussion on current sexual health service provision for the Waitemata population and what may be possible in the future.

A revised steering group and clinical and consumer advisory group were established to provide direction and clinical expertise as the information gathering process progressed. A questionnaire was also developed to gather feedback from those interested in this process.

Proposed Service Delivery Model

Following the initial consultation, a high level service delivery model was developed incorporating clinical governance across secondary and primary care services. Due to their high level of clinical expertise, the Auckland Sexual Health Service was identified to lead the Clinical Governance network for sexual health services, with active participation from the primary care sector.

This proposed service delivery model will provide an opportunity for our communities to receive the right access to sexual health services, at the right place and at the right time. Positive benefits for services include: up-skilling staff and a more accessible, seamless sexual health service to communities.

Next steps

While consultation and advisory measures have been in place throughout this process, a formal consultation process will now be undertaken. Once a proposed service delivery model is approved by CEOs of both Auckland and Waitemata DHBs, wider consultation with other interested parties will take place. This will include those who attended the original hui to shape the delivery model and other secondary and primary care service groups delivering sexual health services. The final model will be approved by the CEOs following this wider consultation.
Following the formal consultation process, a transition and implementation plan will be established. These plans will ensure that all service delivery is meeting the required standard. It is expected that a six month implementation period will include adequate training and up skilling for those staff requiring such support. The proposed service delivery model will be implemented from July 1, 2015.

2.3 Women's Health

Maternity
A procurement plan for the information component of Pregnancy and Parenting Information and Education services is being prepared. The procurement of services will be staged with the RFP for the second phase, education, occurring in 2015.

The women's health collaboration, planning maternity services to 2025, continues to refine data and information including birth projections and stakeholder views on current services. Initial findings will be shared and validated with internal stakeholders this year, with broader information sharing and consultation taking place after the summer break.

Cervical
The pilot data match between the National Cervical Screening Programme (NCSP) Register and ProCare information systems continues. The purpose of the data match is to provide practices with lists of women screened in a clinically prioritised format, based on whether women are overdue or have never been screened. The practices will then be supported to invite and recall women for a cervical screen. Best practice techniques are supported and encouraged through the provision of the newly created "How to Guide". This guide has been developed by the Metro Auckland Cervical Screening Coordinator and will be implemented in all practices. An important aspect of this pilot was the communication with practices on the purpose and detail of the automated data match. The communications have been trialled and will be evaluated separately to the evaluation of the actual data match.

A Metro Auckland cervical screening operational group has been established that includes representation from all PHOs and Independent Service Providers (ISPS), as well as Planning and Funding and the National Screening Unit (NSU). The focus of the group is to identify strategies to engage with 'hard to reach women' who are either overdue or have never had a cervical screen. A stock take of resources available through PHOs and ISPs will be undertaken to help identify gaps in service provision.

The NSU is currently undertaking a review of ISPs. The DHBs will contribute to this review and provide feedback. The model proposed by the NSU would see funding for ISPs for cervical screening and breast screening coming to Planning and Funding teams within DHBs.

2.4 Other

Rheumatic Fever
Multiple streams of work continue in the Rheumatic Fever Prevention response including the primary school based swabbing and management programme, Rapid Response primary and community care services (including Pharmacy), housing referrals, and analysis of secondary cases. It remains too early to know whether we are making a difference to this Better Public Services (BPS) target through our efforts.

The Rheumatic fever hospitalisation rates for the 2013/14 year have been analysed. Both Auckland and Waitemata partially achieved the 2013/2014 Ministry target rate.

- The Waitemata DHB 2013/14 rate of 2.3 per 100,000 population was higher than the 2013/14 target rate of 2.0.
The ADHB 2013/14 rate of 3.6 per 100,000 population was higher than the 2013/14 target rate of 2.9.

Both DHBs targets were partially achieved as the result is within the 95% confidence interval for the target. All DHBs committed to achieving a ten per cent reduction in the rheumatic fever rate, from the baseline rate in 2009/10–2011/12. For 2014/15 the target reduction is more ambitious, at 40 per cent reduction from baseline. We remain hopeful that the sustained efforts being made will result in achieving this target.

The Rheumatic Fever Prevention Programme has been named a finalist in the ADHB Health Excellence awards in the community health and wellbeing category.

**Pomaria Primary Health Day**
Child and Family Service worked in partnership with Pomaria Primary School to develop a Health Day. The need for the event was identified by the public health nurse in the school, as there were concerns about the significant number of health needs and gaps in the community’s knowledge of local health services. Child and Family have traditionally had a strong relationship with Pomaria Primary, and this has been further strengthened by the delivery of the Rheumatic Fever school based throat swabbing and management programme over the past 12 months.

The aim of the event was to increase the community’s knowledge and understanding of key health issues, as well as showcasing health services available in the local community.

The Health Day was held on 2 October. Over 20 organisations (including Plunket, Waipareria Trust, The Fono, Auckland Regional Dental Service, Asthma NZ, Marinoto, Surf Life Saving, Safe Auckland, the Police and 5+ a Day) took part and promoted their services through interactive educational stalls, provision of resources and giveaways. The families accessed screening services (e.g. ear health, vision and hearing screening and B4 school checks). Families received information about important health issues, such as Rheumatic Fever and immunisation.

In total, over 500 participants attended the day and each stall was visited on average by 88 participants. A variety of fun health activities and entertainment were held throughout the day, including a family Zumba workout class and cycling courses.

Positive feedback has been received from both attendees and the school. The Child and Family service has now been approached by other local schools requesting assistance to develop a similar programme.

**Ranui Caravan Park Initiative**
Additional funding was provided to Child and Family Service (WDHB) to enhance the current services delivered to the residents of the Western Village Caravan Park in Ranui. The funding will enable:

- Continued funding of a part time co-ordinator (employed by Monte Cecilia Trust)
- An additional day of public health nursing every week
- Support to residents to access primary care and prescriptions.

An initial meeting has been held with Monte Cecilia Trust to discuss the co-ordinator role. A work plan is currently under development. Additional public health nursing hours have been implemented.
3. Health of Older People

3.1 Home Based Support Services (HBSS)
Joint Working Group
A joint working group of Waitemata and Auckland DHB clinical leads (geriatric, medicine, nursing, allied health, NASC) and service managers along with the Funder are reviewing HBSS models currently used at both DHBs to inform the best way forward with the future delivery of this service.

In-between Travel Time
The Settlement Agreement for In-between Travel Time i.e. paying support workers for their time travelling between clients has been ratified by all DHBs albeit with conditions that will need to be met including no individual DHB will be financially disadvantaged. The Agreement will become effective 1 July 2015.

3.2 Dementia Care Pathway
Northern Region
The Northern Region cognitive Impairment Pathway (for Primary Care) has been converted into a dynamic pathway and is currently being trialled in 10 GP practices prior to a roll-out to pilot.

Implementation of the recommendation arising from the Psycho-Geriatric (PG) service review is progressing. Two regional protocols have been developed:
1. Admission, review and discharge of a PG resident
2. Referral to the regional Mental Health Unit for Older Adults (Counties Manukau DHB).
These are being forwarded to DHBs and ARRC providers for sign-off prior to testing.

Auckland DHB
The Dementia Network project has used a co-design methodology and focused on identifying key issues for people with dementia and their carers. Actions over the last quarter include the following.
• A carer assessment tool has been developed and is currently being piloted in ADHB Mental Health Services and Community Health Services. The tool ensures a comprehensive assessment of carer needs that will lead to referral for appropriate supports e.g. Alzheimers Auckland.
• Electronic Shared Care Record is viewed as a key mechanism for communicating and sharing the clinical information between members of the care team. A dementia assessment template has been developed and a small pilot of the Shared Care Record has started with people with dementia currently being enrolled from secondary care. The next phase of the project is to seek support for wider roll out to include primary care, community pharmacists and NGO providers.
• A project proposal has been drafted for ‘Better Brain Care/Dementia Friendly Hospital’ to enable screening, early identification and appropriate support for hospital in-patients with cognitive impairment.

Waitemata DHB
The evaluation report on the Waitemata DHB Cognitive Impairment Clinical Pathway is due on 31 January 2015. The evaluation is being undertaken by the Department of Geriatric Medicine, University of Auckland.
3.3 Aged Related Residential Care

Auckland DHB

All ADHB aged residential care facilities are engaged in interRAI (comprehensive clinical assessment) training as follows:

- 34% are fully competent (required number of nurses trained)
- 30% are competent (at least one nurse trained)
- 7% are engaged in training
- 29% engaged (signed an engagement agreement with MoH).

The ARRC cluster group model continues to make progress. There is a bimonthly Steering Group meeting with the cluster groups meeting in the alternate months. The focus has been on achieving the First Do No Harm targets to reduce pressure injuries and falls by 20%. However, a range of other initiatives have also been implemented through the model. Gerontology Nurse Specialists attend meetings and provide advice and support.

Waitemata DHB

All Waitemata DHB ARRC facilities are now engaged with interRAI training as follows:

- 27% fully competent (required number of nurses trained)
- 45% competent (at least one nurse trained)
- 13% in training
- 15% scheduled for training.

ARRC facilities continue meeting bi-monthly as part of the Residential Aged Care Integration Programme (RACIP) work group. RACIP projects have included developing a resource for family members of people with advanced and end-stage dementia living in residential care and resources for end stage lung disease and end stage heart disease are currently being developed. Onsite education topics continue to be offered bi-monthly.

Cluster groups have been formed in response to the targets set by First Do No Harm to reduce pressure injuries and falls by 20%. There are four cluster groups that represent 20 ARRC facilities in the DHB. As a result of this collaboration an incident data collection tool has been developed and made available to other ARRC facilities. This enables staff to recognise patterns and causes of incidents.

3.4 Long-Term Supports for Chronic Health Conditions (LTS-CHC)

For the 2014/15 year LTS-CHC has transitioned from a regional risk share to each DHB managing their own risk and utilisation costs through their respective PBFF. A regional IDF process has been established for the LTS-CHC residential care services.

Due to the transition away from the regional risk share ADHB and Waitemata DHB have been through a process of replicating formerly held regional contracts including an Individualised Funding Contract with Manawanui In Charge (MIC). MIC act as an agency which administers the fund for the client for a small fee (between 6-8%) but the clients themselves are responsible for managing and employing staff to meet their care needs.

The lack of consistent methodology when determining dual funding agreements and the need to reduce dual assessments of clients has been raised at the National LTS-CHC and Disability Support Service (DSS) Resolution Panel as an issue to be considered and addressed. The National Panel has agreed to look at the various LTS-CHC and DSS guidelines to provide better clarity between LTS-CHC and DSS eligibility criteria.
Regional support continues to be provided through the Regional Review Panel, which reviews and monitors clients with an annual service package of $80k or more. Sixteen clients were reviewed and monitored by the Panel in Quarter 1. The Panel also provides peer review to compare assessment outcomes and service utilisation across the region.

4. Maori Health Gain

Staffing
We are sad to advise the departure of Marty Rogers from the Maori Health Gain team. Marty has taken up an exciting new opportunity as the Auckland Region Manager with Te Puni Kokiri. We want to acknowledge her passion for Maori health and the contribution she has made for both Waitemata and Auckland DHBs.

Recruitment to the Maori Health Gain Manager position is currently underway.

Ethnicity Data Audit Tool
Implementation of the Ethnicity Data Audit Tool (EDAT) Project is progressing well. The training package for West Coast DHB has been delivered with negotiations underway for a delivery of training for Bay of Plenty and Counties Manukau District Health Boards.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Actual</th>
<th>Target</th>
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<tbody>
<tr>
<td>Implementation of EDAT</td>
<td>25%</td>
<td>95% of General Practitioner Practices have implemented EDAT</td>
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Healthy Babies Healthy Futures
We attended the National Maternal and Infant Nutrition and Physical Activity Conference. A key component of the conference was to share progress/learnings from the seven programmes that are being implemented around the country. The Auckland and Waitemata DHB programme stood out because of the unique cultural and community components utilising ethnic based community providers to lead the implementation of the programme. Registrations and the Text Match component of the programme are underway for the Asian and South Asian communities with the Māori and Pasifeka numbers expected to increase in the coming months.

<table>
<thead>
<tr>
<th>Total</th>
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<tbody>
<tr>
<td>No. of clients registered</td>
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<tr>
<td>No. of clients receiving Text Match</td>
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</table>

National target - Cardiovascular disease
Performance against the ‘More Heart and Diabetes Checks’ target has increased steadily for Māori in both DHBs with Auckland DHB almost achieving the target for quarter four. We will continue to monitor performance against this target.
5. Pacific Health Gain

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

The Pacific Health Action Plan has six priorities and an update on the progress of implementation of the priorities is as follows:

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

- Continued participation in the Auckland Family Violence Project Board (with Police, Justice, Corrections and Ministry of Social Development)
- Pacific providers of the Incredible Years parenting program will meet with interested churches and community groups on 13th November.
The first meeting of a working group consisting of church ministers and elders and a Pacific psychotherapist will take place on 4th December. The intention of the meeting is to design the content of a family violence prevention program specifically for Pacific people.

We are still on track to deliver at least two programs of either parenting support or violence prevention within the current financial year as is required by DAP.

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

- The number of HVAZ churches who are self-reporting as being totally smoke free in terms of their halls and grounds (at 80%) is encouraging and suggests that the target of all HVAZ and Enua Ola churches being smoke free by July 2016 is realistic. However it is felt that an auditing process is necessary to ensure that the practice is maintained and we will work towards developing an audit tool and implementing it. We will work with other smoke-free providers such as the Heart Foundation to do this.

- In terms of cessation services, Waitemata PHO recently launched its Quit Smoke Bus and one of the workers on the Bus is a Pacific/Samoan quit smoke coach. The Quit Bus provides a quit smoke service for enrolled patients of West Fono Health Trust in Henderson (as well as other providers), so makes the service immediately accessible to patients. Staff of the Pacific Quit Smoke Service provided by ARPHS can also work from the Quit Bus to provide a service that matches smokers and quit coaches language wise. The Quit Bus provides a model that takes the service to the smokers’ medical home and makes the service accessible and offers the service in English, Samoan and Tongan languages. A number of different providers are collaborating to make this possible.

The third priority is that Pacific people eat healthy and stay active. The weekly physical activities and nutrition training is continuing. The Aiga Challenge which is the annual 8 week weight loss competition ended on 5th October and two events will be held, one on 22nd November at Massey University to announce the winners of the Enua Ola competition and another on the 2nd December for the HVAZ churches.

The data that has been collected will be presented back to the churches / groups next year and will be used as part of a process of reviewing the current programme.

The fourth priority is that we seek help early. Monthly meetings with AH+ to monitor the new service model of addressing the health needs of families works in through the provision of packages of care is now occurring.

We are meeting with contract managers from the Ministry of Social Development who manage their Family Start services. Family Start targets families with high social support needs and seeks similar outcomes to those of the contract that we have with AH+ for packages of care. (The difference is that Family Start only works with families of pregnant women and new born children.) The purpose of the meeting is to compare our service specifications including outputs, outcomes and funding levels.

The fifth priority is that Pacific people use hospital services when needed. The General Manager for Pacific Hospital Services reports on this priority.

The sixth priority is that Pacific families live in warm healthy houses that are not overcrowded. The intention of the Pacific team is to link to housing advocacy groups in West Auckland and part of Central Auckland and to facilitate participation of Pacific community leaders in these groups. Some churches have expressed an interest in gaining a better understanding of the social housing policy that the government has developed. We have offered to bring together interested churches / groups with the appropriate Ministry of Social Development policy people when they want that to happen.