Community and Public Health Advisory Committees Meeting

Wednesday, 30th April 2014

2.00pm

Venue

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

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.
AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
30th April 2014

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

COMMITTEE MEMBERS
Gwen Tepania-Palmer – Committee Chair (WDHB and ADHB Board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Deputy Chair
Jo Agnew - ADHB Board member
Peter Atkkin - ADHB Board member
Judith Bassett – ADHB Board member
Pat Booth - WDHB Board member
Chris Chambers - ADHB Board member
Sandra Coney - WDHB Board member
Warren Flaunty - Committee Deputy Chair (WDHB Board member)
Lee Mathias - ADHB Deputy Chair
Robyn Northey - ADHB Board member
Christine Rankin - WDHB Board member
Allison Roe - WDHB Board member
Tim Jelleyman - Co-opted member
Eru Lyndon - Co-opted member

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

Apologies: Ailsa Claire

AGENDA

KARAKIA

DISCLOSURE OF INTERESTS
- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that might give rise to a conflict of interest with a matter on the agenda?

Items to be considered in public meeting
All recommendations/resolutions are subject to approval of the ADHB and WDHB Boards.

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

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES
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<th>Committee Member</th>
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| **Lester Levy**  | Chair – Auckland District Health Board  
Chairman – Auckland Transport  
Deputy Chair – Health Benefits Limited  
Independent Chairman – Tonkin & Taylor  
Chief Executive – New Zealand Leadership Institute  
Professor of Leadership – University of Auckland Business School  
Trustee– Well Foundation (ex-officio member) | 20/03/14 |
| **Max Abbott**   | Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology  
Patron – Raeburn House  
Advisor – Health Workforce New Zealand  
Board Member, AUT Millennium Ownership Trust  
Chair – Social Services Online Trust  
Board Member – The Rotary National Science and Technology Trust | 19/03/14 |
| **Jo Agnew**     | Professional Teaching Fellow - School of Nursing, Auckland University  
Trustee - Starship Foundation  
Casual Staff Nurse - ADHB | 01/03/14 |
| **Peter Aitken** | Pharmacist  
Shareholder/Director, Consultant - Pharmacy Care Systems Ltd  
Shareholder/Director – Pharmacy New Lynn Medical Centre | 15/05/13 |
| **Judith Bassett** | Nil | 09/12/10 |
| **Pat Booth**    | Consulting Editor – Fairfax Suburban Papers in Auckland | 24/06/09 |
| **Chris Chambers** | Employee – Auckland District Health Board (wife employed by Starship Trauma Service)  
Clinical Senior Lecturer – Anaesthesia Auckland Clinical School  
Associate – Epsom Anaesthetic Group  
Member – ASMS  
Shareholder – Ormiston Surgical | 20/04/11 |
| **Sandra Coney** | Elected Member – Chair: Waitakere Ranges Local Board, Auckland Council | 12/12/13 |
| **Warren Flaunty** | Member – Henderson - Massey and Rodney Local Boards, Auckland Council  
Trustee - West Auckland Hospice  
Trustee (Vice President) - Waitakere Licensing Trust  
Shareholder - EBOS Group  
Shareholder – Pharmacy Brands Ltd  
Director – Westgate Pharmacy Ltd  
Chair – Three Harbours Health Foundation  
Director - Trusts Community Foundation Ltd | 12/12/13 |
| **Lee Mathias**  | Chair – Counties Manukau District Health Board  
Managing Director – Lee Mathias Ltd  
Trustee – Lee Mathias Family Trust  
Trustee – Awamoana Family Trust  
Director – Pictor Ltd  
Director – John Seabrook Holdings Ltd  
Chair – Health Promotion Agency  
Director – iAC IP Ltd  
Advisory Chair, Company of Women Ltd | 03/02/14 |
| **Robyn Northey** | Project management, service review, planning etc. – Self employed Contractor  
Board member – Hope Foundation Northern Region  
Trustee, A+ Charitable Trust | 18/07/12 |
| **Christine Rankin** | Member - Upper Harbour Local Board, Auckland Council  
Director – The Transformational Leadership Company  
CEO – Conservative Party | 17/05/13 |
### Register of Interests continued...

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Allison Roe</td>
<td>Member – Devonport-Takapuna Local Board, Auckland Council&lt;br&gt;Member – Board of Kaipara Medical Centre&lt;br&gt;Chairperson – Matakana Trail Trust</td>
<td>11/02/14</td>
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<td>Gwen Tepania-Palmer</td>
<td>Chairperson – Ngatihine Health Trust, Bay of Islands&lt;br&gt;Life Member-National Council Maori Nurses&lt;br&gt;Alumni – Massey University MBA&lt;br&gt;Director – Manaia Health PHO, Whangarei&lt;br&gt;Board Member – Auckland District Health Board&lt;br&gt;Committee Member – Lottery Northland Community Committee</td>
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<td>Dr Tim Jelleyman</td>
<td>Member - Active Clinic Network for Greater Auckland Integrated Health Network&lt;br&gt;Member - ASMS&lt;br&gt;Chair - Child Health Network, Northern Regional Health Plan&lt;br&gt;Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland&lt;br&gt;Member – Board of Kaipara Medical Centre</td>
<td>22/04/13</td>
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<td>Eru Lyndon</td>
<td>Honorary Research Fellow – Auckland University&lt;br&gt;Member – AUT Business School Industry Advisory Committee&lt;br&gt;Regional Commissioner, Social Development, Northland - Ministry of Social Development&lt;br&gt;Director – Tamaki Development Company</td>
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✓ in attendance
* absent
* attended part of the meeting only
# absent on Board business
2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 19\textsuperscript{th} March 2014

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 19\textsuperscript{th} March 2014 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 19 March 2014

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.00p.m.

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair)
Max Abbott (WDHB Board member)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren Flaunty (Committee Deputy Chair (WDHB Board member)
Lee Mathias (ADHB Deputy Chair)
Robyn Northey (ADHB Board member)
Allison Roe (WDHB Board member) (present until 3.45p.m)
Tim Jelleyman (Co-opted member)

ALSO PRESENT: Dale Bramley (WDHB, Chief Executive)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Tim Wood (ADHB and WDHB, Funding & Development Manager, Primary Care)
Marty Rogers (ADHB and WDHB, Manager, Maori Health Gain)
Andrew Old (ADHB, Chief Strategy/Participation and Innovation Officer)
Rachel Mattison (ADHB and WDHB, Associate Planning and Funding Manager)
Jean McQueen (ADHB and WDHB, Primary Care Nursing Director)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Lynda Williams, Auckland Women’s Health Council
Tracy McIntyre, Waitakere Health Link
Anne Curtis, Health Link North
Tereki Stewart, Te Runanga o Ngati Whatua
Jude Sprott, Procare
Kate Moodabe, ETHC/Total Healthcare

APOLOGIES: Apologies were received and accepted from Christine Rankin and Ailsa Claire, together with an apology for early departure from Allison Roe.
WELCOME

The Committee Chair welcomed those present, with special acknowledgement of the Pacific team and members of the Pacific community present to support the Pacific Health Action Plan; the MOU partners, Ngati Whatua and Waipareira Trust; the PHOs; Healthlink representatives and the Auckland Regional Public Health Service.

DISCLOSURE OF INTERESTS

Jo Agnew advised that she has been appointed a Trustee of the Starship Foundation, as a representative of the Auckland District Health Board.

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

PRESENTATION: Cervical Screening Ethnicity Data Quality Improvement Project

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

Dr Karen Bartholomew provided a power point presentation, previously provided to Manawa Ora, covering Waitemata DHB cervical screening ethnicity work, the Data Quality Improvement Project, its findings, evaluation and current and planned work. A copy of the presentation is available on request from the WDHB Board Secretary.

Matters covered in discussion and response to questions included:

- The importance of having correct ethnicity data in terms of decisions made about allocation of resources.
- The impact of the project work will be clearer when the next set of data is received from the National Screening Unit.
- The standard ethnicity question used in the project is the Census 2001 question.
- In terms of future comparisons with other DHBs, the project provided useful data to talk to the National Screening Unit about efficacy of ethnicity classifications. A positive outcome from the project is that a process to update the NHI has been approved by the Ministry of Health. The findings are also being shared with other DHBs, so that they are aware of the issues the project identified.
- It is understood that the National Screening Unit is investigating transferring NHI information to the Cervical Screening Register. The role of the National Screening Unit and the Cervical Screening Unit has not changed.
- In discussion it was suggested that the new census classification (introduced in 2009) of MELAA (Middle Eastern, Latin American, African) is not useful, particularly from a health perspective. It was noted that a health needs assessment by ARPHS had shown different health needs within the different ethnic groups covered by MELAA. Dale Bramley advised that Statistics New Zealand does consult with a wide range of affected sectors (including health) about proposed ethnicity classifications for censuses. This concern can certainly be raised when that consultation next occurs. Census statistics are used for a wide variety of purposes and Statistics New Zealand needs to weigh up input from all those affected.
- The project illustrated the general need for care in interpretation of statistics.

The Committee Chair thanked Dr Karen Bartholomew and the team involved in the Project, noting that previously there had been a lot of suspicion about the reliability of data, and there was now clear evidence of how misclassification of ethnicity had occurred.
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 05 February 2014 (agenda pages 1-10)**

A correction was noted on page 3 of the minutes (last paragraph). Child Rehabilitation Services (provided from Starship) extend to the whole of New Zealand. It is the services provided by the Wilson Home that extend to the north of Taupo.

It was also suggested that it would be preferable to generally avoid the terminology “drive this process” and use instead something on the lines of “facilitate this process”.

**Resolution** (Moved Warren Flaunty/Seconded Lee Matthias)

That with the correction noted at the meeting, the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 05 February 2014 be approved.

**Carried**

**Matters Arising:**

Sandra Coney will be provided with a copy of the finalised Auckland Regional Public Health Service submission on the Unitary Plan.

3. **DECISION ITEMS**

3.1 **Pacific Health Action Plan 2013-2016 (agenda pages 11-42)**

Lita Foliaki (Pacific Health Gain Manager), Bruce Levi (Acting General Manager Pacific Hospital Services), Dr Alan Moffit (Clinical Director, Alliance Health+) and the Reverend Dr Featuna’i Liuaana (community representative) presented this report.

Bruce Levi introduced the Pacific Health Action Plan and those present.

Lita Foliaki commented on the inclusion of Pacific health providers and community representatives in the development of the plan and two major impacts from that. Firstly the priorities identified were unexpected in some cases, for example identification of safe children and violence free Pacific families as the number one priority. Secondly, there was the impact on the format of the Plan, to make it easily understandable by Pacific people in the community. The Plan accepted that the DHBs on their own can’t address the health needs of the Pacific community. There is some risk is in the ambitious nature of the Plan, but those involved considered that risk can be managed. She introduced community representative, Reverend Dr Featuna’i Liuaana.
The Reverend Featuna’i Liuaana commented that his church (Sandringham Samoan Congregational Church) looked after over 60 families and had been trying to improve their health for the last 15 years. In the last five years there had been a dramatic improvement as a result of a very radical change in the way they do things. The important thing was the people’s perception of what would work for them. For example with the self management programme from ProCare, developed at Stanford University, success had depended on adapting it to what would work for the Samoan community. It was extremely important to involve the community from the outset. Their view is that if you deal with the underlying social issues such as family violence and alcoholism, then other health problems will be solved. Pacific people also had a holistic view of the health system and thought resources should be spread consistently across the system and not dependent on which PHO is involved.

The Reverend Featuna’i Liuaana also commented on the importance of targeting the churches in reaching the Pacific community; a lot can be achieved with health programmes through working through them. Also important to Pacific people is recognition of their voice.

Dr Alan Moffitt noted that the process of developing the Pacific Health Action Plan had involved all the PHOs and was considered by them to be an exemplary process. He particularly liked the plain language of the Plan and considered the actions pragmatic and achievable. They aligned well with PHO priorities, for example for CVD and diabetes. He agreed with the emphasis on self directed care. Improving self management of health is one area where resourcing would need to be looked at. Apart from that the PHOs are well focused on achieving the Plan’s outcomes.

Lita Foliaki advised that something she had learned from the process is that Pacific people are demoralised by presentation of graphs which show the extent of health problems by ethnicity; the opposite of motivating people to improve their health. What is needed is working with communities on all aspects of planning and a flexible approach. For example with parish nurses, the Sandringham Samoan Congregational Church invited the parish nurse to go on a weekend camp with them, providing opportunities to design healthy menus and talk to people on a range of health issues.

Matters covered in discussion and response to questions included:

- With the resource implications listed on page 13 of the agenda, Lita Foliaki advised that the first two items (Enua Ola Parish Nurses and roll out of pilot to increase CVD management adherence) would bring Waitemata DHB close to the Auckland DHB programme. There are some areas where Waitemata DHB provides more funding than Auckland DHB: Pacific Mental Health and Older People Services.
- The Committee asked that the goal of achieving consistency of service across the region continue to be kept in mind.
- One of the reasons for supporting extension of the Parish Nurse concept to Waitemata DHB is the better coverage rate for Pacific people achieved by Auckland DHB for breast screening, CVD screening and cervical screening. The long term relationships that evolve with having Parish Nurses seem to be valuable.
- Reverend Featuna’i Liuaana commented on the importance for Pacific people that programmes are long term; they are disturbed by programmes that last only one year. Where something is of long term proven benefit, such as free Saturday health checks, the Pacific community may fund raise to help keep that going.
The Committee Chair acknowledged the work that the Pacific Team, the community, the churches and the PHOs had done in developing the Action Plan. More will be seen of this approach as different models are developed with the community, particularly as the DHBs look at how scarce resources can be best utilised to meet priorities.

**Resolution** (Moved Max Abbott/Seconded Allison Roe)

That the Auckland and Waitemata DHB Community and Public Health Advisory Committees affirm their support for the Pacific Health Action Plan 2013-2016 and recommend to the Auckland and Waitemata DHB Boards:

That the Board endorse the Pacific Health Action Plan 2013-2016.

**Carried**

### 3.2 Auckland Metro Clinical Governance Forum (agenda pages 43-48)

Tim Wood (Deputy Director Funding, Auckland and Waitemata DHBs), Dr Stuart Jenkins (Clinical Director, Primary Care, Auckland and Waitemata DHBs) and Dr Alan Moffit (Clinical Director, Alliance Health+ who had been involved in developing the Terms of Reference) were present for this item.

Tim Wood briefly outlined the proposed Terms of Reference. Alan Moffitt confirmed support for them.

Matters covered in discussion and response to questions included:

- With regard to the large number of members proposed for the Forum, Tim Wood advised that they were trying to get a broad perspective across the table. Alan Moffitt noted that what is proposed is probably not as large as some of the existing groups the Forum would replace. He expected that it might be possible to phase down the numbers over time.

- Some strong concerns were expressed at the use of the term “governance” in the name of the Forum, whereas its role appeared to be about collaboration and consistency. The Terms of Reference did not cover such governance issues as accountability lines and how it will be transparent. In health one of the big problems is the tendency to put titles on things which don’t describe what they are doing. In response to these concerns the meeting was advised that at this stage the Forum is about getting consistency, but over time a stronger clinical governance focus will develop, covering the performance of the system in terms of quality and safety. It was suggested that the Forum should be seen as a work in progress.

- The proposed Forum will replace two existing fora: the GAIHN Alliance Clinical Network and the Primary Care Clinical Advisory Group.

- Concerns were expressed at the absence of patient/consumer representation in the Forum.

**Resolution** (Moved Sandra Coney/Seconded Allison Roe)

That the Terms of Reference include patient representation.

**Carried**
There was further discussion of the naming of the Forum, future development of its governance role and subsequent review period for the Terms of Reference.

Resolution (Moved Max Abbott/Seconded Jo Agnew)

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

(a) Receive with interest the draft terms of Reference for the Auckland Metro Clinical Governance Forum and recognise the work done to date in developing these.

(b) Recommend to the Auckland and Waitemata DHB Boards:

That the Board endorse the proposed Terms of Reference for the Auckland Metro Clinical Governance Forum, noting that these are to be seen as a work in progress. Endorsement is subject to:

- Inclusion of patient representation in the Terms of Reference.
- The Terms of Reference being reviewed in 6 months time (September 2014) by the Clinical Governance Forum with a view to strengthening clinical governance.
- The revised Terms of Reference being reported back to the Auckland and Waitemata DHB Boards for endorsement following the review.

Carried

4. INFORMATION ITEMS

4.1 Child Health Service: Planning a Sustainable Future (agenda pages 49-54)

Stephanie Doe (Operations Manager, Child Health Services, Waitemata DHB), Linda Harun (General Manager, Child Women and Family Service, Waitemata DHB) and Dr Tim Jelleyman (Head of Division Medicine, Child, Women and Family Service, Waitemata DHB) were present for this item. Stephanie Doe introduced the report.

Matters covered in discussion and response to questions included:
- There was appreciation of the report making the direction in which Child Health is heading a lot clearer.
- The Committee Chair emphasised the importance of making linkages with the Pacific Health Plan and the Maori Health Plan in planning for the future of Child Health services clear and explicit. Linda Harun agreed that this would be important.

Resolution (Moved Lee Matthias/Seconded Robyn Northey)

That the report be received.

Carried
4.2 Women’s Health Collaboration (agenda pages 55-58)

Ruth Bijl (Funding and Development Manager, Women, Children and Youth, Auckland and Waitemata DHBs), Linda Harun (General Manager, Child Women and Family Service, Waitemata DHB), Dr Peter van de Weijer (Clinical Director Gynaecology, Waitemata DHB), Emma Farmer (Head of Division Midwifery, Waitemata DHB) and Maggie O’Brien (Director of Midwifery, Auckland DHB) were present for this item. An apology was conveyed from Sue Fleming (Director of National Women’s, Auckland DHB).

Ruth Bijl introduced the report. She noted the ten year planning horizon and the use of an external provider to support the project. She also advised that the proposed timelines had been impacted by the Government’s announcement of an early election date, as there is a period of time before the elections when public consultation processes should not occur.

Matters covered in discussion and response to questions included:

- Ruth Bijl advised that reducing caesarean section rates is one of the drivers for the project, but at this stage they are trying not to pre-empt solutions, but to concentrate on setting up a good process for the collaboration project.
- Linda Harun advised that it is accepted that facilities on the Waitakere Hospital site were not purpose built for maternity and they wanted to find the right long term solution. However in the short term there is also commitment to improving the current facilities.
- With regard to the appointment of the independent advisors, there had been a strongly contested RFP process. Health Partners Consulting Group has a lot of relevant experience.
- The importance of the common theme of consistency in terms of service offered across the region.
- The cost of the independent advisers is $200,000 spread across the two DHBs. They will be expected to provide robust analysis; robust modelling and projections of what can be expected over time; and a number of options that the Steering Group would then consult on. With regard to maternity expertise, that would be provided from within the DHB to the advisers. The Board Chair noted that at times there is a need to bring in outside assistance to progress projects such as this, in view of high existing workloads. The CEOs are quite prudent about when this is done.
- There is a commitment to having consumer representation at each stage of the project.
- The role of the Health Partners Consulting Group includes engaging with Maori Health and Pacific Health and considering issues of health inequalities.
- The Committee Chair requested that in future reports how this is being approached in projects be made clear from project establishment, representation and implementation.
- If this is a ten year planning horizon for Women’s Health Collaboration then Maori, Pacific and Asian women need to be included at all levels of this project and this aligns to the DHBs’ values and also to addressing health inequities for these groups.

Resolution (Moved Pat Booth/Seconded Robyn Northey)

That the Committee notes that the planned Women’s Health Collaboration project will focus on maternity services across Auckland and Waitemata DHBs over a ten year planning horizon.
That the team reports back to the next CPHAC Committee meeting on the specifics for Maori, Pacific and Asian Women within this project.

Carried

5. STANDARD MONTHLY REPORTS

5.1 Primary Care Update Quarter 2, 2013/14 (agenda pages 59-84)

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

Tim Wood highlighted some aspects of the report, including:

- Immunisation on track to target, with Auckland DHB exceeding the national target.
- Heart and Diabetes Checks – there has been a huge effort across the PHOs. Except for Waitemata PHO, they were now all above 80%, but it is extremely difficult to progress from there to the 90% target. The PHOs should be complimented for their work on this.
- With Advice to Smokers to Quit, a lot of effort is being put into texting patients about confirming their smoking status and asking them if they would like advice about stopping smoking.
- Work is taking place to align PHO targets for high needs populations with targets for the total population.
- The goal for all PPP targets to be the same for each PHO (page 78 of the agenda). The Ministry of Health has released a paper on an integrated incentive performance framework, which it is hoped will be in place for 1 July.

Matters covered in discussion and response to questions included:

- Information on adolescents enrolled in dental care will come through the quarterly Oral Health report.
- Some demographic information relating to “Access to Diagnostics” will be included in the next Primary Care report.
- After Hours Service – the recent media story about someone being charged $92 at a West Auckland Accident and Emergency Service will be investigated. The charge should only have been $38. Negotiations for the continuation of the After Hours Network after 1 July are taking place. The report from the independent evaluation of after hours service has been received but is currently embargoed.
- There is now recognition by the PHOs that GPs have an obligation to provide after hours care. This is being developed as a Code of Practice goal.

Tim Wood and Stuart Jenkins were thanked for the report.

The report was received.
5.2 Planning and Funding Update (agenda pages 85-92)

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

- Collaboration in Planning, Funding and Outcomes – currently the consultation document for the next stage of the restructure is being finalised. It is intended to go out to consultation in April, with a paper back to the Boards in June. Janine Pratt has been appointed as Project Director for the transition process. Currently they are looking at the best use of space at 15 Shea Terrace.
- Annual Plan 2014/15 – the Draft Annual Plans and Maori Health Plans for the two DHBs had been submitted to the Ministry of Health on 14 March, having been updated and revised in the week leading up to that. They are currently being refined further. Feedback is expected from the Ministry and that will be responded to.
- The Primary Care Patient Safety Initiative (detailed on page 87 of the agenda).
- Child Health activity (pages 87-88 of the agenda).

The report was received.

The Committee Chair thanked all staff for their work and noted that there had been improvements in some areas with performance against targets.

6. General Business

There was no general business.

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

The meeting concluded at 4.30 p.m.
#### Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 22nd April 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 27/11/13</td>
<td>3.1</td>
<td>Child and Youth Mental Services – further update report on progress developing common systems and processes across Auckland and Waitemata DHBs to be provided in three months time.</td>
<td>Helen Wood</td>
<td>CPHAC 30/04/14</td>
<td>Report 4.2 on this agenda.</td>
</tr>
<tr>
<td>CPHAC 27/11/13</td>
<td>4.2</td>
<td>Rheumatic Fever Prevention and Intervention Programme - further update report to be provided in the first quarter of 2014 calendar year.</td>
<td>Ruth Bijl</td>
<td>CPHAC 30/04/14</td>
<td>Report 4.1 on this agenda</td>
</tr>
<tr>
<td>ADHB HAC 11/12/13 (transfer to CPHAC)</td>
<td>5.2</td>
<td>Diabetes Checking – report to be provided on how screening and monitoring is undertaken for those reported as positive during diabetes checking.</td>
<td>Debbie Holdsworth</td>
<td>CPHAC 11/06/14</td>
<td></td>
</tr>
<tr>
<td>CPHAC 05/02/14</td>
<td>3.1</td>
<td>Healthy Eating and Physical Activity – request to ARPHS to bring back a report to CPHAC on opportunities for interventions in the promotion of products that influence levels of obesity.</td>
<td>William Rainger</td>
<td>CPHAC 11/06/14</td>
<td></td>
</tr>
<tr>
<td>CPHAC 19/03/14</td>
<td>2.1</td>
<td>ARPHS Submission on the Unitary Plan – copy to be provided to Sandra Coney.</td>
<td>Simon Bowen</td>
<td>Actioned – emailed 09/04/14</td>
<td></td>
</tr>
<tr>
<td>CPHAC 19/03/14</td>
<td>4.2</td>
<td>Womens’ Health Collaboration – team involved to report back to April CPHAC meeting on the specifics for Maori, Pacific and Asian women within this project.</td>
<td>Ruth Bijl</td>
<td>CPHAC 11/06/14</td>
<td>Delayed one meeting</td>
</tr>
<tr>
<td>CPHAC 19/03/14</td>
<td>5.1</td>
<td>Primary Care Update – to include some demographic information relating to “Access to Diagnostics” in next quarterly report.</td>
<td>Tim Wood</td>
<td>CPHAC 11/06/14</td>
<td></td>
</tr>
</tbody>
</table>
3.1 Oral Health

Recommendation:

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

a) Note that both Waitemata and Auckland DHB are currently exceeding the national target of no more than 10% of children not examined within one month outside their recall period: Auckland and Waitemata currently tracking at 7%.

b) Endorse the current activity, including strategies and new initiatives in order to maintain the Ministry of Health targets including:

- Maintaining the Ministry of Health 7% arrears target by continuing current practices and oversight
- Achieving the Ministry of Health target of 85% for pre-school enrolments
- Increasing the number of pre-school examinations completed.

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

Endorsed by: Dr Debbie Holdsworth (Director Funding Auckland and Waitemata DHBs)

Glossary

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

1. Background – Community Based Dental Services

Auckland Regional Dental Service (ARDS) is the regional provider of dental services for children from birth to 18 years of age. ARDS provides screening, early detection, preventive, restorative and surgical dental services. Adolescent services are provided by ARDS to support contracted private dentists, mainly to those at high risk or with access difficulties preventing them from utilising the contracted dentist in their area.

Services are provided via a hub and spoke model of care. Hub clinics are situated across the three District Health Boards (DHBs) throughout the Auckland region. Forty four hub clinics across the region are supported by two levels of mobile clinics. The diagnostic vans provide diagnostic and preventive treatments only. Transportable Dental Units (TDUs) provide all treatments in the dental therapist’s scope of practice and visit targeted schools across the
Waitemata DHB and Counties Manukau DHB areas. Service in the Auckland DHB area is provided utilising six diagnostic vans and fourteen hub clinics.

ARDS also provides a regional adolescent coordination service that facilitates and coordinates the transfer of Year 8 children onto contracted private dentists who provide care for adolescents (13-18 years). Adolescents at high risk of poor oral health, of low utilisation or those who wish to are able to remain with ARDS as a provider.

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

2. ARDS activity/performance

The following information provides an overview of ARDS activity and performance in five areas:

- Workforce
- Arrears
- Enrolment
- Productivity - attendances, treatments, completions, pre-school enrolments and examinations

2.1 Workforce

As outlined in the previous report in November 2013, active recruitment of new graduates took place in December 2013. Table 1 demonstrates the increased recruitment over time since 2008. ARDS successfully recruited twenty two new graduates who started employment in January/February 2014 and who have now progressed through their orientation successfully. The enhanced number of dental therapists has impacted positively on arrears by providing greater appointment availability. Recruitment of Dental Assistants throughout the year enables an adequate ratio of assistants to therapists to be maintained. The clinical model used by ARDS and endorsed by MoH recommends 0.8 FTE dental assistant to 1.0 FTE dental therapist.

Table 1 – Recruitment levels of Dental Therapists (DT) and Assistants (DA) since 2008
2.2 Arrears
A child is considered in arrears if they have not been examined within one month outside their recall period. Currently the Ministry of Health target is 10% or less. The target will be increasing from 1 July 2014 to 7%. The arrears are currently tracking better than the current target, achieving 7% in both Auckland and Waitemata.

Table 2 shows that ARDS has been achieving the MoH target for arrears consistently since September 2013 across all ethnicities. In September 2013 all areas achieved better than the MoH target of 10%. From January 2014 all areas achieved the June 2014 target of 7%. All DHBs are required to report monthly on arrears to MoH. The service improvement in this area has been acknowledged by MoH on a number of occasions.

Table 2 - Arrears

<table>
<thead>
<tr>
<th>Year</th>
<th>Asian</th>
<th>Maori</th>
<th>Other</th>
<th>Pacific Island</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
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<td></td>
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<td>2012</td>
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<tr>
<td>2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.2.1 Update of the arrears action plan
The following actions were implemented by the service to reduce the arrears to MoH target of 10%.

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

- A production plan for chair utilisation has been developed with assistance from decision support. This is in the early stages of implementation. Team Leaders are using the plan to assist them in allocating staff and resources. The plan provides information such as DNA’s, IDC’s and arrears at team level.
• Targeted clinics are open for extended hours to provide more appointments and increase accessibility. Extended hours are available in the following clinics: Westgate, Edmonton, Glen Eden, Henderson, Northcross, Greenlane and Sylvia Park.

• The Operations Manager continues to monitor the arrears situation weekly.

2.3 Pre-school Enrolment
The current target for pre-school enrolment is 85%. At the end of December 2013 in the Waitemata DHB area 81% of pre-school children were enrolled, and in the Auckland DHB area 76% were enrolled. Table 3 shows the percentage of pre-school enrolment achieved compared to target. Enrolments for the pre-school age group have improved from previous years. The pre-school enrolment programme is currently being reviewed to identify ways to improve enrolment and to provide consistency across the three DHBs.

Table 3 – Pre-school enrolment by DHB

<table>
<thead>
<tr>
<th>DHB</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>15000</td>
<td>16000</td>
<td>17000</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>20000</td>
<td>22000</td>
<td>24000</td>
</tr>
<tr>
<td>Waitemata</td>
<td>25000</td>
<td>27000</td>
<td>29000</td>
</tr>
</tbody>
</table>

Enrolment: 0-4 Years

- Population
- Enrolments
- Target
- Age

Waitemata and Auckland DHB Community and Public Health Advisory Committee Meeting 30/04/14
Table 4 – Pre-school enrolment by Ethnicity

The data in table 4 shows the percentage of 0-4 year old children enrolled by ethnicity. The percentage enrolment for Maori is less than other groups across the region. Further focus on Maori and Pacific enrolment will be achieved through the preschool programme.

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

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

2.4 Productivity
Table 5 shows a comparison of productivity between the same periods in 2013 and 2014. There has been an increase in productivity for attendances, completions, examinations (pre-school) and treatments. New enrolments for this period are slightly lower than the same period last year. This can be attributed to the focus on seeing currently enrolled children on time to achieve the MoH target for arrears. Now that arrears are within acceptable parameters, new enrolment and early examination of preschool children is a priority.
3. Adolescent utilisation update

Table 6 below shows the percentage of Auckland DHB adolescents utilising publicly funded dental services since 2006. Preliminary figures show that in 2013 approximately 85% of adolescents accessed this service in Auckland DHB; in Waitemata DHB this figure is significantly lower (65%). This variation between the two DHBs can be attributed to cross boundary issues and adolescents attending schools in the Auckland DHB area but who are living in the Waitemata DHB area. The national target for 2014 is 85%.

4. Risks/Issues

Currently there are 249,000 children enrolled with the ARDS service. The service has received a number of complaints recently in relation to the difficulties navigating the current call platform and difficulties of patients getting in touch with the clinics. At times, all staff in smaller clinics can be actively engaged in clinic related activity and parents calling to make or
change appointments are required to leave a message. This causes some frustration for parents who wish to speak to someone regarding their request.

The majority of clinics have found that the administrative support required to manage the demand from parents has been a challenge.

To address this issue, changes to the call platform have been made to enable easier navigation for parents, particularly when they need to change appointments. Text messages have been changed to include the clinic address to reduce the need for parents to call for more information and an additional telephone line has been initiated at Greenlane where there was a high rate of calls. Developing an on-line enrolment and a centralised call centre to deal with changes of appointments, enquiries, and enrolments is the next step to improving the client experience in this area.

5. New Service Initiatives

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

ARDS is currently part way through the implementation of a two year pilot programme providing free oral health services for high risk pregnant women and up to nine months post-partum. This pilot is being delivered from the community oral health hub facilities located in Waitemata DHB. The pilot concludes on 25 February 2015.

5.2 Specific Strategies for Maori and other high needs groups
To improve service accessibility and uptake for Maori and other high needs children, adolescents and their families and whanau, the following strategies are in place.

- The pre-school programme targets pre-schools in areas of high risk. Regular onsite visits are made to provide examinations and preventive treatments to targeted high needs Child Care Centres, Kohanga Reo and Pacific Language Nests.
- On site treatment is provided at schools in high needs areas via transportable dental units
- Eligible high needs pregnant women access the Maternal Oral Health programme and receive oral health education, oral health examination and dental treatments as appropriate.
- Continue to train Plunket nurses and other Well Child Tamariki Ora providers on Oral assessment and referral. This ensures that high risk children are enrolled with the service and early intervention can be offered.
- Continue to contact high risk families by telephone, where possible, to arrange appointments. Follow up phone calls are made to pre-school families in high risk areas when the diagnostic van is in the local area.
- Continue focus on increasing enrolment and examinations of pre-school children particularly for Maori and Pacific.
- Continue to offer extended hours from targeted clinics to provide more appointments and increase accessibility. Extended hours are offered at Westgate, Edmonton, Glen Eden, Henderson, Northcross, Greenlane and Sylvia Park.
6. Conclusion

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

- Maintaining the MoH 7% arrears target by continuing current practices and oversight.
- Achieving the MoH target of 85% for pre-school enrolments
- Increasing the number of pre-school examinations completed.
4.1 Rheumatic Fever Prevention and Intervention Programme in Auckland and Waitemata District Health Boards

Recommendation

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

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ARF</td>
<td>Acute Rheumatic Fever</td>
</tr>
<tr>
<td>AWHI</td>
<td>Auckland-wide Healthy Housing Initiative</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CMDHB</td>
<td>Counties Manukau District Health Board</td>
</tr>
<tr>
<td>CPHAC</td>
<td>Community and Public Health Advisory Committee</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>ECCA</td>
<td>Energy Efficiency Conservation Authority</td>
</tr>
<tr>
<td>GAS</td>
<td>Group A Streptococcus</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HPA</td>
<td>Health Promotion Agency</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NHC</td>
<td>National Hauora Coalition</td>
</tr>
<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>RhF</td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>RHD</td>
<td>Rheumatic Heart Disease</td>
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1. Introduction

This paper provides an update on the implementation of the Rheumatic Fever (RhF) prevention and intervention programmes across Auckland and Waitemata District Health Boards (DHBs).

2. Background

In June 2012, the Government announced 10 Better Public Service targets. Reducing the incidence of RhF by two thirds to 1.4 cases per 100,000 nationally by 2017 is one of those targets. The New Zealand incidence of Acute Rheumatic Fever (ARF) is currently 4.1:100,000. Local targets have been set by the Government at 1.2:100,000, down from 3.5:100,000, and 0.8:100,000, down from 2.3:100,000, by 2017/18 for Auckland and Waitemata respectively.
The Ministry of Health (MoH) Rheumatic Fever Response Strategy identifies three levels of intervention to achieve this goal within the next five years:

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

### 3. Summary of progress to 10th April 2014

Auckland and Waitemata DHBs are taking an integrated whole of population approach to reducing the incidence of ARF as endorsed by CPHAC in November 2012. The incidence of RhF across populations is variable. A multi-faceted prevention and intervention programme is now underway that targets efforts for populations at most risk and also recognises the geographically dispersed incidence of RhF.

Ministry of Health (MoH) funding was provided to DHBs to firstly develop primary school based sore throat management programmes. In 2013, further initiatives were funded with a targeted approach in the Auckland region for the next four years. Initiatives include:

- Nurse-led rapid response services/clinics in primary care settings (DHBs via PHOs)
- Pacific health literacy/community awareness raising (MoH regional contract with Alliance Health Plus (AH+))
- Healthy homes advice and referral (MoH regional contract with National Hauora Coalition (NHC) and AH+).

Given that risk for Rheumatic Fever is highest for Māori, Pacific and Quintile 5 children and young people it is important that Māori and Pacific stakeholders are actively engaged in the Rheumatic Fever programme.

#### 3.1 Māori and Pacific engagement in the development and implementation of the DHBs’ Rheumatic Fever Plans

Māori and Pacific stakeholders have been actively involved in both the development of the Auckland and Waitemata DHB Rheumatic Fever Prevention Plans October 2013 – June 2017 and the overall leadership and strategic direction for implementation of the plans. Engagement has occurred through the Waitemata DHB Steering Group and Auckland DHB Steering Group and Service Alliance Leadership Team (SALT). The following groups are responsible for ensuring work-streams are well planned, assisting in the allocation of funding and monitoring progress and for refining the programme to ensure targets are achieved and the programme remains focused on Māori and Pacific communities.

- Māori and Pacific DHB General Managers retaining oversight of the programme and having delegated representation through the Maori Health Gain and Pacific Health Gain teams on the Waitemata DHB Steering Group and Auckland DHB SALT
- named Māori and Pacific provider representatives or their delegates on the Waitemata DHB Steering Group
- Māori and Pacific led PHO membership and representation on the Auckland DHB SALT
• Waitemata DHB Māori Public Health Medicine Specialist on the Waitemata DHB Steering Group and on the Heart Foundation Guidelines Group
• Waitemata and Auckland DHBs reporting regularly to Manawa Ora, providing progress updates to the broader Waitemata DHB and Auckland DHB Māori Health team including Executives and Board members.

At the operational level, key Māori, Pacific and NGO providers operating in the DHB areas and servicing high need families likely to be at risk of Rheumatic Fever are currently engaged in RhF awareness raising, the delivery of sore throat management services and the AWHI housing initiative as follows:

• Te Whānau o Waipareira Trust has been funded by Waitemata DHB to provide community based swabbing using their nurse team, and to facilitate follow up with primary care via the child’s GP
• The Fono is contracted to provide a Rapid Response clinic and to deliver the Pacific Engagement Strategy providing face to face awareness raising on the prevention, consequences and treatment options for Rheumatic Fever
• AH+, a Pacific led PHO, is contracted by the SALT to deliver the Rapid Response programme in Auckland DHB and rapid response clinics through their GP practices. They are also responsible for the Pacific Engagement Strategy and jointly responsible with NHC for the AWHI programme
• NHC, a Māori led PHO and NGO, delivers Rapid Response clinics through its GP practices and is jointly responsible with AH+ for the AWHI programme
• HealthWest is contracted by AWHI to assist families/whānau attain warm and healthy homes in the Waitemata DHB. This service is provided in the Auckland DHB area by Te Hononga O Tāmaki Me Hoturoa, Health Star Pacific Trust and the Tongan Health Society (Langimalie).

The Waitemata DHB Steering Group and Auckland DHB SALT are responsible for obtaining and utilising feedback from Māori and Pacific stakeholders on the Rheumatic Fever programme, and to reflect this in the ongoing development of their Rheumatic Fever Prevention Plans. The Māori and Pacific Health teams are actively seeking feedback on what is working, what is not and areas for development in the delivery of the RhF programme through the Pacific Engagement Strategy and the proposed development of a Māori Engagement Strategy.

Pacific Engagement Strategy
The Ministry commissioned AH+ to develop and deliver the Pacific Engagement Strategy (PES), a Rheumatic Fever Prevention initiative, targeting Pacific communities in the Auckland Region. AH+ and their network of Pacific providers have been engaging Pacific communities in high risk areas. This is achieved through existing Pacific health providers already making health visits to homes in the Auckland regions and trained to talk about rheumatic fever to Pacific people to raise awareness, promote healthy communal living and increase levels of rheumatic fever health literacy, including sore throat management and access to existing services. The Pacific Health Team will seek feedback and advice on areas for development through AH+ monthly forums, with Pacific providers involved in PES, Rapid Response clinics and AWHI.
Māori Engagement Strategy

In recognition of the need and issues facing Māori whānau within the Waitemata and Auckland DHB areas, the development of a Māori Engagement Strategy has been prioritised following a meeting of Māori stakeholders involved in managing and delivering the Rheumatic Fever Prevention Programme across both DHBs. The development process will explore opportunities to raise the overall understanding and engagement of health services across the spectrum, and ensure a connection to and the ability to leverage off existing Rheumatic Fever resources. Counties Manukau has expressed an interest in participating in a regional approach.

3.2 Primordial - Housing and Social Issues

The Ministry of Health has funded the development and implementation of the Auckland-Wide Healthy Housing Initiative (AWHI) in acknowledgement of the link between housing conditions, particularly overcrowding, and rheumatic fever. AWHI is an Auckland-based service that aims to identify households with children at risk of rheumatic fever. It offers a range of interventions (such as insulation and curtains) to address structural and functional household crowding and subsequently reduce the spread of Group A Streptococcal (GAS) infection.

AWHI is led by two Auckland PHOs, NHC and AH+, operating as a joint venture. Members of the Waitemata DHB RhF Steering Group and Auckland DHB’s SALT were involved in the working and steering groups set up to develop the AWHI initiative.

The intention is to reach 3,500 households a year once the initiative is established. To date, over 300 families have been referred to AWHI since they started receiving referrals in December 2013. AWHI staff have completed more than 210 initial assessments and plans with eligible families, and have referred more than 65 families to Housing New Zealand Corporation’s fast tracking scheme (a change to the Social Allocation System from August last year to fast-track families with children at risk of rheumatic fever to the top of the waiting list for state housing).

AWHI were initially encouraged to pursue a volume target. However the Ministry has since acknowledged the need for stakeholders in the AWHI initiative to first:

- set up and embed sustainable systems and processes to identify and refer appropriate families/whānau to AWHI, and
- ensure the range of interventions required to address housing needs are accessible and available to families/whānau.

Auckland and Waitemata DHBs have developed resources and referral pathways to ensure eligible families are identified and referred through the three AWHI referral points: the prophylactic bicillin service, the school-based rheumatic fever prevention programmes, and the three Auckland hospitals where children are admitted with specific housing related conditions. These resources and pathways will be refined and extended as implementation is reviewed and data is collected and analysed on referrals and outcomes for families/whānau. The Ministry has funded Ko Awatea to support DHBs to use Rapid Cycle Change for this work. In both Auckland and Waitemata DHBs:

- All children on the bicillin service are being systematically assessed for their eligibility to be referred to AWHI through the social work and/or Public Health Nurse services. To date, CCAHDS have assessed 79 of the 107 client base on bicillin: 53 have been referred to AWHI, 16 cases were not eligible, 5 families declined and 5 had moved out of area. In Waitemata DHB the responsibility for the children’s bicillin service is being transferred to the Public Health Nurse service and, as part of this process, all 66 children and their families will have their housing needs assessed. Two referrals to AWHI have been made to date.
• The school-based health clinics have a process in place to assess the eligibility of children and their families and, to date, 100% of children meeting the AWHI criteria and with family/whānau consent have been referred from this programme. Referral numbers from this service will be relatively low as families have to meet the three or more GAS in the previous 3 months criteria, as well as income, housing and additional child eligibility criteria.

• Inpatient services: A range of staff including Māori, Pacific, CALD and social work team members and clinicians, from frontline to management, have been involved in developing a secondary care process to assess whether children hospitalised with lower respiratory illnesses including bronchiolitis and pneumonia, meningitis, bronchiectasis and acute rheumatic fever are eligible to be referred to AWHI and, if so, the referral, feedback and recording functions. To date, Auckland DHB have made 33 referrals from Starship and Waitemata DHB 9 referrals (48% and 13% respectively of all hospital referrals) to AWHI.

This inpatient services’ work requires:
• a change in culture for staff who have previously had a lack of clarity on pathways, roles and responsibilities, and a sense of futility, regarding housing referrals
• the development of systems and processes that ensure all children meeting the medical diagnostic criteria are assessed as to their eligibility to be referred to AWHI
• embedding this approach as part of normal clinical activity
• developing feedback mechanisms
• a systemic approach to measuring the performance of AWHI and housing outcomes for families/whānau

Documentation about housing and social conditions will need to be integrated into the clinical records to support assessment, planning and action. This work is currently underway. The Ministry of Health is currently working with AWHI to determine whether referral criteria will be extended in 2014 to include a range of conditions that are identified in primary and community care.

3.3 Primary Prevention

3.3.1 Primary School Based Programmes

Early identification and treatment of GAS is essential for the prevention of ARF. Both Auckland DHB and Waitemata DHB have implemented a school-based sore throat swabbing programme in selected high risk primary and intermediate schools. This includes four schools in West Auckland, one in Northcote, and 16 schools in the Auckland DHB area. To date, 4324 children have had throat swabs taken by the school-based health service in Auckland DHB and 4762 in Waitemata DHB, with an average of 15% GAS. The GAS rate varies by school and time of the term, with rates higher at the beginning of term and dropping off towards the end of the term as the GAS load in the schools reduces.

The school-based programme incorporates activities to improve health literacy and families’/whānau awareness of key health messages. The school programme encourages early and timely access to health providers. In Waitemata, the school-based providers offer families/whānau the opportunity to link back to their usual primary care provider for medication, however, the majority of families/whānau choose to access free medication through the Public Health Nurses. In both Auckland DHB and Waitemata DHB, communication back to the primary medical home occurs early in the process.
The impact of a targeted school-based throat swabbing programme is limited to the extent that the disease occurs in those school communities. In contrast to CMDHB where more than 83% of cases of RhF affected children are attending decile 1 schools, Auckland DHB and Waitemata DHB have more geographically dispersed disease with identifiable clusters of dense disease. The school-based throat swabbing programme in the high risk schools in Auckland DHB is estimated to reach 35% of vulnerable children and less than 10% in Waitemata DHB. The school-based programme is therefore only one component of the overall RhF prevention plan in both Auckland and Waitemata DHBs.¹

In Waitemata DHB, the school programme is supplemented by outreach initiatives which Te Whānau o Waipareira Trust has been contracted to deliver. Te Whānau o Waipareira Trust are working with the Child and Family Service to ensure the RhF target group in 13 other primary and intermediate schools in the Waitemata DHB area have information on RhF prevention and access to sore throat treatment and management.

Children are in school for 40 weeks of the calendar year and the Rapid Response programme (described below) is designed to provide throat swabbing and treatment services for at risk children and youth who are not in designated schools with school-based clinics, and for all at risk children outside of school hours and during school holidays. Auckland and Waitemata DHBs are working collaboratively with primary care and the schools to ensure children and their families/whānau are informed of the existence and location of free, open access clinics in their area.

### 3.3.2 Rapid Response Programmes

Both DHBs had implementation plans for their Rapid Response services agreed by the Ministry in October 2013. The aim of the Rapid Response programme is to provide open access to sore throat management to children and young people (4 – 19 years) outside of school hours, in school holidays and to Māori and Pacific and Quintile 5 children and young people not attending one of the high needs schools involved in the primary school-based programme. The target is to ensure that 80% of vulnerable children have open access to services. For this programme ‘vulnerable children’ are defined by the Ministry of Health as the target populations of Māori and Pacific children, and also children living in quintile 5 NZ Deprivation Index areas. The implementation of the Rapid Response programme across the two DHBs reflects the geographical location of the RhF target population and existing service provision.

Work in both DHBs with primary care and Pacific and community providers, has involved training of nursing and community health workers to support the delivery of the programme and implementation of the National Heart Foundation Sore Throat Guidelines. The three metro DHBs have commissioned NHC to develop an Advanced Form that will support decision pathways for GPs and practice nurses, and support DHBs and PHOs to monitor and report on the Rapid response clinics. As there is little evidence as to ‘what works’ in delivering RhF Rapid Response programmes, monitoring will help determine effectiveness and whether delivery models are continued or developed as appropriate.

To date there has been minimal use of Rapid Response clinics in either DHB. The reason for low use could be due to the warmer summer months, along with the lack of a national campaign highlighting the links between sore throats and RhF, the importance of having sore throats

¹ In addition to throat swabbing and sore throat management, the nurses are providing early identification and treatment of skin sepsis in the schools. This is one of the top three reasons for admission to Starship and Waitakere Hospitals and an important cause of avoidable hospitalisations in children.
checked and the existence and location of Rapid Response clinics during this period. As noted in 3.4 below, a national multi-media campaign is being developed and will be rolled out this autumn and winter.

Auckland DHB has entered into a Service Alliance with the four local PHOs to manage the Rapid Response programme. AH+ is the lead provider of the primary care based rapid response programme, supported by the three other PHOs. Auckland DHB’s approach to delivering Rapid Response includes:

- Nurse-led rapid response clinics in 15 general practices with a further 25 practices to start this autumn
- Community Pharmacies - trialling a clinic in a community pharmacy in Glen Innes where a significant amount of awareness raising has been done through the school-based programme
- Supplementary services in the decile 1 enhanced secondary school-based health services programme including swabbing and treatment services.

Waitemata DHB’s approach to managing and delivering the Rapid Response programme in primary care and outreach in the community, is through a direct contracting arrangement with the two Primary Health Organisations:

- Nurse-led rapid response clinics in nine general practices with more to be commissioned during the autumn period

Together with a strong and effective communications campaign (see 3.4 below) these approaches are expected to reach 80% of the target children and young people in both DHBs.

3.4 Community Based Outreach Services

Te Whānau o Waipareira Trust is a community based provider working with high risk families/whānau in the RhF target population, using a nurse team that engages with over 1,200 high risk children. They provide a Whānau Ora approach to health, education and social service provision, and link closely with local service providers from these sectors, including schools and general practices. As a result of Te Whānau o Waipareira Trust’s capacity to engage the RhF target group and their integrated approach, Waitemata DHB has funded this provider to extend its existing outreach health services to provide:

- throat swabbing, antibiotic treatment, and referral services as required, consistent with the Heart Foundation guidelines (eligible children and young people) through home visiting and in community based settings such as schools not involved in the school based programme with whom they have existing relationships
- household contacts (aged four years and above) of eligible children and young people, are offered throat swabbing, and if required antibiotic treatment, when there have been three or more cases of GAS pharyngitis in the household within three months, or there is a family history of rheumatic fever
- all children and/or their families/whānau in identified high risk communities, will be provided with adequate information about the importance of rheumatic fever prevention, and may be referred to other services.
An important aspect of this model is the ability of Te Whānau o Waipareira Trust nurses and community workers to utilise their Whānau Ora approach to link these high need children and families/whānau back to GP services and, where families/whānau have other needs, to appropriate local services.

3.5 Disease Management and Secondary Prevention

In Auckland DHB, RhF cases are concentrated in three main geographical areas; Tamaki-Glen Innes, Otahuhu, and Mt Roskill/Avondale. However, cases are also spread across other areas within Auckland DHB, and more recently in Oranga. In Waitemata DHB, over half the cases have previously occurred in Massey-Henderson, with the remainder distributed widely across the district geographically. Due to the relatively small numbers of cases each year, there is considerable variation in numbers and caution must be exercised in interpreting change in numbers. For example, whilst the number of new cases in Auckland DHB was reported to be 22 in 2013, an increase from 8 in 2012, this is a similar pattern to previous years with considerable variation across the years. None of the new cases arose from schools with school-based health services. A spatial analysis of cases over time and geographic area is currently underway for the Auckland region.

All new cases of ARF are being reviewed to identify any potential missed opportunities. This information will be fed back via existing quality mechanisms and will inform system development. All new cases of proven or suspected RhF will now be referred to infectious diseases teams in Auckland DHB, either paediatric or adult depending on the age of the patient. Notification to public health has been streamlined and the notification form redesigned.

Secondary prevention refers to the on-going management of RhF to prevent recurrences. Approximately 60% of people affected with ARF have Rheumatic Heart Disease (RHD). Recurrences of rheumatic fever increase the risk and severity of RHD and thus significantly increase healthcare costs, and reduce life expectancy. The most important preventative activity is delivery of secondary antibiotics prophylaxis via injections of penicillin every 21-28 days. This is provided by Public Health Nurses (PHNs) for children and young people still at school, and by primary care and/or the district nursing service for young people and adults. CCHADS monitors compliance and completes risk pros for every injection delivered outside the recommended range (25-33 days). Waitemata PHNs have recently started delivering prophylaxis and are setting up systems to record compliance. No system is currently in place for monitoring compliance of prophylaxis among adults. A regional bicillin working group has been established to develop this. No data exist on bicillin prophylaxis in primary care thus a specific project is underway to examine this across the region for the adolescent and young adult population with RhF (15-24 years).

Both DHBs are involved in the review of bicillin follow-up, the development of a standardised case review form (i.e. RF cases admitted to hospital) and other processes to improve assessment, management and follow-up of RhF cases. This includes ensuring that activities are delivering intended results and reinforcing appropriate messages to the family/whānau as well as linking them with appropriate medical, social and housing services.

Work is currently underway to review the Auckland Regional Rheumatic Fever Register and a business case has been developed to support the development of a sustainable register with patient management functionality.
3.6 Communications and Awareness Raising

Public awareness raising is fundamental to the success of the overall RhF programme. The MoH, Health Promotion Agency (HPA) and DHBs have developed communication strategies to raise awareness about sore throat management as well as key messages about the links between sore throats and RhF through a multi-media national campaign and regional and local initiatives.

3.6.1 National Campaign 2014

In acknowledgement of the need to promote RhF prevention and sore throat treatment, the Ministry of Health has been asked to deliver a 2014 campaign alongside the Health Promotion Agency. The campaign timeline is tight and will be running as soon as possible before winter starts. The campaign targets Pacific and Māori parents and caregivers of at-risk children and young people. The campaign will be pre-tested with at-risk population groups and key stakeholders and will complement other Ministry, District Health Board (DHB) and provider rheumatic fever activities. Messages will be refreshed and developed with at-risk population groups to ensure they are culturally appropriate, engaging and not stigmatising. The main objectives (agreed with the Minister) are to raise awareness about:

1. the link between sore throats and rheumatic fever
2. the importance of getting sore throats in at-risk children checked by a health professional
3. the importance of completing the full antibiotic course for children who have Group A streptococcal bacteria
4. rapid response clinics and where they are, to help concerned parents and caregivers get their children’s throats checked quickly.

The mass media campaign will include national TV advertising backed up by regional promotions in Auckland, Porirua and the Hutt Valley, including a heavily weighted radio component alongside online banners, print outdoor promotions, social media activities, and a high-level public relations campaign. The different parts of the campaign will be rolled out gradually over May to August 2014 and will be delivered in a sequenced approach. As currently planned, the focus for the national TV component is to raise awareness of rheumatic fever and its link to sore throats rather than specifically driving audiences to general practice to have sore throats checked. The Ministry is aware that they do not wish to encourage the ‘worried well’ to general practice.

The Ministry will be using HealthLine as a key contact point for parents and caregivers who are concerned about the sore throats of the children they care for. The Ministry is working with HealthLine to make sure they have as much information and lead-in time as possible and envision that they will deliver messages directly to concerned families around seeking attention for a sore throat, only directing the most appropriate cases to general practice.

3.6.2 Regional Community Communications Partnership Group

This group began in January 2014 and is facilitated by the Ministry with representation from all four of the Northern DHBs communications staff, Māori and Pacific led PHOs /NGOs and other key agencies and sectors. The purpose of the Community Communications Partnership is to advise, influence and challenge the Rheumatic Fever Prevention Programme (RFPP) on the development, implementation and effectiveness of its communications and engagement strategies and work together on practical actions to engage impacted families, clinicians and the wider public with the Rheumatic Fever Prevention Programme.
The outcome of this work to date is a youth engagement project on Rheumatic fever. The findings from this project will influence national, regional and local approaches for communication with youth on Rheumatic fever awareness raising, prevention and treatment. Phase 1 of the project involved the Ministry of Youth Development engaging with young people from the RhF target audience through the four DHBs’ youth participation forums. Focus groups with young people from Māori and Pasifika backgrounds were held across the northern DHB region in March. These groups looked at designing meaningful, youth-appropriate rheumatic fever messages. The groups were also asked to determine the most effective communications channels for delivering rheumatic fever messages to young people. This information will be used to design and develop a winter 2014 youth-focused communication campaign.

### 3.6.3 Local Campaign

Diagram 1 indicates the activities currently underway to raise awareness about sore throats, Rheumatic fever and treatment at the local level.

**Diagram 1**

- **Children and parents/carers**
  - Health promoting schools teams and PHN/CHWers developing consistent regional strategy for schools not involved in systematic swabbing programme

- **Youth**
  - Youth Engagement Strategy being implemented to determine best communications approach

- **Maori Community**
  - A Maori Engagement Strategy is in development across ADHB and WDHB led by the Maori Health Gain team

- **Pacific Community**
  - Pacific Engagement Strategy ensures all families involved are given information on sore throat treatment and the location of Rapid Response clinics

- **Local Community**
  - Collateral developed for display and as handouts in community settings where the target population go

**Children and parents/carers at schools not involved in the school based programmes**

The Auckland metro DHBs have taken a regional approach whereby Health Promoting Schools staff, Public Health Nurses and Community Health Workers are developing a consistent strategy and toolbox of resources to engage schools not involved in the RhF school swabbing and treatment programme and with students from the RhF target population. The aim is to raise awareness with children and their families/whānau on the importance of treating sore throats, preventing RhF and how to access free sore throat treatment through Rapid response clinics.
Youth

As previously noted, a northern region youth engagement strategy is currently underway and will inform the design and development of a winter 2014 youth-focused communication campaign. This will, in turn, determine local activities.

Pacific Community

During all Pacific Engagement Strategy activities, information to Pacific families and communities is provided on the importance of treating sore throats, preventing RhF and how to access free sore throat treatment through Rapid response clinics. It is expected that the national communications campaign will also use Pacific ethnic media and communications channels to promote sore throat treatment, RhF prevention and Rapid response clinics.

Māori Community

The Māori Engagement Strategy, led by the Māori Health Gain team, will inform wider engagement with Māori in the Waitemata and Auckland DHB areas. It is expected that the national communications campaign will also use Māori media and communications channels to promote sore throat treatment, RhF prevention and Rapid response clinics.

Local Community Engagement and Sectors Interfacing with the RhF Target Audience

Diagram 2 outlines the channels Auckland and Waitemata DHBs have identified for getting messages out to the RhF target group through other sectors and organisations providing services to the RhF target communities. Initial contact has been made with these organizations and once the location of Rapid Response clinics are confirmed, providers will be offered information and collateral to promote sore throat treatment, raise awareness about RhF prevention and the location of Rapid response clinics.

Diagram 2 - RhF prevention and Rapid response clinics.

Getting the Message Out – Local Communities and Services
4. Conclusion

To a large extent, ARF is the outcome of a combination of crowded living conditions, socio-economic deprivation, the presence of rheumatogenic GAS and access barriers to primary health care services. Families at high risk of ARF are Māori, Pacific and those in low socio-economic areas. To be effective, the programme needs to focus on these families and achieve high levels of engagement. Both DHBs have engaged with local communities and providers to ensure improved access of high risk children to sore throat management programmes and improved housing conditions.

The delivery of the programme requires a pragmatic, integrated and adaptive approach. Relationships with and integration between local Māori, Pacific and primary care providers as key influencers and service delivery agents remain fundamental to the success of the programme. Active progress continues to be made across the spectrum of prevention strategies.

As this is a new and unknown programme, ongoing communication between the Ministry, DHBs, PHOs and providers enables flexibility, and where necessary changes, in the programme design. With the school-based programme now embedded, Rapid response clinics established and more being rolled out, the Pacific Engagement strategy underway, the Māori Engagement strategy in development, the AWHI initiative progressing and a national multi-media campaign starting in May 2014 we would expect to be able to report an increase in access to primary care for the treatment of sore throats over the winter months and improved outcomes for families/whanau requiring warm and healthy housing.
4.2 Child and Youth Mental Health Services Update

Progress Update on the development of common systems and processes across the Auckland and Waitemata District Health Boards

Recommendation:

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

Prepared by: Helen Wood (General Manager, Mental Health and Addictions, Waitemata DHB) and Selena Griffith (Mental Health & Addictions Project Coordinator, Waitemata DHB/Auckland DHB)
Endorsed by: Dr Clive Bensemann (Director Mental Health and Addictions, Auckland DHB), Fionnagh Dougan (Director of Provided Services and Acting GM, Auckland DHB), Anna Schofield (Nurse Director Mental Health & Addictions, Auckland DHB), Alex Craig (Head of Division Nursing Mental Health and Addictions, Waitemata DHB) and Murray Patton (Clinical Director Mental Health and Addictions, Waitemata DHB)

Glossary

CADS - Community Alcohol and Drug Services
CAMHS - Child and Adolescent Mental Health Services
CAPA - Choice and Partnership Approach
COPMIA - Children of parents with a mental illness/addiction issue
CPHAC - Community and Public Health Advisory Committee
CYF - Child Youth and Family
DAP - District Annual Plan
DHB - District Health Board
ICSS - Youth Intensive Clinical Support Service

1. Executive Summary

This information paper provides a response to the request from the Auckland and Waitemata District Health Board (DHB) Community and Public Health Advisory Committees (CPHAC) on the 27th November 2013. A progress report was requested to update the committees on the work underway to align some systems and processes across Auckland and Waitemata DHB Child and Youth Mental Health Services.

As identified in the previous decision paper, the prioritised areas for alignment are:
1. Multi-Agency Work (Working Better Together) - focus with Child, Youth and Family
2. Service Development for Intervening Earlier
   - Children of Parents with a Mental Illness/Addiction Issue
   - Infant and Perinatal Mental Health
3. Workforce Development
2. **Introduction/Background**

Last year the Auckland and Waitemata DHB Community and Public Health Advisory Committees (CPHAC) requested further information about the potential for alignment of some systems and processes, after both DHBs presented their Child and Youth plans. An outline of the current work programmes was then presented on the 17th November 2013; these were divided into 3 main areas:

- **ADHB/WDHB Mental Health and Addiction Service collaboration work programme**
  As part of the Auckland DHB/Waitemata DHB collaboration programme, the Child and Youth Service Leaders identified key opportunities for collaboration. These were: Children of parents with a mental illness/addiction issue (COPMIA); The Youth Intensive Clinical Support Service (ICSS); and the sharing of project and service development activities.

- **Common areas of focus for both ADHB/WDHB Child and Youth strategic planning**
  The strategic plans for both services have prioritised working together across agencies to deliver better outcomes, improve experience of care and ensure better value for money. This particularly involves how they work with the Ministry of Social Development (Child, Youth and Family (CYF)), Education, Primary Care and the NGO sector. Greater interagency collaboration and partnership is a key focus area in the recent National Mental Health Strategy and Government agencies’ priorities such as Better Public Services.

- **Recent recommendations of Coronial Inquiry**
  A recent Coronial inquiry highlighted the need to strengthen collaborative planning and delivery of care, especially when young people are living between separated parents who live in different DHB areas.

The Auckland and Waitemata DHB Community and Public Health Advisory Committees (CPHAC) then endorsed the following areas for Auckland DHB/Waitemata DHB Child and Youth Mental Health Services to focus on:

1. Multi-Agency Work (Working Better Together)- focus with Child, Youth and Family
2. Service Development for Intervening Earlier
   - Children of Parents with a Mental Illness/Addiction Issue
   - Infant and Perinatal Mental Health
3. Workforce Development

3. **Risks/Issues**

Services remain committed to maintaining areas of collaboration that result in benefits for services users and their families, especially those that involve a regional approach. The change in momentum of the Auckland DHB/Waitemata DHB collaboration however may result in the loss of some opportunities.
4. **Progress/Achievements/Activity**

4.1 Multi-Agency Work (Working Better Together)

A governance group has been established with senior representatives from Child, Youth and Family (CYF), Child Adolescent Mental Health Services (CAMHS) and DHB General Management and Clinical Leaders. This group meets quarterly and is now a Regional entity inclusive of CAMHS representation from Waitemata, Auckland and Counties Manukau District Health Boards.

The purpose of the governance group is to:

- Lead the implementation of a collaborative approach to meet the needs of young people who have complex mental health needs and care and protection issues
- Early resolution of service delivery issues
- Work in partnership to provide an integrated strategic direction for both services
- Improve outcomes for young people by ensuring systems and processes are aligned and effective
- Provide a forum to discuss complex cases that require high level input
- Ensure continuity of pathways for young people through close alignment of services
- To reduce the experience of young people and their whanau of agency silos and separation.

A recent outcome of this meeting was the development of guidelines regarding management of young people who may move across DHB boundaries while they are in the care of Child Youth and Family and are receiving mental health services input. This has been supported by the Regional Child and Adolescent Mental Health Services (RCAMHS).

These guidelines include the following principles:

1. Although CAMHS have a primary responsibility to those in their geographical catchment area, treatment for a young person (especially those at moderate to high risk) should not be jeopardised because they move. Transition planning between services needs to be comprehensive and collaborative.

2. The specific circumstances for each young person are usually unique and a flexible approach, involving active liaison between CAMHS and CYF, is required to enable an optimal outcome in each case. Solutions that best fit the young person’s needs, and are mindful of specific limitations of each service, will be actively sought.

3. Should the contrary occur or there is a disagreement about the best solution to continuity of care issue, the Clinical Directors of each CAMHS will resolve the issue by direct consultation. They undertake to develop mechanisms to promote the rapid escalation of potential transition issues to Clinical Director level within their CAMHS if the above principles are not adhered to.

Some examples of how specific situations might be managed are as follows:

- A treating CAMHS team could maintain treatment if a young person moves to another DHB catchment and that move is time-limited and known to be brief (e.g. young person moves to respite care)
- A treating CAMHS team could maintain treatment when a young person moves to another DHB catchment if they have a well-established relationship with a young
person/family, and it is unclear if the relocation will be on-going (e.g. if a young person is placed in temporary care). This interim care by out of area CAMHS would be ideally less than 8 weeks.

• A treating CAMHS team might not maintain their involvement in the event of a DHB catchment move, when there is little prior history of involvement/engagement; however they could assist with transition to the local CAMHS team.

• If a young person moves to another DHB catchment, with the expectation of that placement lasting 8 weeks or longer, then transfer involving appropriate transition planning to the local CAMHS is likely to occur.

5. Crisis/acute services out of hours is always provided by the DHB of residence therefore it is necessary to negotiate and liaise with those services for young people remaining under the care of a different DHB.

6. CAMHS and CYF leaders will meet several times through the year to discuss these issues and review complex cases where continuity of care issues has arisen.

This new process appears to be working well. A current example is that of a young person under the care of Waitemata DHB CAMHS who has recently moved to Auckland DHB catchment area. It was agreed that Waitemata DHB would retain clinical responsibility to ensure the client could complete a course of psychological therapy and receive the support they require from the team they are familiar with. The situation will be reviewed when the therapy programme has finished.

We have completed a map of shared forums between Auckland DHB/Waitemata DHB CAMHS and Child, Youth Family. This is to ensure agencies are working better together and that there are forums available for services to resolve issues.

Opportunities for joint orientation and training of caregivers are currently being explored across agencies.

4.2 Service Development for Intervening Earlier

4.2.1 Children of parents with a mental illness/addiction issue (COPMIA)

Work to date is around aligning the service processes across both DHBs. This includes sharing of expertise, shared supervision and considering joint training opportunities. WDHB has developed a proposal (within the DAP funding bids) to align service provision with ADHB. This will ensure there is equitable access to children’s programmes to promote the resilience and wellbeing of children and adolescents of Adult service users.

Other initiatives include development of a resource kit for Adult Service clinicians; identifying Adult Service COPMIA champions; identifying CAMHS liaison clinicians for those champions; sourcing of dedicated Adult Service and CADS FTE for development and implementation of COPMIA pathways and on-going co-ordination of staff and resources.

4.2.2 Infant and Perinatal Mental Health (Intervening Earlier)

*Regional Maternal Mental Health Acute Options.*

New funding has been made available to the Northern region to expand the continuum of acute mental health services available for mothers (and fathers or primary carers) and babies. Metro-Auckland services are working collaboratively to enhance acute options and prioritised areas include models of care, clinical pathways and recruitment of staff.
4.3 Workforce Development

Intensive Clinical Support Service
Progression on integration of this service has been placed on hold. Both the DHBs are building on current capability and are working on a shared model of practice. Skill sharing, supervision, and networking continue between both services. Waitemata DHB is progressing well with becoming the first New Zealand service to be indexed for fidelity with the Wraparound Systems of Care model.

Shared internal expertise
Both DHBs have utilised opportunities for collaboration through a shared training calendar and cross DHB supervision and mentoring.

Each DHB will appoint a CAMHS Clinical Nurse Advisor into role, with the expectation that they work closely together and maximise opportunities to align systems and processes across Child and Adolescent Mental Health Services.

Sharing of expertise around supply and demand (efficiency and productivity)
Auckland DHB has recently completed a review of entry processes using the six sigma framework; this had significant impact on staff regarding team workload burden and client management. Findings and key learnings have been shared with Waitemata DHB to explore ways of alignment and service improvement.

Next step for both DHBs is working with Primary Care on their differences, especially regarding referral pathways and access issues.

5. Conclusion

This paper has outlined the work to date to align some systems and processes across Auckland and Waitemata DHB Child and Youth Mental Health Services. We recommend that this report be received as an update.
4.3 Community Pharmacy Update

Recommendation:

That the report be received.

Prepared by: John Kristiansen (Pharmacy Programme Manager Auckland DHB/Waitemata DHB), Tim Wood (Funding and Development Manager Primary Care Waitemata DHB/Auckland DHB)

Glossary

CPSA - Community Pharmacy Services Agreement (the national base contract for community pharmacy services)
DHBSS - DHB Shared Services (assist the 20 DHBs to deliver services at a national level)
eShared Care platform - Computer software that produces an electronic care plan
HPDT - Health Practitioners Disciplinary Tribunal (hears and determines disciplinary proceedings brought against health practitioners)
Locality - A geographic area that encompasses all people usually resident in the area
Locality approach - An approach that places local communities at the heart of health service planning and delivery, and better co-ordinates and integrate health services at the locality level
MAP - Medicines Adherence Plan (a care plan that defines mutually agreed medicines-related problems, goals and actions for all involved, and increases the person's participation in their care)
PAG - Pharmacy Advisory Group (pharmacy sector representatives that provide expert advice to the DHBs on pharmacy-related matters)
Pharmaceutical - Of, or relating to medicines used in medical treatments

1. Executive Summary

This information paper provides the Auckland and Waitemata District Health Board Community and Public Health Advisory Committees with an update on the local implementation of the national Community Pharmacy Services Agreement.

The paper describes details relating to the fourth and final stage of this transitional agreement, and some of the new patient-centred community pharmacy services that have been introduced recently. In particular, services that improve medicines adherence support for patients with long-term conditions.

Integration of community pharmacy with the wider health care sector is needed to optimise these new services. This is currently supported by local clinical engagement activities, ‘medication adherence plan’ software developments, and regional collaboration between DHBs and pharmacy stakeholders.
2. **Introduction/Background**

In July 2012 a new, nationally-agreed Community Pharmacy Services Agreement (CPSA) came into effect that transformed the funding and service model for community pharmacy. The objective of the CPSA is to manage the transition from a fee-for-service model to more patient-focused pharmacy services, with a particular emphasis on supporting patients to manage their medicines more effectively.

A major focus of the new contract concerns community pharmacy working more collaboratively with other primary care health professionals, in particular general practice. The CPSA is being implemented in stages over a three-year period; the fourth and final phase is expected to start on 1 August 2014.

The purpose of this paper is to provide CPHAC with an update about the CPSA’s implementation in Auckland and Waitemata DHBs, and to brief members about local issues relating to the community pharmacy sector.

3. **Risks/Issues**

**Community Pharmacy Services Agreement - Stage 4**

The Community Pharmacy Programme at DHB Shared Services (DHBSS) is currently preparing a formal proposal for consultation concerning Stage 4 model options, the contingency model, and the supporting systems and processes.

The main elements of this consultation will relate to:

1. introducing a new payment mechanism for ‘Core’ patients (a cohort of the population that typically requires a low level of pharmaceutical care);
2. a proposed adjustment to the service fees for ‘Long-Term Conditions’ patients; and
3. delaying the implementation of a quality incentive framework until July 2015.

Engagement with the pharmacy sector will run from 19 May to 12 June 2014. As with the CPSA’s previous transition points (and associated tight timeframes and complexity), many pharmacists may struggle to understand the technical details of the proposed changes. This is particularly problematic in Auckland and Waitemata DHBs due to the large number of pharmacies involved (135 and 117 pharmacies respectively).

To mitigate this risk, the consultation will be supported by a national DHBSS road show, with meetings already scheduled during this period in all three Metro DHBs. Funding Team staff will also be available to support providers, where necessary.

4. **Progress/Achievements/Activity**

**Long-Term Conditions (LTC) Service**

A key component of the CPSA is the LTC Service; this is designed to support patients with identified medicine adherence issues. The eligibility of a patient is managed through the LTC Service Eligibility Assessment Tool, a nationally consistent set of criteria for entry into the service. The assessment is used to identify factors that may affect a patient’s ability to adhere
to their medication regimen. The pharmacist and the patient then work together to address each issue identified.

For instance, agreed actions may include: a ‘medicines adherence plan’ (MAP), monthly contact, synchronisation of their medicines (ie dispensed at the same time rather than on an ad hoc basis), or SMS (mobile phone text) message reminders when their repeat prescription is due.

DHB Shared Services have conducted an analysis of the comparative rates of LTC registrations to gauge the level of service delivery variation across DHBs. The data used was active LTC registrations as of 30 November 2013, divided by patients with at least one Core or LTC item dispensed during the period 1 September to 30 November 2013. This data was then standardised to adjust for age, ethnicity, gender and deprivation. The figures presented in Figure 1 show the actual rate (standardised) of registration compared to the expected rate (standardised) and are expressed as an index, with 100 being the base. The expected rate is derived by applying national rates by demographic group to the population being served.

![Figure 1. Actual standardised LTC registration rates by DHB. Source: DHB Shared Services Mar 2014](image)

Given the higher index rates for Auckland and Waitemata DHB compared with base rates, these findings suggest that community pharmacy have embraced the new service model, and there is a low risk that the LTC Service is not being delivered to eligible patients by community pharmacy. Conversely, the figures may also represent over-utilisation, eg inappropriate registration of ineligible patients into the service.

Quality issues relating to service delivery, in particular over-servicing and the eligibility of patients who have been registered into the service, is overseen by the Ministry of Health’s (MoH) Audit and Compliance Unit. During the first week of April 2014, an Audit and Compliance representative will be visiting several pharmacies in Waitemata DHB. Pharmacies have been selected based on claiming queries that have identified possible non-compliance with LTC Service rules. The approach taken nationally during the early stages of service implementation has been educational rather than punitive.
Similar visits took place at Auckland DHB during May 2013; the focus of these was to gain a better understanding about service delivery on the ground, and to identify and address any issues, eg software enhancements to allow for automation of processes.

**Community Pharmacy Anti-Coagulant Management Service (CPAMS)**

From 1 February 2014, additional CPAMS agreements came into effect in Auckland and Waitemata DHBs, bringing the total number of contracted providers to seven (Auckland DHB) and 10 (Waitemata DHB). The default contracted volume per pharmacy is 50 patients.

This service involves point-of-care testing and adjustment of warfarin (a blood thinning agent) doses by community pharmacists, with the aid of a computerised decision support system. This service is convenient for patients and also supports closer working relationships between general practice and community pharmacies; a national priority. CPAMS providers must work against standing orders with nominated general practitioners, who retain overall responsibility for patient care.

The extent of service delivery is favourable across Auckland and Waitemata DHBs. Excluding five new contract holders that began providing the service from 1 February 2014, as of 31 March 2014 there was an average of 27 CPAMS patients per CPAMS pharmacy, compared with a national average of 21 patients per pharmacy. To encourage service provision, pharmacies are expected to meet service expectations within 6 months. Additional agreements are expected to be issued during 2014/15, in line with a national process.

**Pharmacy High-needs Adherence Management service (PHAMS)**

Patients who have complex medication needs, a high risk profile and are socially disconnected or unsupported with medication management will be eligible. The pharmacy will dispense more frequently for these patients and wrap a supportive service around them. Only a limited number of pharmacies have accessed this funding stream.

**Community Residential Care Services (CRC)**

A new service specification has been developed for service users living in Community Residential Facilities. CRC Services are paid using the same funding mechanisms as Age Related Residential Care (ARRC). Service delivery to ARRC facilities has remained essentially unchanged under the new CPSA.

**Clinical Engagement Activities**

There is an expectation at a national level that DHBs will support implementation of the CPSA by engaging with front-line health professionals about the recent changes to community pharmacy services, and supporting clinical partnerships between pharmacists and other health providers.

Engagement with general practice has occurred via Primary Health Organisations (PHOs), with inpatient pharmacy teams at DHB hospitals, and community and secondary care providers who care for individuals with long-term conditions (especially mental health service users). Engagement with secondary providers has been welcomed. However engagement with general practices via PHOs has been slow and required significant resource for small gains. Further engagement is planned within key areas, Tamaki and West Rodney, through the locality approach.
Further engagement work that is occurring regionally will involve up to 12 pharmacies that will pilot the eShared Care platform over the coming months, further leveraging the investment already made by the DHBs. The pharmacies will develop and evaluate software functionality that will document (using a MAP) and deliver LTC services to their patients. They will also assess the eShared Care platform’s role in improving engagement with prescribers and patients.

**Metro Auckland Pharmacy Advisory Group (PAG)**

During May 2013, Auckland and Waitemata DHBs, in conjunction with Counties Manukau DHB, sought feedback on a proposal to create a Metro Auckland PAG to replace the three existing Metro Auckland DHB PAGs, and Northern Region Pharmacy Leadership and Advisory Group. The drivers for creating a single group included: closer collaboration between Auckland and Waitemata DHB’s primary care and pharmacy work streams, and Metro DHBs working together to support CPSA implementation.

Bi-monthly meetings began in November 2013. The immediate focus of the group will be medication-related process improvements around the time of patients being discharged home from hospital.

**Health Practitioners Disciplinary Tribunal (HPDT) Decision**

The proprietors of Te Puna Hauora Pharmacy (a pharmacy within the Waitemata DHB area) have been subject to ongoing actions by Waitemata DHB and the MoH since a Pharmacy Audit Report revealed numerous legal and contractual breaches in 2011.

During November 2013, the proprietors were subject to a HPDT hearing. At the hearing a charge of professional misconduct was made out against both pharmacists; they were also censured, fined and ordered to pay costs. Neither pharmacist was suspended from practice. Details about the charges and the HPDT’s determinations have been published.

5. **Conclusion**

The current national contract for community pharmacy services is focused on patient-centred services and pharmacy working with the wider health workforce, more so than with previous agreements.

Implementation of this new transitional service and funding model has been complex and challenging for community pharmacy. However, new services have been recently introduced in Auckland and Waitemata DHB, which should benefit patients. These include medicines management support for better medicines adherence, and a convenient pharmacy-based point-of-care anticoagulant monitoring service. Audit activities will play an important role to ensure the new services are delivered appropriately, and to a high standard.

Integration of community pharmacy services with the wider primary care sector, and secondary care, is needed to get the best out of these new services. This is currently supported by local clinical engagement activities, e-Shared care software developments, and regional collaboration by DHBs and pharmacy stakeholders on system improvements.
4.4 Palliative Care

Recommendation:

That the report be received and the Committee note:

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

Prepared by: Stephanie Muncaster (Programme Manager, Chronic and Palliative Care) and Sarmila Gray (Project Manager, Planning, Funding & Outcomes, Auckland and Waitemata DHBs)

Endorsed by: Tim Wood (Deputy Director Funding & Funding and Development Manager, Primary Healthcare, Planning, Funding & Outcomes, Auckland and Waitemata DHBs)

Glossary

DHB - District Health Board

1. Executive Summary

Palliative care is a key component of health services offered for people with a life limiting illness. The palliative care services provided by the Auckland and Waitemata DHBs cover a range of services across primary as well as secondary care. Usually the DHBs provide palliative care during the last year of patient’s life. Services are also available to the patient’s family, whanau and friends.

This report provides the members of the Community and Public Health Advisory Committees with an update on a number of services and projects that are currently underway within the two DHBs remit.

Hospice West Auckland opened their inpatients unit in October 2013 however to date they have not been able to admit inpatients due to difficulty with the recruitment of medical staff. Currently work is underway to develop an implementation plan and a funding model for the recently developed model of care for adult palliative care services in the Waitemata district.

The Auckland District Palliative Care Steering Group has been endorsed by the Auckland DHB Senior Management Team to continue their function as the governing body of palliative care services provided in the Auckland district.

Development of palliative care services across the DHBs are at differing stages. The funder will work with stakeholders to identify opportunities for alignment and the staging of this.

2. Background

Each DHB offers the same range of services including primary care, hospices, and DHB delivered services.
Core hospice services include assessment and coordination of care for people referred to them for specialist palliative care. Some patients may be assessed as not having a specialist palliative care need at the time of the initial assessment. These people will be sent back to their general practice, however can be referred back at a later date if their condition changes. On completion of the initial assessment the hospice team will identify their specialist palliative care needs and agree a care plan with the patient and their family and whanau. The hospices within the two DHB areas are:

- Mercy Hospice (Auckland DHB)
- Hibiscus Hospice (Waitemata DHB)
- Hospice North Shore (Waitemata DHB)
- Hospice West Auckland (Waitemata DHB)

Each hospice provides the following services:

- Community care that can be delivered at the hospice or in the person’s place of residence
- Nursing and medical care
- Family support
- Grief and bereavement support
- Inpatient care
- End of life care planning
- 24 hour a day telephone contact for patients, whanau, as well as for GPs and Aged Related Residential Care facilities
- Education for individuals, communities and organisations

The DHBs also provide limited funding to support general practitioners to deliver primary palliative care services in the community. Patients enrolled with ProCare (across both DHBs) and Waitemata PHO (Waitemata DHB) general practices have access to a fixed number of packages of care that are available to their GPs for patients who are likely to die within the next year. This programme has been in place since 2009. General practitioners need to complete certain educational requirements to qualify for this funding. Additionally, the PHOs often allocate revenue from the Flexible Funding pool to support this programme.

3. Hospice Data

The Funder continues to work with the hospices to obtain improved service utilisation data. This section provides an overview of some of the key elements. Figure 1 shows the average number of patient contacts provided by the hospices in both DHBs.
As shown in the graph above, Waitemata DHB patients have on average between six to eight contacts a quarter whilst Auckland DHB patients have on average between five to seven contacts a quarter.

Inpatient care is currently provided by three of the four hospices. Hospice West Auckland, (see below - section 6), are still to open their inpatient facility. Inpatient care includes specialist palliative care for symptom management, respite care and end of life care. Figure 2 shows the average length of stay in hospice inpatient unit in both DHBs.
As shown in the graph above the average length of stay varies from eight to twelve days for both DHBs. If a patient is likely to require inpatient care for more than two weeks, an assessment will be undertaken by Needs Assessment and Service Coordination. Patients over 65 years will be placed in an Age Related Residential Care facility. For patients under the age of 65, appropriate placement will be arranged based on the patient’s need and availability of beds.

Approximately 96% of the after hours calls are managed by the hospice specialist palliative care nurse with only 4% of after hour calls requiring transfer to a palliative medicine specialist. About 61% of these calls are made by care givers and 21% are from patients themselves. The remaining 18% of the calls are made by Aged Related Residential Care Facilities, general practice, and secondary care teams.

4. **Place of Death**

One of the key goals of palliative care services is to provide care that allows people to die in the place of their preference.

**Figure 3: Place of death for Auckland DHB hospice patients**
As shown in the graphs above, in Auckland DHB, on average 29% of palliative patients die at their usual place of residence compared to 41% in Waitemata DHB. On the other hand an average of 26% of patients within Auckland DHB die in hospital compared to 14% within Waitemata DHB. At this time there is insufficient information to inform why this is the situation. More work is needed to better explain these variances and identify remedial action if any.

5. **Workforce Development**

The hospices provide workforce education support to the health sector through the Hospice NZ Fundamental Programme. The programme is made up of several modules. The hospices work directly with providers to identify which modules will be of benefit to their workforce and clients. A hospice may also offer the full programme at a specific time and location to allow staff from small organisations to attend.

As of 31 December 2013, 15 Fundamental modules have been delivered to Aged Related Residential Care Providers in Auckland DHB with 98 people attending. In addition, 98 palliative care education sessions have been held in Auckland DHB with 2349 people attending. Forty seven Fundamental modules have been delivered in the Waitemata DHB area with 668 people attending.

6. **Hospice West Auckland Inpatient Unit**

In March 2013 Waitemata DHB entered into an Agreement with Hospice West Auckland for the provision of two specialist palliative care beds. The hospice completed the construction of the inpatient unit in September 2013 and this was opened formally in October 2013.
The Hospice commenced the employment of nursing staff in October 2013, with the full complement employed in December 2013. However the hospice has been less successful in attracting palliative care specialists. This means to date the hospice hasn’t been able to commence admitting inpatients. However the inpatient staff have completed an orientation programme and are extending their palliative care skills by working with the community teams. The hospice continues work to recruit medical staff and they expect to be able to admit patients by May 2014. In the meantime, patients from West Auckland who need specialist inpatient palliative care continue to have access to beds at the other two hospices in the Waitemata DHB area.

7. Auckland District Palliative Care Steering Group

Auckland DHB has a District Palliative Care Steering Group that was established in 2006 to oversee the development and implementation of an Integrated Adult Palliative Care Strategy for the Auckland district. The group had been very successful in improving services for palliative patients. However, the group fell into abeyance with it being re-initiated October 2013. The Director of the Adult Community and Long Term Conditions Directorate, Auckland DHB and the Deputy Director of Funding, Auckland and Waitemata DHBs are the co-sponsors of the group.

8. Waitemata DHB Model of Care Project

In late 2012 Waitemata DHB commissioned a project to develop a standard model of care. This was done through a clinically lead process with wide stakeholder engagement. The model of care has five core principles:

1. Palliative care aims to affirm and optimise the quality of life for patients who, with family and whānau, are at the centre of care delivery;
2. Family and whānau are respected as providers as well as recipients of palliative care;
3. All palliative care patients have timely access to high quality, evidence based palliative care (primary as well as specialist) twenty four hours a day, seven days a week;
4. The disciplines of care supplied are offered in a culturally safe and sensitive manner according to need, including supporting patient choices with respect to place of death;
5. The patient experience is of a seamless and coordinated healthcare system, irrespective of diagnosis, setting, or location.

The five core principles are supplemented by nine key elements:

1. **Collaboration and Integration between all Service Providers** - this is fundamental to the model of care and is underpinned by *Formal Partnership Agreements* amongst providers to ensure clarity of roles and responsibilities and facilitate improved collaboration and sharing of resources to address need and gain efficiency;
2. **Need Based Service Provision** - the majority of palliative care needs are moderately complex which can therefore be adequately met by primary care providers themselves with indirect or direct involvement of specialist providers. Only a relatively small proportion of patients with complex needs require direct specialist involvement;
3. **Led by Primary Care supported by Specialists** – the proposed model is led and driven by primary palliative care providers. The patient’s GP is regarded as the ‘lead carer’ twenty four hours seven days a week. A member of the general practice team (preferably a practice nurse) or a registered nurse from ARRC is the designated ‘lead palliative care coordinator’;

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1 Or, Nurse Practitioner if applicable, e.g. in age related residential care facilities
4. **Locality Based Clinical Governance Framework** - this will be in line with the Waitemata and Auckland DHBs’ locality based planning. Each locality will have one or more local palliative care team(s) (PCTs) who will be the ‘link’ between primary and specialist providers and will provide ongoing support and education to primary providers. PCT(s) will be accountable to the Locality Palliative Care Governance Groups who will report to the Waitemata DHB Palliative Care Clinical Governance Group;

5. **A Nodal Network Approach** – this refers to a shared approach to scarce resources whereby specialist palliative care providers work in a collaborative and flexible manner to maximise utilisation of scarce resources to achieve efficiency and address need. ‘Single employer’ could be one mechanism to achieve this. However there could be alternative options that require further exploration;

6. **After-hours Palliative Medicine & Nursing Specialist Support** – an agreement is required with regards to a district wide twenty four hours seven days a week palliative medicine and nursing specialist cover including telephone support;

7. **Inpatient Beds** – Finding an equitable, efficient and sustainable solution to future configuration of inpatient beds in the district will require detailed economic analysis and transparency around current funding before a sustainable future state can be proposed;

8. **Clinical Pathways** – standard pathways and clear roles and responsibilities need to be defined and agreed to; and

9. **Clinical Services** – these need to be underpinned by a robust clinical governance framework to ensure equity and evidence based practice.

The model of care was approved by the Board of Waitemata DHB near the end of 2013. The next stages are:

- Development of an implementation plan (including stakeholder engagement plan, workforce development plan, education strategy and outcomes measurement framework) and,
- Development of a funding model including options analysis.

To date the following activities have been undertaken.

- **Re-appointment of the Independent Chair** - Stakeholder feedback suggested that the independent chair played a vital role in successful completion of the previous stage of the project. It was felt that going forward an independent chair would continue to be critical in ensuring that all stakeholder views were considered in a fair and unbiased fashion and the focus was on meeting the needs of patients, families and Whanau. John Robertson has been reappointed as the independent chair for the next phase of the project.

- **Stakeholder Engagement** - The independent chair and the project manager continue to engage with the governance teams and senior clinical groups/committees of key stakeholders to present the new model of care and to seek their support with the development of the implementation plan. Feedback suggests stakeholder support with the model of care and willingness to participate in developing the implementation plan.

- **Re-establishment of the Waitemata District Palliative Care Clinical Governance Group** - The main purpose of this group is to provide guidance and oversight of the development of the implementation plan and ensure that the project is successfully completed on time. This group is chaired by John Robertson. This group consists of seven members providing guidance and leadership for the work programme, and not as a representative
of any particular stakeholder group. To date six members have been appointed and work is in progress to appoint the remaining member, a general practitioner.

- Waitemata District Palliative Care Clinical Reference Group - This group will be tasked with working out the clinical and practical details of the implementation plan. Reporting to the governance group, this group will be comprised of a range of senior clinicians (about 12 members) directly involved with the provision of primary and specialist palliative care on a day to day basis. Members are being selected to join the group based on their clinical expertise and technical knowledge of their respective disciplines, not the stakeholder they may belong to.

To date eight members have been recruited and work is in progress to appoint the remaining members including the chair. The appointment of the chair to lead the reference group is critical to commencing this work. To date the DHB’s efforts to find a suitable chair from within and outside the district has been unsuccessful. The DHB is currently working with stakeholders and exploring alternative options to resolve this matter. Appointment of a Chair is delaying this group in making progress.

- Funding Model - The development of the Funding Model has been initiated. Discussions are being held with technical experts from the School of Population Health and the Business School, University of Auckland to support this work programme. This work will commence by reviewing existing international models and then a proposed work plan for developing the model will be submitted to the governance group.

7. Conclusion

Auckland and Waitemata DHBs are committed to ensuring that people who need palliative care services receive a consistent level of care regardless of the provider, diagnosis, setting or location. Going forward clinical leadership will play a key role in driving the provision of quality palliative care services. This will be supported by the Waitemata DHB model of care work as well as by the reestablishment of the Auckland District Palliative Care Steering Group.
4.5 Quality Use of Medicines

Recommendation:

That the report be received.

Prepared by: Angela Lambie and John Kristiansen (Project Managers, Quality Use of Medicines Team, Waitemata DHB)

Glossary

Health Quality and Safety Commission - Leads and coordinates improvements in safety and quality in healthcare in New Zealand
Institute of Healthcare Improvement - An international organisation that aims to optimise health system performance
Health Navigator - A New Zealand-based website that provides patient information about medicines and health conditions
Healthpoint - An online directory of health providers and resources within Northern Region and Capital and Coast DHBs
Opioid - a group of medicines that relieve pain (e.g. morphine)
Goodfellow Unit - an organisation that provides learning resources to general practice teams
Northern Region DHBs - Auckland, Counties Manukau, Northland and Waitemata DHBs
QUM - Quality Use of Medicines

1. Executive Summary

This report is to provide CPHAC with an update on four projects that are being coordinated by the Quality Use of Medicines team. For each project there is a brief summary which provides background and key achievements. All projects are on track.

2. Introduction/Background

The Quality Use of Medicines (QUM) team manages projects that are focused on promoting medicines safety. The QUM team works closely with primary and secondary care services to highlight important medicines safety messages. A key component of this is to support health literacy and patient self-management by providing culturally appropriate educational material.

Governance of QUM projects is provided by a multidisciplinary Steering Group that meets quarterly. The QUM team has established collaborative links with regional and national medicine safety stakeholders including the University of Auckland, New Zealand Formulary, First Do No Harm Group, and Health Quality and Safety Commission (HQSC).
3. **Risks/Issues**

None identified.

4. **Progress/Achievements/Activity**

4.1 **Pictorial Asthma Medication Plan (PAMP)**

[www.pamp.co.nz](http://www.pamp.co.nz) is a website that health professionals can use to create personalised asthma education materials for children and their caregivers with a particular focus on Pacific families (Samoan, Tongan and Tuvaluan versions are available).

An evaluation published in the New Zealand Medical Journal in 2012 concluded that the PAMP resources were effective at improving inhaler knowledge and supporting symptom recognition, and that the features of a ‘less-is–more’ approach, pictorial format, and first language availability are characteristics that may benefit other ethnicities.

A recent survey of users (predominately asthma educators and general practice nurses) showed favourable use and utility of English and translated versions of the PAMP in Pacific children, often alongside other asthma resources; 79% (19 of 24 respondents) reported that they had used a PAMP in children of other (non-Pacific) ethnicities.

During March 2014 the website had 39 unique visitors and 33 PAMPs were generated. Currently, Te Reo Māori and Simplified Chinese versions are being developed by Healthalliance in response to demand from users.

4.2 **SafeRx**

SafeRx® promotes the safe and effective use of medicines to primary care health professionals. The QUM team produces and distributes bulletins, guidelines and patient guides to 1200 general practice members, midwives and community pharmacies who are SafeRx® members. The team has produced 31 SafeRx® bulletins, four practice guidelines, 14 patient guides, and 3 patient leaflets.

In 2012 SafeRx® received funding from the HQSC to expand SafeRx® to all Northern Region primary care teams. General practice software providers and the New Zealand Formulary have links and logos to click on for specific medicines, which lead users to the relevant resources on [www.saferx.co.nz](http://www.saferx.co.nz). We are in discussion with community pharmacy software providers to offer a similar service to pharmacy. The SafeRx® website had 582 unique views in March 2014 (increasing from 44 in March 2010).

The bulletins and guidelines are peer-reviewed, and the patient guides and leaflets undergo rigorous clinical and consumer review. Some leaflets are available in other languages. An evaluation of the project was performed by the School of Pharmacy in 2010; the majority of SafeRx® members agreed the resources had added value over and above other medicines information resources, because the bulletins targeted specific safety issues.
4.3 Patient Booklets
Culturally appropriate patient information booklets have been produced to explain medicines for three long-term conditions: ‘Heart failure’, ‘Coronary artery disease’, and ‘Starting insulin for type 2 diabetes’. These booklets are available in English, Korean, Chinese and Samoan. The insulin booklet is also available in Tongan.

All booklets undergo rigorous clinical and consumer review and are regularly updated. Distribution is predominantly via the Waitemata DHB Cardiology and Diabetes Services to newly diagnosed patients. The booklets are distributed to primary care providers on request. Electronic versions are available via Health Navigator, Healthpoint, Waitemata DHB and Asian Health Services websites. Since 2006 over 20,000 booklets have been distributed (12,825 in English and 8,819 in other languages).

4.4 e-Learning – Safe Use of Medicines Courses
The QUM team works closely with Waitemata DHB’s e-Learning team and secondary care services to develop peer-reviewed courses that promote the safe use of medicines. There are 13 courses available to all staff at Waitemata DHB, and they are integrated into the Junior Doctors teaching programme. These courses will be shared with Auckland DHB secondary services, and further courses will be developed collaboratively for use in both DHBs. The Medication Chart course has been completed by 75% of first year doctors; 82% of them consider the course to be useful and applicable to their practice. Certificates are produced upon course completion. A range of clinical staff including dieticians, midwives, nurses and pharmacists frequently access these courses.

The courses are shared with other DHBs on request, ProCare PHO, the Goodfellow Unit, the HQSC, Southern Cross Hospitals, and The University of Auckland. The ‘Pharmacological Management of Pain’ course has recently been updated as part of a larger project within Waitemata DHB, which has used the Institute of Healthcare Improvement methodology to reduce opioid-related harm.

5. Conclusion
The QUM team are on track with projects that aim to improve the safe and quality use of medicines. The resources and results of QUM project evaluations are being actively shared regionally and nationally.
5.1 Planning and Funding Update

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence, Waitemata and Auckland DHBs), Tim Wood (Funding and Development Manager Primary Care, Waitemata and Auckland DHBs), Marty Rogers (Maori Health Gain Manager, Waitemata and Auckland DHBs), Samantha Bennett (Manager Asian, Migrant and Refugee Health Gain, Waitemata and Auckland DHBs)
Endorsed by: Dr Debbie Holdsworth (Director Funding, Waitemata and Auckland DHBs), Simon Bowen (Director Health Outcomes, Waitemata and Auckland DHBs)

Glossary

DHB - District Health Board
PHO - Primary Health Organisation

1. Introduction

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

2. Summary of activities in common

2.1 Collaboration in Planning, Funding, and Outcomes

Another key milestone in the collaboration has been achieved with the consultation on the draft structure for Planning, Funding and Outcomes Unit which began on 16 April. This is stage 2 in the transition of the Planning, Funding and Outcomes Unit. Meetings were held at the North Shore and Greenlane to ensure all staff had an opportunity to hear the presentation and ask any questions. Staff have been provided three weeks until 7 May to provide feedback on the proposed structure.

Once the feedback has been collated, the final structure will be taken to both boards for endorsement. The implementation of the final structure is currently anticipated for July 2014.

Space planning is continuing to ensure the offices at 15 and 17 Shea Terrace can accommodate all of the staff in the unit. The current configuration of seating will need to be modified for the additional desks required.

2.2 Planning

The Auckland and Waitemata DHB Annual Plans are now well advanced and draft 2 is presented at this meeting for review. We have responded to informal feedback from the National Health Board. However, formal feedback is not due until 28 April so is not included in this draft. See paper for more detail.
2.3 Healthy Families EOI

Healthy Families New Zealand is a new initiative that aims to improve people’s health where they live, learn, work and play in order to prevent chronic disease. The Ministry of Health is leading the establishment of HFNZ communities in 10 locations across New Zealand. The locations are:

- East Cape
- Far North District
- Invercargill City
- Lower Hutt City
- Rotorua District
- Manukau Ward
- Manurewa-Papakura Ward
- Spreydon-Heathcote Ward
- Waitakere Ward
- Whanganui District

The Ministry of Health is running an Expressions of Interest process with a closing date for responses of 14 May 2014. The funding for Healthy Families NZ will allow providers to:

- establish and build a local health promotion workforce
- support communities to find local solutions to local needs
- roll out a range of programmes that provide skills and support for families to achieve better health
- support prevention partnerships within their communities (e.g. with government, non-government organisations, businesses and community members)
- support health promoting early childhood services, schools, workplaces and communities
- tailor health messaging to local circumstances and needs
- contribute to research and evaluation.

We are aware of several providers who are considering responding to the Expression of Interest.

More information can be found at http://www.health.govt.nz/our-work/preventative-health-wellness/healthy-families-nz

2.4 Streamlining Contracting with NGOs

Cabinet directed the Ministry of Business, Innovation and Employment (MBIE) to lead a programme of work to begin transitioning public service departments and the wider state services agencies that contract with NGOs onto a new “outcome-focused” streamlined contracting framework over the next 3 years. The streamlined contracting framework was developed during a pilot programme undertaken in mid-late 2012.

The contracting framework encourages greater consistency, coordination, collaboration and information sharing by government agencies and Crown entities to reduce duplication of contract management activity and reduce the compliance burden on NGO providers.

The contracting framework creates a new and scalable standard contract for use when a government agency purchases services from a NGO provider. The framework should have the same look and feel no matter which government agency uses it.
MBIE are starting the engagement with DHBs to consider how the framework can be implemented with NGOs in the health sector. It has been proposed that this framework could be piloted with some mental health NGOs. Updates will be provided as progress is made.

More information can be found at [http://www.business.govt.nz/procurement](http://www.business.govt.nz/procurement)

### 3. Maori Health Gain

#### 3.1 Maori Health Plans 2014-2015

These plans were submitted in line with MOH requirements and we are awaiting feedback. All PHOs, MOU partners and Manawa Ora, have received, reviewed and provided feedback in the development of the initial draft plans and the current version being worked on. It is intended that both plans with be submitted to each DHB board in line with MoH sign off criteria.

#### 3.2 Maternal and Infant Nutrition & Exercise project

The Auckland and Waitemata DHB Maternal and Child Nutrition and Activity project “Healthy Babies: Healthy Future” is due to begin in earnest on the 1st May. This is a MoH funded project and has a number of providers across the Maori, Pacific, Asian and South East Asian communities involved and also a number of specialist groups like Maternity Services, Primary Care, Plunket etc. The programme was launched nationally last year by Minister Ryall and the point of difference for the project here in Auckland is the collective approach supported by an innovative Txt messaging tool.

Key activities that have been identified in the plan include:

- Cross cultural support to messages
- Integrated message delivery through services and communities
- Use of community leaders to advance kaupapa

#### 3.3 Cancer

In the last quarter the MoH put out a RFP to meet the FCT (Faster Cancer Treatment) times. Through the regional GM Maori forum and the Regional Cancer Maori Leadership group, a proposal to increase the interaction point with Maori whanau along the diagnostic pathway was developed. The focus will be on Whanau Ora assessment early on the pathway to support and ensure service responsiveness to whanau and whanau engagement through increased understanding and support of the process and pathway.

Cervical screening coverage has had a slight increase for Waitemata DHB. Work planned and currently underway with the Metro Auckland Cervical Screening Governance group is focussing on increasing coverage for Maori and Pacific women. This includes a number of approaches working with Primary Care, Independent Service Providers and communities. The changes made to the National Screening Unit database have almost been completed and it is expected that we may see a slight change in coverage for Waitemata as a result of the ethnicity project.

The Bowel Screening Pilot project has the potential to contribute to good health outcomes for the community and in particular Maori. Uptake over years 1 and 2 for Maori is less than non-Maori and as a result of this a number of activities in services and communities are planned. The Kaitiaki Roopu has been working with the programme team to assist with increasing uptake, supporting staff and whanau, and providing advice regarding process when and where necessary.
3.4 Whanau ora

The business case for a Whanau Ora centre in Glen Innes has been endorsed by the Auckland DHB Audit and Finance committee however a source of funding is yet to be identified.

The localities work in West Rodney has had good participation by the Maori community, MOU partner and broader community groups. The potential for a Whanau Ora centre kaupapa in this area is being considered, with a decision yet to be confirmed.

The integrated contracts are nearing completion and sign off by each of the providers. This kaupapa is an initial step in facilitating an environment that allows the providers to develop their services to be responsive and deliver in a Whanau Ora paradigm.
7. Resolution to Exclude the Public

Recommendation:

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

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

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
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<tbody>
<tr>
<td>1. Programme Update</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]</td>
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<td>Negotiations The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]</td>
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<td>2. Review of 2014/15 Annual Plan and Statement of Intent</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Obligation of Confidence The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]</td>
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