Community and Public Health Advisory Committees Meeting

Wednesday, 30th July 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 JULY 2014

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

COMMITTEE MEMBERS

Gwen Tepania-Palmer – Committee Chair (WDHB and ADHB Board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Deputy Chair
Jo Agnew - ADHB Board member
Peter Aitken - ADHB Board member
Judith Bassett – ADHB Board member
Pat Booth - WDHB Board member
Chris Chambers - ADHB Board member
Sandra Coney - WDHB Board member
Warren 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

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: Robyn Northey and 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
  2.00pm  2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health
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11th June meeting cancelled due to power cut

* absent
* attended part of the meeting only
# absent on Board business
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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)  
|                  | Max Abbott – 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)  
| 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  
| Jo Agnew          | Professional Teaching Fellow - School of Nursing, Auckland University  
|                  | Trustee Starship Foundation  
|                  | Casual Staff Nurse - ADHB  
| Peter Aitken      | Pharmacist  
|                  | Shareholder/Director, Consultant - Pharmacy Care Systems Ltd  
|                  | Shareholder/Director – Pharmacy New Lynn Medical Centre  
| Judith Bassett    | Nil  
| Pat Booth         | Consulting Editor – Fairfax Suburban Papers in Auckland  
| 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  
| Sandra Coney      | Elected Member – Chair: Waitakere Ranges Local Board, Auckland Council  
| 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  
| Lee Mathias       | Chair – Counties Manukau District Health Board  
|                  | Chair-Unitec  
|                  | Managing Director – Lee Mathias Ltd  
|                  | Trustee – Lee Mathias Family Trust  
|                  | Trustee – Awamoana Family Trust  
|                  | Director – Pictor Ltd  
|                  | Director – John Seabrook Holdings Ltd  
|                  | Chair – Health Promotion Agency  
|                  | Director – iAC IP Ltd  
|                  | Advisory Chair, Company of Women Ltd  
| Robyn Northey     | Project management, service review, planning etc. – Self employed Contractor  
|                  | Board member – Hope Foundation Northern Region  
|                  | Trustee, A+ Charitable Trust  
| Christine Rankin  | Member - Upper Harbour Local Board, Auckland Council  
|                  | Director – The Transformational Leadership Company  
|                  | CEO – Conservative Party  

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 30/07/14
**Register of Interests continued...**

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<tr>
<th>Name</th>
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<tr>
<td><strong>Allison Roe</strong></td>
<td>Member – Devonport-Takapuna Local Board, Auckland Council</td>
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<td>Chairperson – Matakana Coast Trail Trust</td>
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<td><strong>Gwen Tepania-Palmer</strong></td>
<td>Chairperson – Ngatihine Health Trust, Bay of Islands</td>
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<td>Life Member-National Council Maori Nurses</td>
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<td>Alumni – Massey University MBA</td>
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<td>Member - Active Clinic Network for Greater Auckland Integrated Health Network</td>
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<td>Chair - Child Health Network, Northern Regional Health Plan</td>
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<td>Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland</td>
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2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 30th April 2014

Recommendation:

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

Community and Public Health Advisory Committees

Wednesday 30 April 2014

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

PART 1 – Items considered in public meeting

COMMITTEE MEMBERS PRESENT:

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

ALSO PRESENT:
Dale Bramley (WDHB, Chief Executive)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Marty Rogers (ADHB and WDHB, Manager, Maori Health Gain)
Rachel Mattison (ADHB and WDHB, Associate Planning and Funding Manager)
Jean McQueen (ADHB and WDHB, Primary Care Nursing Director)
Ruth Bijl (ADHB and WDHB, Funding and Development Manager)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

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

WELCOME The Committee Chair welcomed all those present.

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

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

Carried

DISCLOSURE OF INTERESTS

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

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

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 19 March 2014 (agenda pages 1-11)

Resolution (Moved Warren Flaunty/Seconded Jo Agnew)

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

Carried

Matters Arising:

No issues were raised.

3 DECISION ITEMS

3.1 Oral Health (agenda pages 12-19)

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

- The two year oral health pilot for high risk pregnant women in Waitemata DHB, which concludes on 25 February 2015, will be evaluated by the independent company Litmus, along with two other different pilots addressing this matter elsewhere in New Zealand. Litmus will make a recommendation to the Ministry of Health on the pilots’ effectiveness and efficiency. It will then be up to the Minister of Health to decide whether to run this nationally or not.

- In oral health, “high risk children” are identified by decay levels and oral health practices. Plunket has been provided with an assessment tool which categorises high risk children for referral to ARDS.

- Dr Tim Jelleyman advised that integration of different types of enrolment is being looked at as part of the Well Child Improvement Programme.

- With regard to achievement of pre-school enrolment targets, Helene May advised that the focus for ARDS needs to be 0-2 year olds and Maori children.

- There is a link with the B4 School Check Programme in terms of getting children enrolled with ARDS.

Resolution (Moved Robyn Northey/Seconded Jo Agnew)

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

Carried

Resolution (Moved Lee Mathias/Seconded Max Abbott)

That the Auckland and Waitemata DHB Community and Public Health Advisory Committees endorse the current activity, including strategies and new initiatives, in order to maintain the Ministry of Health targets including:

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

Carried

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

4. INFORMATION ITEMS

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

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

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

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

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

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

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

Matters covered in discussion and response to questions included:

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

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

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

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

**Resolution** (Moved Robyn Northey/Seconded Max Abbott)

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

Carried

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

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

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

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

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

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

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

Matters covered in discussion and response to questions included:

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

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

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

**Carried**

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

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

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

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

Matters covered in discussion and response to questions included:

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

**Resolution** (Moved Jo Agnew/Seconded Christine Rankin)

That the report be received.

Carried

4.4 **Palliative Care** (agenda pages 42-49)

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

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

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

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

**Carried**

Other matters covered in discussion and response to questions included:

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

**Resolution** (Moved Lee Mathias/Seconded Peter Aitken)

That the report be received and the Committee note:

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

**Carried**

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

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

Matters covered in discussion and response to questions included:

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

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

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

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

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

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

Resolution (Moved Max Abbott/Seconded Jo Agnew)

That the report be received.

Carried

5. STANDARD MONTHLY REPORTS

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

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

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

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

Resolution (Moved Warren Flaunty/Seconded Max Abbott)

That the report be received.
Carried

6. General Business
There was no general business.

7. Resolution to Exclude the Public

Resolution (Moved Lee Mathias/Seconded Jo Agnew)

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

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

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| 1. Programme Update                     | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)] | Commercial Activities
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]

Negotiations
The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)] |
| 2. Review of 2014/15 Annual Plan and Statement of Intent | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)] | Obligation of Confidence
The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)] |
3.45p.m - 4.27p.m - Public excluded session.

4.27p.m – open meeting resumed.

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

The meeting concluded at 4.27 p.m.
### Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 22\textsuperscript{nd} July 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>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>Refer Report 7.1 – Long Term Conditions.</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 03/09/14</td>
<td></td>
</tr>
<tr>
<td>CPHAC 19/03/14</td>
<td>5.1</td>
<td>Primary Care Update – to include some demographic information relating to &quot;Access to Diagnostics&quot; in next quarterly report.</td>
<td>Tim Wood</td>
<td>CPHAC 11/06/14</td>
<td>Included in Primary Care report, item 7.3.</td>
</tr>
<tr>
<td>CPHAC 30/04/14</td>
<td>4.1</td>
<td>Rheumatic Fever Prevention and Intervention Programme – resolving regional database issue to be pursued as a significant issue and reported on in next update report.</td>
<td>Ruth Bijl</td>
<td>CPHAC 30/07/14</td>
<td>Refer report 4.1.</td>
</tr>
<tr>
<td>CPHAC 30/04/14</td>
<td>4.4</td>
<td>Palliative Care – information relating to Eastern Bays Hospice to be obtained and reported to Auckland DHB.</td>
<td>Stephanie Muncaster/ Sarmila Gray</td>
<td>ADHB Board 06/08/14</td>
<td>Being prepared for ADHB Board.</td>
</tr>
<tr>
<td>CPHAC 30/04/14</td>
<td>4.5</td>
<td>Preparing Consumer Information for Different Ethnicities – report to be provided on how this is done, including information on websites and resource materials, and advising on whether how this is done needs more attention.</td>
<td>Tim Wood</td>
<td>CPHAC 03/09/14</td>
<td></td>
</tr>
</tbody>
</table>
3.1 Tobacco Control Update

Recommendation:

That the report be received and the Auckland and Waitemata DHBs’ CPHAC Committees:

a) Endorse the current and planned tobacco control activity in Auckland and Waitemata DHBs.

b) Note that Auckland and Waitemata DHBs expect to achieve both the hospitals and primary care ‘better help for smokers to quit’ health targets for 2013-14.

c) Note the Planning, Funding and Outcomes Unit are developing a combined tobacco control plan for 2015-18 for Auckland and Waitemata DHBs.

Prepared by: Leanne Catchpole (Programme Manager, Primary Care Team); Lis Cowling (Smokefree Team Manager Waitemata DHB); Georgina Darkens (Mental Health Smokefree Coordinator Waitemata DHB); Leanne Kirton (NGO Mental Health Smokefree Project Manager NRA); Tom Robinson (Public Health Physician); Karen Stevens (Smokefree Services Team Manager ADHB);

Endorsed by: Tim Wood (Deputy Director Funding); Marty Rogers (Māori Health Gain Manager); Dr Debbie Holdsworth (Director Funding), Simon Bowen (Director Health Outcomes)

Glossary

ABC - Ask, Brief advice, Support to quit
DHB - District Health Board
NRT - Nicotine Replacement Therapy
LMC - Lead Maternity Carer
MOH - Ministry of Health
NGO - Non-government Organisations
NRA - Northern Regional Alliance
NRT - Nicotine Replacement Therapy
PHO - Primary Health Organisation

1. Summary

This report updates the Committees on Auckland and Waitemata DHBs’ tobacco control activity. Reducing the number of people who smoke and the harm from tobacco products is one of the government’s health targets, referred to as ‘better help for smokers to quit’. Activity to meet the targets is the focus of tobacco control work in secondary and primary care. The DHBs have met the hospitals target for the past couple of years and expect to meet the primary care target for the first time in quarter four 2013-14. There is also a target to provide better help for pregnant women to quit smoking, however the Ministry of Health (MOH) does not currently report on this target.

The 2013 Census has provided a valuable update on the number of smokers in our populations. The data is showing a steady decline in the rate of smoking across all ethnicities.
There are nine quit smoking services available in Auckland and Waitemata DHB areas that provide face-to-face support to help people to quit smoking. Referrals to these services have increased recently due to additional promotional activity and more referrals coming from primary care.

There is a high rate of smoking by mental health service users, thus the DHBs are undertaking projects to promote smokefree lifestyles within mental health services. There is also a regional project led by the Northern Regional Alliance (NRA) that is working with all mental health Non-government Organisations (NGOs). From July 2014 Auckland DHB mental health services are also starting a smokefree project.

There are five projects occurring in the Auckland and Waitemata DHB areas that are funded by the Ministry of Health (MOH) Pathway to 2025 Innovation Fund. These projects are trialling new and innovative ways to reduce smoking in our communities.

The Planning, Funding and Outcomes Unit are developing a combined tobacco control plan for 2015-18 for Auckland and Waitemata DHBs.

2. Background

Smoking is the single most modifiable risk factor causing disease and death in our community. This is particularly so for our Māori and Pacific populations, resulting in a significant reduction of quality of life and years of life. New Zealand also has relatively high rates of smoking in pregnancy; reducing these rates leads to better maternity and neonatal outcomes.

The Government has set a goal of ‘Smokefree Aotearoa 2025’. The measure of achievement for this goal is that the rate of smoking in New Zealand is 5% (or less) of the population by 2025. DHBs have a key role in supporting the achievement of this vision.

The Ministry of Health (MOH) has contracts with both Auckland and Waitemata DHBs for tobacco control activity and some quit smoking support services. Through the tobacco control contracts, DHBs have been resourced to lead, coordinate and develop tobacco control activities and meet the ‘better help for smokers to quit’ health targets. The DHB tobacco control contracts therefore also allow for the strengthening of relationships and for finding better ways of working between communities, primary and secondary care.

In 2009 the Government introduced the ‘better help for smokers’ to quit health target. The target requires 95% of patients who smoke and are seen by a health practitioner in a public hospital, 90% of patients who smoke and are seen by a health practitioner in a primary care setting and 90% of pregnant women (who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer (LMC)) to be offered brief advice and support to stop smoking. More specifically, the target is designed to prompt health providers to (1) ask about and document every person’s smoking status, (2) give brief advice to stop to every person who smokes, and (3) strongly encourage every person who smokes to use support to quit smoking (a combination of behavioural support and stop-smoking medicine works best) and offer to help them access it. This process is commonly known as ABC. There is strong evidence that brief advice is effective at prompting quit attempts and long-term quit success. An offer of treatment is even more likely to prompt a quit attempt than brief advice alone.
Māori, Pacific people and pregnant women are priority population groups for all tobacco control work, due to the higher prevalence and/or higher impact of smoking in these groups. Mental health clients are also high users of tobacco products and are considered a priority group in our tobacco control plans.

3. Population Smoking Rates

Note: much of this information is taken from the 2013 Census. The data available is not the final Census data, which will be adjusted for people out of the area on census night and undercount. It should also be noted that the Census questions (2006 and 2013) only ask about cigarette smoking (i.e. pipe and cigar smokers are not included).

In the 2013 Census 12% of the Waitemata adult population and 11% of the Auckland adult population said that they were regular (tobacco) cigarette smokers.

Table 1, estimated number of regular smokers, Auckland and Waitemata DHB, 2013

<table>
<thead>
<tr>
<th>Age group</th>
<th>Asian</th>
<th>Māori</th>
<th>Other</th>
<th>Pacific</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB Total</td>
<td>9,027</td>
<td>6,883</td>
<td>20,046</td>
<td>7,867</td>
<td>43,824</td>
</tr>
<tr>
<td>Waitemata DHB Total</td>
<td>6,612</td>
<td>9,683</td>
<td>31,947</td>
<td>5,515</td>
<td>53,757</td>
</tr>
</tbody>
</table>

The proportion of people who were regular smokers varies by age, gender, and ethnicity.

Māori men and women and Pacific men have particularly high rates of smoking, over double the rates of the total population. The DHB’s Māori and Pacific plans have specific actions to reduce the rate of smoking in these populations. Asian women have very low rates of smoking.

Figure 1, smoking rates by ethnicity and gender for Auckland and Waitemata DHBs
Smoking rates increase in the teens and early twenties and thereafter decline, particularly during the thirties and then after the age of 50. A similar pattern is reflected in the proportion of our population who are ex-smokers.

There have been substantial drops in smoking rates between the 2006 and 2013 Censuses in both Waitemata and Auckland DHBs. If the trend was to continue at the same rate for the next 12 years both DHBs would reach the national target of 5% of adult population being smokers. Ethnic specific rates were only available for Waitemata DHB in 2006, but they show a fall in smoking rates for all ethnic groups, with the steepest decline being for Māori.

Figure 2, proportion of Auckland and Waitemata DHB populations who are current and ex-smokers, by age in 2013

Figure 3, smoking prevalence in 2006 and 2013 Censuses and 2025 target for Auckland and Waitemata DHBs
Action on Smoking and Health (ASH) undertakes an annual survey of year 10 students (14-15 year olds) smoking habits. This has shown dramatic declines in the proportion of students who are regular smokers. This seems to be levelling off at around 5%.

Figure 4, proportion of year 10 students who are regular smokers, by year for Auckland and Waitemata DHBs (Action on Smoking and Health)

4. Hospitals Health Target Update

“95 per cent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking” – hospitals, better help for smokers to quit, health target.

Auckland DHB has consistently achieved this target since December 2012. For the 2013-14 year there have been 97,536 discharges over this period with 94,154 coded at the time of writing. Within these coded figures 12,095 current smokers were identified (12.8% smoking rate). Brief advice to stop smoking and an offer of support to quit was given to 11,612 (96%) of the smoking population. For Māori, there were 8,836 coded discharges, of which 2,821 smoke (31.9%) and 2,713 (96.2%) were given brief advice and an offer of support to quit. For Pacific peoples there were 11,926 coded discharges, of which 1,848 (15.5%) smoke and 1,785 (96.6%) were given brief advice and an offer of support to quit smoking.

Waitemata DHB has consistently achieved this target since September 2011. For the 2013-14 year, North Shore and Waitakere Hospitals had combined admissions of 94,143. Of these, 13,667 (15%) were identified as currently smoking and 13,278 (97%) were given brief advice and support to quit smoking. For Māori, the total number of admissions was 7,746 of which 2,956 (38%) smoke and 2,873 (97%) were given brief advice and support to quit smoking, and for Pacific, the totals were 7,003 of which 1,261 (18%) smoke and 1,233 (98%) were given brief advice and support to quit smoking.
All admitted patients across both hospitals are asked if they smoke tobacco. After identifying a current smoker brief advice to stop smoking is given by a health professional and documented in the patient’s paper file. This is again reinforced through advice/support options contained in the electronic discharge summary for those identified as current smokers.

Both hospitals have a Smokefree Services team that supports the achievement of this target through systems, training and auditing. To maintain the focus on documentation, weekly auditing is carried out by the Smokefree Services team of the notes of smokers that have not been given advice and support to quit. The Smokefree Services teams provide targeted training when an audit shows an area is not performing well. Every week the health target results are calculated for each inpatient ward/service. These results are then displayed showing the reporting service percentage, alongside the overall percentage result, and distributed by email by the CEO. For those services where the 95% target is not met, the respective Charge Nurses are contacted and strategies requested to minimise a reoccurrence.

To move towards a more sustainable system, Smokefree Leads (in Auckland DHB these are the Charge Nurses) within each service area are trained, resourced and supported by the Smokefree Team in order, to then in turn, support their colleagues and peers. In Waitemata DHB the goal of having 90% of inpatient services with a Smokefree Lead (including the Māori Health Team) by June 2014 has been met (currently 29 services from 31 represented).

There a number of ways in which a patient can be provided with support to quit on discharge. This can be by giving the patient a Quit Card (a voucher for subsidised NRT that can be redeemed at any pharmacy) or through a medical script. In Auckland DHB Smokefree Services provides a triage service for patients wanting support to quit smoking; they receive between 80-100 referrals a month and refer these patients to community providers for support to quit. In Waitemata DHB very few patients have been referred on to community based support to quit smoking upon discharge. To increase the number of hospitalised smoking patients being referred for support to quit post-discharge, as in Auckland DHB, a central referral and triage service is being developed. Patients wanting support to quit smoking will be referred to the Smokefree Team who will then assess and refer to the most appropriate service for them. Both DHBs are developing a process for Māori and Pacific patients who would like support to quit smoking to be proactively followed-up on post-referral to ensure that they have had every opportunity to engage with a quit smoking service.

The Smokefree Services teams also maintain a general awareness of the target such as being present on Welcome Day for all new employees and holding World Smokefree Day activities in May.

5. Primary Care Health Target Update

“90 percent of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking.” - primary care, better help for smokers to quit, health target.

Both Auckland and Waitemata DHBs anticipate that they have met the primary care ‘better help for smokers to quit’ health target for the first time in quarter four 2013-14. All of the PHOs have put in a fantastic effort and made the achievement of this target a priority. Four of the five PHOs have estimated that their result will be over 90% and one PHO estimates their result will be close to 90%.
A key success factor in achieving the target is the leadership that has been shown by the PHOs. All of the PHOs put additional resources into project teams that supported General Practice to achieve the target. The DHBs also contributed additional funding to each PHO to proactively contact patients by text and phone that had missed receiving advice and support to quit from General Practice.

The proactive text and phone calls proved to be a very useful activity and were well received by the patients they contacted. Of those contacted and given brief advice approximately 20% accepted an offer of support to quit. It was also an opportunity to update smoking status, as some patients had already quit and their General Practice record was not up to date.

Some of the other activities that the PHOs have undertaken to meet the target include:

- Reviewing data management systems to ensure they are producing accurate results
- Promoting the Quitline one-step e-referral tool on Medtech
- Producing performance reports that compare General Practice results and using them as a learning opportunity in cell group meetings
- Promoting a whole of Practice approach, with receptionists and nurses also contributing to activity to meet the target
- A one touch Patient Dashboard System (Medtech practices) to make it easier for GPs and practice nurses to record smoking status and brief cessation advice given
- Use of alert systems within the practice management systems to identify all smokers and the need to offer brief cessation advice
- Running audits of patient notes to identify patients prescribed NRT and not recorded as having been given brief cessation advice
- Direct support to practices through the PHO Smokefree Coordinator, Practice Liaison Team and Practice Liaison GP / Clinical Lead, to answer any questions related to giving patients brief cessation advice and interventions
- Training and supporting smokefree champions within Practices
- Providing financial incentives to Practices that reach the target.

The level of activity and support provided by the PHOs to General Practice in 2013-14 is not sustainable on an on-going basis. The focus for the next year is to embed providing advice and support to quit as a clinical intervention that is part of ‘usual care’ within General Practice. A further focus needs to be on the offer of support to quit. The DHBs will be developing a local target to increase the number of patients that are offered support to quit in 2014-15. Auckland and Waitemata DHBs are continuing to support the health target in 2014-15 through a contract for smokefree coordination with each PHO.

6. Maternity Health Target Update

“Progress towards 90 percent of pregnant women (who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer (LMC)) are offered advice and support to quit.” – maternity, better help for smokers to quit, health target.

On 1 July 2012, this new indicator was included in the ‘better help for smokers to quit’ health target. This indicator focuses on prompting and supporting quit attempts by pregnant women who smoke, as early in their pregnancy as possible.
Since 2012 Waitemata DHB has had a Maternity Health Target Working Group and plan to meet the health target and reduce the number of pregnant women that smoke. With the merger of the Auckland and Waitemata DHB Funding and Planning Teams, a new Smokefree Maternity Working Group has been formed across both DHBs. This group will learn from and replicate (where possible) successful initiatives in each DHB, and plan and deliver new activities across both DHBs.

As the MOH does not have a mechanism for reporting on this target, the DHBs have developed local data gathering mechanisms to monitor that advice and support to quit smoking is given early in pregnancy. Analysis of this DHB data indicates that all pregnant women that smoke are being provided with advice and support to quit by their LMC to quit smoking at the time of confirmation of pregnancy.

LMCs and hospital midwives are kept informed of new evidence and developments to support pregnant women to quit smoking through a variety of means, including newsletters, training sessions and some midwife clinic visits.

A collaborative project called ‘Smokefree Beginnings’ between AUT Communications Students, Waitemata DHB and Hapai Te Hauora was held at the Atamira – Māori in the City event last year. The project developed a campaign to encourage hapu wahine who smoke, to come forward early in their pregnancy for support and help to quit smoking. Different messages were trialled to gauge which statements worked best to meet our campaign objective. Those visiting the Smokefree Beginnings booth were encouraged to have their photos taken, selecting a message of their choice from the samples on offer before they were uploaded onto the Smokefree Beginning’s Facebook page. There was a prize for the photo with the most ‘likes’ thus promoting the sharing of the page amongst participants on Facebook. The page is still active, and now contains links to supportive information and services and is administered by Auckland and Waitemata DHBs, and Waitemata PHO.

The Waitemata DHB Hospital Midwifery Team has purchased two carbon monoxide monitors. Specific training has been delivered to DHB midwives on the positive use of these monitors to encourage women who smoke during pregnancy to quit, with the ultimate outcome of increasing referrals for support.

7. **Support to Quit Smoking Services Update**

In addition to the support to quit smoking available from primary care, there are a number of publicly funded options available across both DHBs. These options are described below. At the time of writing this report, utilisation figures for the local services for 2013-14 were not yet available. The utilisation and quit rates of these services will be analysed to inform the development of the tobacco control plan. Many of the services have had a significant increase in referrals during April to June 2014, as a result of the proactive work by primary care to reach the health target.

<table>
<thead>
<tr>
<th>Service and coverage</th>
<th>Provider</th>
<th>Funder</th>
<th>Service description</th>
<th>Target enrolments per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quitline (national)</td>
<td>The Quit Group</td>
<td>MOH</td>
<td>Phone, text, blog, NRT</td>
<td>Enrolments received in 2013/14; 3,227</td>
</tr>
<tr>
<td>Service and coverage</td>
<td>Provider</td>
<td>Funder</td>
<td>Service description</td>
<td>Target enrolments per year</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------------------------------------------</td>
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<td>-----------------------------</td>
</tr>
<tr>
<td>Aukati Kai Paipa (Auckland and Waitemata DHBs)</td>
<td>Ngati Whatua O Rakei and Te Ha O Te Oranga O Ngati Whataua</td>
<td>MOH</td>
<td>Face-to-face, text and NRT targeted to Maori</td>
<td>640</td>
</tr>
<tr>
<td>Pacific Quit Service (Auckland and Waitemata DHBs)</td>
<td>Auckland Regional Public Health Service</td>
<td>MOH contract with both DHBs</td>
<td>Face-to-face, text and NRT by Pacific language speakers</td>
<td>360</td>
</tr>
<tr>
<td>Elect Service (Waitemata DHB only)</td>
<td>Waitemata DHB</td>
<td>MOH contract with Waitemata DHB</td>
<td>All smokers referred to Elective Surgical Services are provided with advice and support to quit prior to surgery, including face-to-face, text, NRT</td>
<td>75 (in addition to one-off advice and referral to other services)</td>
</tr>
<tr>
<td>Hospital Outpatient Services (Waitemata DHB only)</td>
<td>Waitemata DHB</td>
<td>Waitemata DHB baseline</td>
<td>Face-to-face or group counselling and NRT, targeted to patients that have a smoking related illness</td>
<td>300</td>
</tr>
<tr>
<td>Whanau Smokefree Communities (Waitemata DHB only)</td>
<td>Waitemata PHO</td>
<td>MOH contract with Waitemata DHB</td>
<td>Face-to-face, phone, text, NRT targeted to families with children</td>
<td>300</td>
</tr>
<tr>
<td>Asian Smokefree Communities (Waitemata DHB only)</td>
<td>Waitemata PHO</td>
<td>Waitemata DHB baseline</td>
<td>Face-to-face, text and email by Asian language speakers</td>
<td>420</td>
</tr>
<tr>
<td>Community Pharmacy (Waitemata DHB only)</td>
<td>16 community pharmacies</td>
<td>MOH contract with Waitemata DHB</td>
<td>Face-to-face support and NRT provided by pharmacy staff</td>
<td>550</td>
</tr>
<tr>
<td>Pregnancy Smokefree Communities (Waitemata DHB only)</td>
<td>Waitemata PHO</td>
<td>MOH</td>
<td>Face-to-face, text, email targeted to pregnant women and their partners</td>
<td>420</td>
</tr>
<tr>
<td>Pregnancy Smokefree Communities (Auckland DHB only)</td>
<td>Auckland DHB</td>
<td>MOH</td>
<td>Face-to-face, text, email targeted to pregnant women and their partners</td>
<td>360</td>
</tr>
</tbody>
</table>
8. Mental Health Smokefree Activity Update

8.1 Waitemata DHB District Mental Health Services

The Waitemata DHB District Mental Health Services have been undertaking a project across all of their adult services (including addiction services) for the past five years to reduce the high rates of smoking in service users and mental health staff. During this culture change many misconceptions have been addressed around smoking by mental health service users, such as they do not want to quit and it is too hard for them to quit.

Service management and clinical leadership has led slow but steady progress over the years in meeting the objectives of their smokefree mental health project plan. They have developed patient smoking assessment and information management systems that support Smokefree/Auahi Kore lifestyles. Over half of all clinical staff have now been trained in how to encourage and support mental health service users that smoke to make repeated quit attempts. The project is being continued for another two years.

Mental health services have developed local policies and procedural guidelines for the use of NRT products. General Health and the Mental Health Services Group policies are now under review to amalgamate all smokefree policies / procedures into three main documents (Clinical Guidelines, Pharmacological Guidelines and Smokefree Environments Policy via a wider group) to take into account recent changes and the new 2014 NZ Guidelines for helping People to Stop Smoking.

The Mental Health Services Group has developed a smokefree assessment form which is now completed with adult mental health service users, and smoking status is routinely asked and recorded. Recent audits show they are consistently providing brief advice; however, currently there is insufficient evidence of clinical support to quit smoking. The Smokefree Assessment form is being adopted by Counties Manukau and Auckland DHB in-patient Mental Health Services. There is also work underway to include the assessment form in their community services.

Māori and Pacific Services have both engaged in discussions on a project proposal to introduce Group Based Treatment into their respective programmes. There has been a positive response and the next step will be to define the project to ensure the services themselves are the driving force.

Waitemata DHB has contracted with the National Institute of Health Innovation to complete an evaluation of the district mental health services smokefree project. It will be completed by December 2014.

8.2 Auckland DHB Community Mental Health Services

To date Auckland DHB community mental health services has had limited capacity to promote and support service users to quit smoking. The Planning, Funding and Outcomes Unit have reallocated some of the MOH tobacco control funding to mental health from July 2014. This project will utilise the learnings and resources that have come through the regional NGO mental health and addictions smokefree project and the Waitemata DHB mental health services project. It will build on the gains that have been made in the other sectors (secondary care and primary care) and the other mental health projects. It will also ensure that mental health service users will receive consistent messages and support to quit smoking from all parts of the health sector.
8.3 NGO Mental Health and Addictions Smokefree Project

The NGO Mental Health and Addictions Smokefree project is a Northern Regional project working with all NGO providers in Auckland, Counties Manukau, Northland, and Waitemata DHB areas. This equates to approximately 85 providers. The project currently employs a Regional Smokefree Coordinator who is based at the NRA.

Latest estimates suggest that smoking prevalence in the general population has reduced. However mental health service users continue to have high rates of smoking and associated tobacco related illness and early death. As at 30 September 2013 most mental health and addiction providers within the Northern Region reported smoking prevalence rates of above 50% amongst service users.

The initial stages of the project involved stakeholder engagement and resource development. In 2012 NGO mental health and addiction providers had a number of smokefree deliverables integrated within their DHB contracts. Providers are now expected to:

- Provide smokefree environments for their service users and staff (both internal and external environments are included)
- Provide brief advice and support to quit to both service users and staff
- Ensure all staff are regularly trained in providing brief advice to service users
- Report on their performance against a set of smokefree performance indicators

The Ministry of Health funding for this project ended in June 2014. The three Auckland DHBs have committed to continue to fund this project for a further two years as more work is required to embed the gains that have been made across all providers.

9. Smokefree Pathway to 2025 Innovation Fund Projects

To assist with developing new approaches and evidence to promote and support smokers to quit the MOH has made additional funding available through a contestable process. This additional funding is called the MOH Pathway to 2025 Innovation Fund. A number of projects from the Auckland and Waitemata DHBs areas were successful and selected for funding. A summary of these projects is provided below.

9.1 The Breakfree Smokefree Programme

A group of NGO mental health and addiction providers have received funding for this programme. The project is being led by Pathways and the NRA will also be actively supporting the project on behalf of DHBs in the Northern Region. The project started in July 2014, and will run for two years.

The programme includes the development and implementation of a quit smoking service specifically designed to meet the needs of mental health service users and their whanau, and the staff that support them. The project will take a group based approach to quit support, and will include training service users to offer a smokefree peer support programme.

9.2 Intersectoral Project

Counties Manukau DHB, in partnership with the Auckland Regional Public Health Service and Auckland and Waitemata DHBs, received funding for this three year project. A total package of smokefree support will be provided to agencies across a range of sectors other than health (including but not limited to social, education and corrections). These agencies serve...
populations with some of the highest smoking rates and therefore are in greatest need of smokefree support. This is a regional project with a targeted approach, focusing on the areas with the highest smoking prevalence across Auckland (i.e. within the catchment areas of the three metropolitan Auckland District Health Boards).

The project aims to normalise smokefree environments and provide access to support to quit smoking in settings with a high smoking prevalence, and that traditionally may be less likely to receive support via the health sector.

The key settings that this project is working with initially are: Work and Income, via Ministry of Social Development and Community Probation Services, via Department of Corrections and community budgeting services.

9.3 NRT Survival Packs
Waitemata DHB received MOH innovation funding for an 18 month project to distribute ‘NRT survival packs’ to people that smoke and who are visiting the hospital. The survival packs will contain Nicotine Replacement lozenges and the design of the pack will provide supportive messaging and information on quitting smoking.

Waitemata DHB has a smokefree environments policy that does not allow smoking on hospital grounds. For those who visit to be with their whanau/fono during a time of hospitalisation, there is currently no sanctioned pathway to offer immediate NRT to assist with nicotine withdrawal. To de-escalate these potentially volatile situations, the Security Team identified the usefulness of small packs containing a strip of lozenges, which could be handed to those individuals as an alternative to lighting up. It is also a useful opportunity for people to try an NRT product.

During the development stage of the project however, it became apparent that the distribution of small packs of lozenges were not fully aligned with the legalities and limitations in the Medicines Act under which NRT is characterised. The Smokefree Team with the support and guidance of key professionals and relevant organisations are working through resolving the presenting issues. The project is continuing to move forward through this extended exploratory phase.

9.4 Quit Bus
Waitemata PHO in partnership with Counties Manukau DHB and Transitioning Out Aotearoa (a Māori Social Services NGO) received funding for three years. Two mobile Quit Buses will provide support to quit smoking in hard to access areas, particularly poor rural and urban settings. Target populations for this service are Māori, Pacific Peoples, pregnant women and youth, who can be engaged in the service anywhere within the Auckland Region. The first bus operated by Counties Manukau DHB and Transitioning Out Aotearoa was launched in February 2014. It has had a high level of interest in visits to tertiary education facilities, some town centres and cultural events, as part of a busy planned schedule. The second bus operated by Waitemata PHO will come into service in early August 2014. Both buses are able to be booked to attend events anywhere within the three Auckland DHB areas.

9.5 Te Whanau O Waipareira Trust
Te Whanau O Waipareira Trust received funding for three years to provide culturally tailored support to quit smoking programme for whanau smokers in the Waitemata DHB area. This includes a quit coach, wrap around care plans and referrals to existing services.
10. Planning, Funding and Outcomes Unit Activity

Waitemata DHB has a three year Tobacco Control Plan that ended in November 2013, and Auckland DHB has a two year Tobacco Control Plan that ends in 2014. DHBs utilise tobacco control plans to outline local objectives and actions to support meeting the health targets in secondary care, primary care and maternity. The plans also include activity within the mental health and non-government organisation sector that reduces the rate of smoking. The Planning, Funding and Outcomes Unit has started developing a combined tobacco control plan for 2015-18 for both DHBs; it will be completed by December 2014.

In 2013 both DHBs added smokefree clauses to all NGO agreements (except some national agreements such as Age Related Residential Care). The clauses require providers to develop comprehensive smokefree policies and train their health professional staff in the ABC approach. The DHBs have provided policy advice and guidance on training and resources on the web. DHB staff have provided policy advice and ABC training upon request from NGO providers.

The Māori Health Team is planning to identify and support Māori community leaders e.g. ‘Aunties’ to champion quitting to their communities.

Stop Smoking Group Based Treatment is a new approach that is effective at supporting people to quit smoking in a group setting. The Primary Care Team is organising this training to be delivered locally in August 2014. Quit smoking practitioners/ coaches will learn the necessary information, knowledge and skills to deliver Stop Smoking Group Based Treatment programmes.

11. Conclusion

Good progress has been made with the ‘better help for smokers to quit’ health targets, with both the hospital and primary care targets now achieved. The rate of smoking in our population is also decreasing as evidenced in the 2013 Census.

The DHB’s priorities over the next year are to;

- Ensure the health targets are sustainable by embedding advice and support to quit as a clinical intervention that is part of ‘usual care’ by health professionals
- Increase the number of smokers that are offered support to quit and referrals to quit smoking services.
- Develop a combined Auckland and Waitemata DHB tobacco control plan of activity for the next three years.

Work is also occurring across the health sector i.e. maternity, mental health and NGO providers, to ensure that the health sector is trained and able to promote quitting smoking whenever someone who smokes engages with health services.
4.1 Rheumatic Fever Prevention and Intervention Programme in Auckland and Waitemata District Health Boards

Recommendation:

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

Prepared by: Ruth Bijl (Funding and Development Manager, Waitemata/ADHB), Alison Leversha (Community Paediatrician, ADHB), Alison Hudgell (Programme Manager, Planning & Funding, Waitemata/ADHB), Leani Sandford (Pacific Health Manager, Waitemata/ADHB), Marty Rogers (Māori Health Gain Manager, Waitemata/ADHB), Tim Jelleyman (Community Paediatrician, Waitemata DHB) and Sue Crengle (Public Health Physician, Waitemata/ADHB)

Glossary

ADHB - Auckland District Health Board
AH+ - Alliance Health Plus
ARF - Acute Rheumatic Fever
AWHI - Auckland-wide Healthy Homes Initiative
CCAHDS - Community Child Health and Disability Service
CHW - Community Health Worker
CMDHB - Counties Manukau District Health Board
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
ECCA - Energy Efficiency Conservation Authority
GAS - Group A Streptococcus
GP - General Practitioner
HPA - Health Promotion Agency
MoH - Ministry of Health
NGO - Non-Government Organisation
NHC - National Hauora Coalition
PHN - Public Health Nurse
PHO - Primary Health Organisation
RhF - Rheumatic Fever
RHD - Rheumatic Heart Disease
WDHB - Waitemata District Health Board

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. Summary of progress to 11th July 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 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:

- Healthy homes advice and referral (MoH regional contract with National Hauora Coalition (NHC) and AH+)) (refer section 3.2)
- Pacific health literacy/community awareness raising (MoH regional contract with Alliance Health Plus (AH+))
- Rapid Response services/clinics in primary and community care settings (DHBs via PHOs and community based providers) (refer section 3.3.2)

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 plan. Engagement has occurred via the Waitemata DHB Steering Group and ADHB Steering Group and Service Alliance Leadership Team (SALT) through:

- Māori and Pacific DHB General Managers retaining oversight of the programme and having delegated representation on the Waitemata DHB Steering Group and ADHB SALT
• named Māori and Pacific provider representatives or their delegates on the Waitemata DHB Steering Group
• the ADHB SALT is now chaired by the Māori Health Gain Manager and there is Māori and Pacific led PHO membership and representation on the 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 ADHB Māori Health team including Executives and Board members.

These groups are responsible for ensuring workstreams are well planned, assisting in the allocation of funding and monitoring progress, refining the programme to achieve the target and ensuring the programme remains effectively targeted to Māori and Pacific communities.

At the operational level key Māori, Pacific and Non-Government Organisation (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 WDHB to provide a pilot community based health literacy for Rheumatic Fever prevention, 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 ADHB 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, deliver Rapid Response clinics through their GP practices and is jointly responsible with AH+ for the AWHI programme (refer section 3.2)
• HealthWest is contracted by Auckland wide Health Homes Initiative (AWHI) to assist families/whānau attain warm and healthy homes in the WDHB area. This service is provided in the ADHB area by Te Hononga O Tāmaki Me Hoturoa, Health Star Pacific Trust and the Tongan Health Society (Langimalie).

The Waitemata DHB Steering Group and ADHB SALT are responsible for obtaining and utilising feedback from Māori and Pacific stakeholders on the Rheumatic Fever programme, and to reflect this in the on-going 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 training existing Pacific health providers already making health visits to homes in the Auckland region 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. To 30 June 2014 (9 months of service delivery), a total of 16,684 Pacific families received an education and information session on how to prevent Rheumatic
Fever (the MoH annual target was 11,000 families) through in-home visits, community education sessions, and health literacy and awareness raising activities.

The Pacific Health Team has sought 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 needs 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 of this strategy 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 initiative that aims to identify households with children at risk of rheumatic fever. It aims to offer a range of interventions (such as insulation, curtains, bedding,) to address structural and functional household crowding and subsequently reduce the spread of Group A Streptococcal (GAS) infection.

AWHI is led by two Auckland primary health organisations operating as an alliance. They are the National Hauora Coalition (NHC) and Alliance Health Plus (AH+). Members of Waitemata DHB’s RhF Steering Group and ADHB’s SALT were involved in the working and steering groups set up to develop the AWHI initiative. These groups have since disbanded and been replaced by the AWHI Operational Group and the AWHI Partnership Forum.

The intention was to reach 3,500 households a year once the initiative was established. 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
- 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 3 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. The Ministry has funded an AWHI project coordinator to work across these services in Auckland and Waitemata, along with Ko Awatea to support the use of the Rapid Cycle Change for this work. These resources and pathways continue to be refined and extended as implementation is reviewed and data is collected and analysed on referrals and outcomes for families/whānau.

The Ministry of Health has also committed to funding a position to focus on the supply side of AWHI and, in particular, sourcing materials including curtains, beds, bedding and floor covering.
As of 23 June there had been 613 referrals to the Auckland-wide Healthy Homes Initiative (AWHI) since they started receiving referrals in December 2013. 369 initial housing assessments have been undertaken and 360 housing plans completed over this period. This has resulted in 75 referrals to the Ministry of Social Development for financial assistance and 134 referrals to Housing New Zealand. Five houses have been insulated and a further 75 referrals for insulation are being processed.

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, Community Child Health and Disability Service (CCAHDS) in ADHB have assessed 98 of the 116 children and young people on Bicillin. Of these 79 met the criteria to be referred to AWHI. 74 of these families agreed to be referred to AWHI, and 5 families declined.

- All of the 69 children and their families in Waitemata will have their housing needs assessed. To date 34 of the 69 children and young people on Bicillin have been assessed. Of these 32 met the criteria to be referred to AWHI. 28 of these families agreed to be referred to AWHI, and 3 families declined.

- There is a representative from the Bicillin service participating in the regional working group. As part of the regional working group a regional spread sheet has been developed. Waitemata DHB Child and Family and District Nursing services are in the process of loading all Bicillin clients onto the spread sheet. The spread sheet will capture information on “Shared Care, compliance, AWHI referrals and date of injections in time frames”.

- 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 3 or more GAS in the previous 3 months criteria, as well as the income, housing and additional child eligibility criteria.

- The inpatient services: A range of staff including Māori, Pacific, CALD and social work team members and clinicians, from the 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 ADHB has made 107 referrals from Starship and Waitemata DHB has made 30 referrals to AWHI.

- This work has meant:
  - 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 and referred as appropriate
  - tracking and improving these processes and engaging cultural teams and health professionals in continuous improvement
  - embedding this approach as part of normal clinical activity
- In establishing the systems to identify families who have a medical diagnosis that qualifies them to be assessed for their eligibility for a referral to AWHI, many examples were found whereby children and their families did not meet the lower age requirement for an additional child in the home to be over 4 years and under 19 years, yet remained at risk of Rheumatic Fever and required warm and healthy homes. Clinical staff engaged with the Ministry of Health and proposed an amendment: to have 2 or more children in the house but the 4 year lower age limit of the additional child to be removed. This amendment was supported by the Ministry and should result in increased programme and clinical consistency, an increase in families eligible for AWHI and greater preventative action for children at risk of Rheumatic Fever.

Documentation about housing and social conditions is being integrated into the clinical records to support assessment, planning and action.

The Ministry of Health is currently working with AWHI to determine whether referral criteria will be extended 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 ADHB 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 sixteen schools in the Auckland DHB area. To date, 6094 children have had throat swabs taken by the school-based health service in ADHB and 895 in Waitemata DHB, with an average of 15% GAS in Auckland and 7% in Waitemata. 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 both ADHB 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 the disease occurs in those school communities. In contrast to CMDHB where more than 83% of cases of RhF affected children attended decile 1 schools, ADHB 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 ADHB is estimated to reach 35% of vulnerable children\(^1\) and less than 10% in Waitemata DHB. The school-based programme is

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\(^1\) 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.
therefore only one component of the overall RhF prevention plan in both Auckland and Waitemata DHBs.\(^2\)

In Waitemata DHB, the school programme is supplemented by a pilot outreach programme 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 thirteen 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.

For example, information on rheumatic fever prevention, sore throat treatment and the location of free rapid response clinics was circulated through all schools involved in the school based sore throat treatment programme, along with several primary and intermediate schools with students from the RhF Maori, Pacific and Q5 target group, to parents/caregivers.

### 3.3.2 Rapid Response Programmes

Both DHBs had implementation plans for their Rapid Response services agreed by the Ministry of Health 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.

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 if delivery models are continued or developed as appropriate.

Whilst there had been minimal usage of the Rapid Response clinics in either DHB (possibly due to the warmer summer months and milder winter and the lack of a national campaign regarding links between sore throats and RhF and the importance of getting them checked and treated at local Rapid Response clinics) this has increased more recently.

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\(^2\) 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.
There has been some confusion regarding reporting on Rapid Response. In particular the difference between the high need Rheumatic Fever population of Maori, Pacific and Quintile 5 aged 4-19 years and high risk population (Maori, Pacific and Quintile 5 aged 3 – 45 years) identified in the National Heart Foundation guidelines and incorporated in the Advanced Form. This is currently being worked through with the Ministry of Health. It is anticipated that this clarification on reporting, coupled with the national multi-media campaign during these colder months, will see an increase in the use of Rapid Response clinics.

ADHB 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 and community care based rapid response programme, supported by the three other PHOs. Waitemata DHB’s approach to managing and delivering the Rapid Response programme in primary and community care is through a direct contracting arrangement with provider organisations including the two Primary Health Organisations. Both DHBs have nurse-led rapid response clinics in general practices in high need areas (32 in Auckland and 19 in Waitemata). ADHB has also trialled a community pharmacy in Glen Innes where a significant amount of awareness raising has been done through the school-based programme.

Both DHBs are working with their respective Steering and Alliance Leadership Groups to expand the Rapid Response programme in Auckland and Waitemata and this will include a mix of:

- community pharmacies in high need areas particularly where there are gaps in current rapid response delivery and open family friendly hours
- supplementary services in the decile 1-3 enhanced secondary school-based health services programme including swabbing and treatment services.

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

Waitemata DHB developed a community pilot with Te Whānau o Waipareira Trust focusing on 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 and schools and general practice. 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 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.

3.5 Disease Management and Secondary Prevention

In ADHB, 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 ADHB, 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 ADHB 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 years.
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 in ADHB and Waitemata 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 are referred to infectious diseases teams in ADHB, either paediatric or adult depending on the age of the patient. Notification to public health has been streamlined and the notification form redesigned.

The 2013 hospitalisation numbers and rates will be released by the Government in the near future as part of the Better Public Service progress report. The key information that will be released is that in 2013, the national incidence of the first episode of Rheumatic Fever was 4.3 cases per 100,000 people – a total of 194 people. This 2013 rate is an increase compared to the 2012 rate of 3.7 cases per 100,000 people (168 people). It is important to note the Better Public Service target uses hospitalisation discharge data (ie diagnosis at the time of discharge) and the Ministry of Health has not been able to exclude cases who were found not to have rheumatic fever after review following discharge (‘confirmed’ cases) from the official rheumatic fever numbers. However these confirmed cases will be taken into account by the Ministry when monitoring individual DHB progress towards the target.

For Auckland and Waitemata DHBs the 2013 rates of Rheumatic fever were: 4.3 per 100,000 (20 cases) for Auckland and 1.6 per 100,000 (9 cases) for Waitemata. Table one shows the number of cases of Rheumatic Fever in Auckland and Waitemata (based on data from the Ministry) for the period 2002 to 2013. This pattern of short term variation from year to year is reflected across country.

Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>Auckland</th>
<th>Waitemata</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>42</td>
<td>5</td>
</tr>
<tr>
<td>2003</td>
<td>25</td>
<td>8</td>
</tr>
<tr>
<td>2004</td>
<td>21</td>
<td>10</td>
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<td>11</td>
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<td>2010</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>2011</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>2012</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>2013</td>
<td>15</td>
<td>8</td>
</tr>
</tbody>
</table>

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 30/07/14
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.

Good compliance mechanisms are in place for the community nursing services with RiskPro incident notifications completed for any child or young person receiving their Bicillin injection outside the recommended time period. CCHADS monitors compliance and completes incident notifications for every injection delivered outside the recommended range (25-33 days). During April-June 2014, an average of 118 patients was on the CCHADS database to receive Bicillin injections: 350 of the possible 355 Bicillin injections were administered within the time period. This includes patients who live in another DHB and receive Bicillin with CCHADS.

The responsibility for the Bicillin service for children domiciled in Waitemata was transferred to the Public Health Nurse Service in April 2014. During April-June 2014, an average of 69 patients were on the Child and Family database to receive Bicillin: 69 of the possible 69 Bicillins were administered within the time period.

Waitemata PHNs have recently started delivering prophylaxis and are setting up systems to record compliance as part of a regional Bicillin working group which has been established to develop this and outcomes to date include an agreed compliance spread sheet for the whole region that will provide DHB specific data to report to the Ministry. The group provided feedback into the NHF guideline on the diagnosis and management of ARF (currently being reviewed). The basis for this system is a spread sheet which captures compliance, Share Care and AWHI referrals. The compliance data will show +/- 28 days (21 where applicable). Share Care will indicate who is responsible at what time for giving the bicillin and will support compliance across DHBs. The District Nursing Service at WDHB are part of this working group and will be able to monitor compliance among adults. No data exists 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). There is no data available yet, but a simplified compliance report has been incorporated into the Rheumatic fever pathway on Healthpoint to support primary care reporting.

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 was asked to deliver a 2014 campaign alongside the Health Promotion Agency. The campaign was launched in May 2014. The campaign is targeted at Pacific and Māori parents and caregivers of at-risk children and young people. It was pre-tested with at-risk population groups and key stakeholders and complements other Ministry, District Health Board (DHB) and provider rheumatic fever activities and has refreshed messaging developed through this process.

The campaign focuses on raising awareness about:

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

The mass media campaign has included national TV advertising backed up by regional promotions in Auckland, Porirua and the Hutt Valley, including a heavy weighted radio component alongside online banners, print outdoor promotions, social media activities, and a high-level public relations campaign.

The campaign will continue to be rolled out gradually through to August 2014 and delivered in a sequenced approach. 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 are aware that they do not wish to encourage the ‘worried well’ to general practice.

The Ministry has used 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 (MYD) engaging with young people from the RhF target audience through the four DHBs youth participation
forums. Focus groups were held with young people from Māori and Pasifika backgrounds across the northern DHB region and a report was produced detailing findings from their feedback on meaningful, youth-appropriate rheumatic fever messages and communications channels for delivering rheumatic fever messages to young people.

This information is now being used in the current implementation phase of this project, coordinated by the Ministry of Health and led by the Ministry of Youth Development.

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 & Parents /Carers at schools not involved in the school based programmes:**
The Auckland metro DHBs continue to take 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. In the Waitemata area this has involved Public Health Nurses undertaking health promotion and Rheumatic Fever prevention work with an additional 13 schools to the 5 schools involved in the school based sore throat treatment service.

- **Youth**
As previously noted in 3.6.2 above, a northern region youth engagement strategy is currently underway and will inform the design and development of a youth-focused communication campaign. This will, in turn, determine local activities.

- **Pacific Community**
During all Pacific Engagement Strategy activities information is provided to Pacific families and communities on the importance of treating sore throats, preventing RhF and how to access...
free sore throat treatment through Rapid response clinics. The national communications campaign has used 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. 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. The Auckland Social Sector Leaders Group have been engaged to support this given that RhF prevention is a Better Public Service target. This approach will be supported with training and collateral for providers 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.**

**3.7 Rheumatic Fever Database update**

The Auckland Regional Rheumatic Fever Database is currently based on a time expired IT system. ADHB has agreed to fund a proportion of the cost required to rebuild this so it is sustainable. CMDHB and Waitemata DHBs have been asked for supportive funding. The regional bicillin and disease management groups have identified add-ons to the current database to enable clinical utility and transformation to a patient management system.

Work is currently underway to explore how the Auckland Database issue can be addressed within a limited budget but still allow expansion to a national database in the future. A working group is meeting regularly to decide minimum data requirements, functionality etc. The work undertaken in the regional bicillin working group has been critical in identifying key system requirements. It is clear the success of the current system is due to the regional register with dedicated and persistent community nursing staff.
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. High risk families 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, on-going 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 being expanded in the next quarter, the Pacific Engagement strategy underway, the AWHI initiative progressing and a national multi-media campaign running from April to August we would expect to be able to report a steady increase in access to primary and community care for the treatment of sore throats over the winter months and improved outcomes for families/whanau requiring warm and healthy housing.
4.2 Specialist Palliative Care - Community Services Provided by Hospices

Recommendation:
That the report be received.

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

Glossary

A+ Link - This is an integrated hospital/community service made up of Home Health and Older People's Health (OPH) for those over 65 years old
ARCF - Aged Residential Care Facility
Continuous Care - Once a person is accepted into the specialist palliative care service they will receive care on a continuous basis. The Patient is not discharged from the service and will be able to access service at any time. This may result in a number of speciality palliative care visits or episodes of care.
DHB - District Health Board
Episode of care - A person will receive a range of specialist palliative care services for a specific need. This episode of care may include a number of visits. Once the specific need has been met or treatment completed the patient will have finished that episode of care. The next episode of care will commence when the next care or treatment is required.
FTE - Full Time Equivalent. One FTE is the total number of hours a staff member would complete if they worked full time. This would range from 35 to 40 hours a week depending on the role being filled
NCCP - National Cost Collection and Pricing Programme
NASC - Needs Assessment Service Coordination
QPS - QPS Benchmarking is Australia and New Zealand's first choice for Health Care benchmarking
PFO - Planning Funding and Outcomes Unit

1. Executive Summary

Specialist Palliative care provides patients, families and whanau with clinical, emotional, spiritual and social support at the end of life. Services are provided to people who have a life-limiting illness and a life expectancy of less than 12 months.

People requiring specialist palliative care may receive services in the community, inpatient hospice service or the hospital setting. Care may be episodic or continuous according to the individual needs and care plan.

The purpose of this paper is to provide an overview of Specialist Palliative Care- Community Services provided by hospices.

Auckland and Waitemata District Health Board (DHBs) fund four hospices to deliver specialist palliative care. Each of the hospices have changed their service models over the last two years.
to better meet patient care requirements while working more effectively with the resources available to them. Technology is now such that staff have remote access to patient hospice records. Outpatient clinics are provided at the hospice for people able to travel. More people are choosing to receive end of life care at home.

Hospices work closely with their community to raise funds and recruit volunteers to work within their services. Volunteers contribute to fundraising, work in the hospice shops and provide non-clinical care and support to people using the hospice services.

Service audits in 2013/14 were completed with good outcomes.

However, hospices do face workforce, funding and other challenges. The Planning Funding and Outcomes Unit (PFO) continues to work with the hospices and boarder palliative care services to refine collaboration and service delivery models.

2. Introduction/Background

Palliative care provides clinical, emotional, social and spiritual support to people at the end of their life. Palliative care and the associated grief and bereavement service have been developed in response to the need to improve the end of life experience for people with life-limiting illness and the support for their family and whānau. Services are provided across the health care sector from primary care to specialist palliative care.

General palliative care is palliative care provided for those affected by life-limiting illness as an integral part of standard clinical practice by any healthcare professional that is not part of a specialist palliative care team (Palliative Care Subcommittee 2007). Specialist palliative care is provided by those who have undergone specific training and/or accreditation in palliative care/medicine, working in the context of an expert interdisciplinary team of palliative care health professionals (Palliative Care Subcommittee 2007).

Specialist palliative care can be provided through secondary care (hospitals) or hospices. Hospital and hospice services work together to provide care for the patient, family and whānau.

Specialist palliative care builds on the palliative care provided by the general health care providers and reflects a higher level of expertise in complex symptom management, spiritual support, psychosocial support, cultural support, and grief and loss support. Specialist palliative care works in two ways:

- Directly: to provide direct management and support to persons and families and whānau where complex palliative care need exceeds the resources of other providers. This can be episodic or continuous depending on their changing needs.
- Indirectly: to provide advice, support, education and training to other health professionals and volunteers to support their provision of palliative care.

Hospice specialist palliative care services provide essential services such as assessment and care co-ordination, clinical care and support care which the person and their family can access. The service includes:
- Specialist medical care
- Specialist nursing care
• Advanced family support
• Multidisciplinary team work
• Workforce education.

The hospices also offer general services including:
• Body therapies
• Counselling and emotional support
• Spiritual support
• Support groups.

This paper focuses on the specialist palliative care services provided by hospice in the community.

3. Overview of Specialist Palliative Care Hospice Community Services

3.1. Care provided in 2013-14
Each of the four DHB funded specialist palliative care hospices provides a community service. The number of people that receive services and the number of episodes of care vary in relation to the service area and the hospice’s relationship with their community. The number of people receiving specialist palliative care through the hospices for the 2013-14 year is noted in Figure 1.

Figure 1: Care Provision in 2013-14

<table>
<thead>
<tr>
<th>Hospice and DHB area</th>
<th>Number of referrals</th>
<th>Episodes of care/visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td></td>
<td>794</td>
</tr>
<tr>
<td>Mercy Hospice</td>
<td>979</td>
<td>794</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td></td>
<td>1300</td>
</tr>
<tr>
<td>Hibiscus Hospice</td>
<td>148 (to 31 March 2014)</td>
<td>320</td>
</tr>
<tr>
<td>Hospice North Shore</td>
<td>585</td>
<td>470</td>
</tr>
<tr>
<td>Hospice West Auckland</td>
<td>298 (to 31 March 2014)</td>
<td>510</td>
</tr>
</tbody>
</table>

Hospices have provided information on the number of people referred to the service in the year. A number of these people will not have received an episode of care. The main reasons for this would be a decline in the person’s health before the initial assessment was undertaken or the person being assessed and not requiring a specialist service at the time.

Specialist palliative care in the community was provided to 794 people in Auckland and 1300 people in Waitemata DHB. Waitemata DHB residents have a higher rate of hospice community specialist palliative care service use than residents in Auckland DHB; 0.23% versus 0.17% respectively. We do not currently understand why there is such a difference in service use across the two DHBs. Further work will be undertaken to increase our understanding.

3.2. Workforce
Each Hospice employs a number of staff to provide their community palliative care services. They also rely on volunteers to provide assistance with the care of their clients, families and whanau. Figure 2 notes paid staff and volunteers that make up the hospice workforce.
Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 30/07/14

Figure 2: Hospice Workforce 1 July 2014

<table>
<thead>
<tr>
<th></th>
<th>Mercy Hospice</th>
<th>Hibiscus Hospice</th>
<th>Hospice North Shore</th>
<th>Hospice West Auckland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical officers</td>
<td>60.5 FTE</td>
<td>2 FTE</td>
<td>4.8 FTE (includes pharmacist)</td>
<td>70 Staff</td>
</tr>
<tr>
<td>Nursing</td>
<td>4.3 FTE</td>
<td>11.9 FTE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Administrator</td>
<td>1 FTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counsellor</td>
<td>0.8 FTE</td>
<td></td>
<td>3.2 FTE</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td>0.7 FTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual care</td>
<td>0.6 FTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bereavement care</td>
<td>0.2 FTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support services, Education and Administration</td>
<td></td>
<td>23.93 FTE or Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphoedema massage</td>
<td>0.1 FTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiawhina</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundraising and Retail staff</td>
<td>17.4 FTE</td>
<td>22.56 FTE/staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community patient support</td>
<td>555 volunteers with 2/3 as retail staff within shops</td>
<td>Volunteers</td>
<td>1106 volunteers</td>
<td>432 volunteers</td>
</tr>
<tr>
<td>Massage therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer drivers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>77.9 FTE plus 555 volunteers</td>
<td>9.7 FTE plus volunteers</td>
<td>66.39 FTE plus 1106 volunteers</td>
<td>70 Staff plus 432 volunteers</td>
</tr>
</tbody>
</table>

The areas marked in grey are where we have no information at this time.

At the time of writing this report we did not have sufficient information as to why the hospices have significant variance in staffing levels. However, this will reflect the service models each hospice has in place which varies from hospice to hospice, see below.

All hospices have a large number of volunteers that help support the hospice through raising funds and provision of patient care. Each hospice has a fundraising and retail team.

3.3. Services Provided

Each hospice provides referral management and multidisciplinary assessment of a patient and their family and whanau needs for specialist palliative care. Care is planned with the patient, family and whanau with support and input from family support team and/or nursing team. The specialist team will liaise with other providers like district nursing and general practices as appropriate to ensure that the general health and social needs of the patient are being met.

Each hospice has developed their own approach to meet the needs of their patients while living within their means. Direct patient care and indirect services have been developed in relation to the hospice’s knowledge of their community and changes in best practice. Thus, the way in which palliative care is delivered varies across the four hospices. The following provides an overview of the community services provided by each of the four hospices.
Mercy Hospice community service includes:

- A community team providing:
  - Symptom management and care coordination in patients’ residence (private home, Aged Residential Care Facility (ARCF), other)
  - Acute doctor visits and mentorship of General Practitioners including a 24 hour doctor direct line
  - Counselling, social work, bereavement
  - Nursing care for carer relief

- Cultural support – provided by Kaiaatawhai, Chinese Nurse Liaison, Pacific Island liaison
- Day Care – social programme twice weekly for socially isolated patients with self-care education programme
- Education – palliative care education courses for primary care providers
- End of Life programme.

Mercy Hospice has seen an increase in the numbers of patients in care, with over 300 per week for the first time. The community has met this demand through:

- Shared care model with A+ Links that includes monthly clinical meetings to discuss complex cases, shared first visit and triage of referrals. District nurses manage people with non-complex care needs and Mercy Hospice provide complex care needs
- Hospice at Home programme initiated with experienced palliative care registered nurses providing care in patients’ homes to reduce acute admissions to hospital. Piloting services in real time to understand whether they are viable as demonstrated by Mercy Hospice’s Hospice at Home programme. Initial information from the service shows lower than expected uptake of the service
- Pilot of a Hub and Spoke model with Aged Residential Care Facilities. The hospice is currently working with sister provider Mercy Parklands to increase nursing capacity (staff number and skill mix, Palliative Care Fundamentals education) to provide palliative care for people with less complex care needs. The Hub and Spoke approach being developed by Mercy Hospice includes:
  - Hospice as the Hub providing workforce education support, medical support and increased clinical nurse support
  - Spoke is the ARCF who up-skill staff, have a higher ratio of registered nurses to patient than general ARCF and have direct access to Hospice specialist team.

Hibiscus Hospice increased their outpatient service, encouraging patients to come to their facility in Red Beach for initial and on-going care. Consequently, there has been a change in service patterns with more patients and families coming to the outpatient clinic. The clinic provides initial assessments and medical consultations. Day treatments are also provided.

The community team provides home visits as the patient’s needs change. This hospice works with the ARCF to provide specialist support to residents and education to staff. The hospice also offers a range of services at the hospice to reduce travel time for their patients. These services include:

- Blood and other medication transfusions
- Central line flushes
- Lymphoedema massage.
The community team has moved to using episodes of care which they report has led to more efficient use of resources. The community team has remote access to the patient management system allowing them to follow treatment plans and update these while in the patient’s home. The use of Skype for their more rural patients, allowing them to better communicate with these patients is being considered. A series of Quick Tips pamphlets and cards related to easy and accessible care advice for patients and families are being developed.

_Hospice North Shore_ provides governance and management support to two hospices: Hospice North Shore and Warkworth Wellsford Hospice. Each hospice provides services specific to the needs of their community. The Hospice North Shore community team provide:

- Symptom management, support and care coordination in patient’s residence (private home, ARCF)
- Acute doctor visits and support for General Practitioners and other health professionals is available 24 hour a day
- Counselling, social work, spiritual care, physiotherapy, cultural support (Kaiawhina and Asian support), bereavement and caregiver groups
- Night nursing
- Outpatient Clinic visits.

The Wellsford and Warkworth Community Team provide all but the night nursing and outpatient clinic visits offered by Hospice North Shore.

Hospice North Shore has restructured their community team. They have:

- Introduced Clinical Nurse Specialist roles
- Increased night nursing
- Increased nursing and medical visits and phone calls
- More support and direction available for community doctors
- Hired a clinical pharmacist
- New FTE in Family Support Team with one team member responsible for the Inpatient Unit (IPU) and a part time social worker working with each community team.
- Introduced an Asian support role.

The hospice reports that this has resulted in an increase in community visits with 483 more visits being provided in 2013-14 than 2012-13. With the increase in community visits more people are dying at home and there is less reliance on inpatient beds. Hospice North Shore has advised that, “with improved capacity and capability of the specialist community team, complex symptoms are being managed better in the community”. The hospice has improved its relationship with District Nurses with a Clinical Nurse Specialist meeting weekly.

_Hospice West Auckland_ works to assist people to participate in their care. The nursing and family support team work extensively with family, whanau and the community to assist people to remain at home or provide practical solutions to increase whanau participation in care. The hospice strives to offer their community the best therapies, clinical practices and wellness programmes.

Hospice West Auckland has focused on the development of the Learning and Development team with a full annual programme and widely dispersed promotion of the Fundamentals of
Palliative Care and other related learning packages. This includes an allocated Specialist Palliative Care team to focus on ARCF.

Hospice West Auckland has well developed community nursing and family support teams. The nursing team provides home visits 24 hours a day.

3.4. **Funding**
Community palliative care services are funded by a mix of District Health Board funding and Hospice fundraising. The DHB funding is used to provide specialist clinical care and family support. Hospice fund raising contributes to clinical care and family support but also pays for general palliative care services, support groups and day programmes.

Each hospice has an active fundraising team. Shops that are run by both paid employees and volunteers are a significant part of the fund raising programmes.

3.5. **Quality**
The four hospices participate in national QPS Benchmarking programme in which community services related data and outcomes are reported using clinical and organisation indicators. This includes annual patient and support person satisfaction surveys. These are undertaken in September each year.

All hospices had a good result for patient and family satisfaction in 2013. The PFO team will provide the outcomes of the September 2014 results in the next palliative care paper.

4. **Key challenges and opportunities**
The key challenges for the hospices include:
- Continuous recruitment, training and up skilling of staff to ensure the provision of specialist palliative care
- Meeting the costs of purchasing equipment and consumables
- Upgrading technology to increase staff effectiveness while in the community
- The difficulty of planning ahead with funding uncertainty and continuous growth in service demand
- Accommodating new services and teams within existing premises.

Opportunities that have been achieved through the change in service include:
- The reduction in service duplication through improved communications with district nurses and implementation of the A+ Links model. The model includes:
  - Monthly Palliative Nurse specialist and A+ Link patient care team discussing patient needs
  - Triage of new patients to the general or specialist service
  - Shared care of people who have changing care needs and move between services.
- Growth in confidence that more care can be delivered at home.
5. Conclusion

The four hospices have different approaches in the provision of palliative care. There has also been significant modification of their community services over the last two years with more care being provided within people’s homes. This has resulted from a need to live within their means while providing evidence based care.

The DHBs recognise the significant work the hospices put into fundraising to deliver both general and specialist palliative care services, and the challenges they face in delivering their services.
4.3 Report on ARPHS Local Alcohol Policy Submission to Council

Recommendation:

That the report be received.

Prepared by: Dr Denise Barnfather (Medical Officer of Health)

Glossary

ARPHS  -  Auckland Regional Public Health Service
ECIA  -  Environmental Cumulative Impact Assessment
LAP  -  Local Alcohol Policy
SASAA 2012  -  Sale and Supply of Alcohol Act 2012

1. Executive Summary

This paper provides the Community and Public Health Advisory Committee (CPHAC) with a summary of ARPHS submission on the Proposed Local Alcohol Policy (LAP), outlines the rationale for development of Auckland Council’s LAP, identifies particular risks/issues with the LAP and further actions ARPHS could undertake to mitigate these risks, and summarises the process by which ARPHS has engaged with the development of the LAP. A copy of the full submission is attached to this paper (Attachment 1).

This paper is intended to provide CPHAC with an overview of ARPHS stance on the draft LAP, which has just closed for public consultation, and of the LAP development process.

ARPHS submission on the Proposed LAP is summarised as follows:

1. ARPHS supports the overall intention of the draft LAP as a means to reduce alcohol related harms. Alcohol is a major source of a wide variety of harms to health. Alcohol is associated with over 200 diseases and is also associated with other harms including vehicle accidents, domestic violence and assault.

2. Alcohol is widely consumed in New Zealand, and often in a hazardous manner. Consequently alcohol is associated with between 600 and 1000 deaths each year in New Zealand. This, and other harmful outcomes, has major social and economic costs. Alcohol is also strongly associated with health inequalities, particularly for young people and Māori and Pacific people.

3. Due to the major harms associated with alcohol consumption we strongly endorse greater restrictions on alcohol availability throughout the draft LAP. Our recommendations are based on policy measures that have been shown to work in reducing alcohol related harms. Our organisation also commissioned a survey that was designed to ensure that public opinion was captured, and the results have also been used to guide these recommendations. Public opinion strongly supports more restrictive provisions for alcohol licensing.
4. Our key recommendations for the Auckland Council LAP to reduce alcohol related harms in the region are:

Broad Areas
- We support the priority overlays\(^1\), but recommend greater restrictions.
- Specifically, we recommend that the entire city centre, Broad Area A, be reclassified as a Priority Overlay Area in recognition of the high levels of alcohol-related disorder throughout the area and to prevent displacement of alcohol-related harm.

Density
- We recommend greater restrictions on the density and number of licensed premises.
- Specifically, we recommend a freeze or sinking lid policy for on and off-licences in Broad Area A, neighbourhood centres, and all Priority Overlay Areas for the six-year duration of the LAP.

Proximity
- We recommend an exclusion zone near sensitive sites (including schools), to limit the proximity of alcohol retailing premises to vulnerable members of society.

Trading Hours
- We recommend further restricting trading hours for licensed premises, and strongly support consistent trading hours across the Auckland region to prevent migratory drinking and any associated harms.
- Specifically, we are strongly opposed to extensions of trading hours for ‘best practice’, or other, operators.
- For on-licensed premises, we support restricted trading hours of 10am – 1am for the whole Auckland region.
- For off-licensed premises, we support restricted trading hours of 10am – 9pm for all premises, including supermarkets.
- If consistent trading hours are not implemented, we advocate the use of a one-way door policy\(^2\).

Discretionary Conditions
- We support discretionary conditions on licences, but note that these are not an adequate substitute for the more effective means of reducing alcohol related harms summarised above.

Environmental Cumulative Impact Assessments
- We support the use of environmental cumulative impact assessments (ECIAs), but note the importance of Council ownership that is separate from the alcohol industry. This helps avoid any conflict of interest caused between the objectives of the EICA, to reduce alcohol related harm, and the industry’s economic imperative.
- We note that the ECIA is not adequate to appropriately protect vulnerable populations.

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\(^1\) Priority Overlay areas are locations in Auckland with high levels of alcohol-related crime and/or high numbers of existing alcohol licences.
\(^2\) One way door policies are restrictions that allow patrons to leave licensed premises but not re-enter during specified times. This acts to prevent migratory drinking occurring - from earlier closing to later closing premises.
Integrated Dispersal Plans
- ARPHS supports the use of integrated dispersal plans to reduce the potential for alcohol related harm by ensuring safe and efficient travel options for patrons of alcohol retailing premises.

Evaluation
- In order to monitor the ongoing effectiveness of the measures used to reduce alcohol related harm in the LAP, we recommend ongoing evaluation.

Consistency with the Unitary Plan
- ARPHS recommends that the LAP and proposed Unitary Plan are consistent. The Unitary Plan proposes growth in many areas of Auckland and a greater mix of housing types.
- Policy should aim to reduce alcohol related harm in these future areas to ensure the effectiveness of the LAP.
- ARPHS believes that more restrictive policy limiting the availability of alcohol is needed to reduce alcohol related harms and effectively meet health-related targets in the Auckland Plan, as well as achieving the Mayoral vision of a highly liveable city.

In conclusion, ARPHS is advocating for further restrictions on trading hours, density and proximity of licensed premises in the Auckland region, than is currently being proposed in Council’s Proposed LAP. Time and again, evidence and experience has shown that in the arena of alcohol, tobacco and drugs, greater regulation leads to less harm to health and society as a whole.

2. Introduction/Background

The Sale and Supply of Alcohol Act 2012 (SASAA 2012) replaced the Sale of Liquor Act 1989 in December 2012, and is intended to benefit our communities by putting in place a new system of control over the sale and supply of alcohol, and to reform the law as a whole relating to the sale, supply and consumption of alcohol. In doing so, SASSA 2012 seeks to achieve the object of the Act which is to ensure that (1) the sale, supply and consumption of alcohol should be undertaken safely and responsibly, and (2) the harm caused by the excessive or inappropriate consumption of alcohol should be minimised.

A key feature of SASAA 2012, is the provision for local communities to have more say about where and when alcohol can be sold, with broader criteria provided for objecting to licence applications, and allowing local councils to create LAPs relating to the sale and consumption of alcohol within their districts. Specifically, SASAA 2012, section 77, allows LAPs to include policies relating to any of the following:
- location of licensed premises by area or proximity to other facilities
- maximum trading hours
- density of licensed premises
- discretionary conditions
- one-way door restrictions.

The executive summary, above, provides a précis of our feedback to Auckland Council on their Proposed LAP as it relates to these and related policies. The Proposed LAP was open for public submissions from 16th June to 16th July 2014.
3. **Risks/Issues**

Once the LAP has been adopted by Auckland Council, all liquor licences will be subject to its policies. The LAP will be in force for six years and runs a very real risk of becoming redundant in many areas of Auckland prior to its evaluation and renewal date. We have highlighted this risk in our submission and strongly recommended that some attempt is made at future-proofing the LAP. This will require that new areas of development in Auckland are catered for, and that a thorough risk assessment of the impact that the LAP policies will have on changing the drinking environment and related drinking behaviour in the region is completed, so that such risks can be mitigated for within the LAP itself.

The LAP provides New Zealand with an excellent opportunity to address the staggering harm to our society caused by the hazardous consumption of alcohol. Evidence tells us that reducing the availability and accessibility of alcohol has significant effects on reducing harm; therefore it is vital that the LAP is strengthened further, as per our recommendations above, as the LAP is the main tool available to New Zealanders by which to reduce the availability and accessibility of alcohol. Every measure instituted to reduce the current widespread availability of alcohol will lead to significant reductions to harm to society as a whole.

In addition to the process outlined below, ARPHS will explore further opportunities for appropriately engaging with Council to facilitate the understanding and uptake of our concerns related to the Proposed LAP. This will occur in the period between public submissions closing and the Provisional LAP being produced. ARPHS is also interested in working with the region’s Emergency Department Clinical Directors to help institute systems by which alcohol harm data may be collected and used to support appropriate oppositions to liquor licence premises, provide useful feedback into further alcohol harm-reduction policy, and inform DHBs of the magnitude of the risk posed by alcohol related harm. ARPHS is also very interested in supporting Auckland DHBs to institute a region-wide intervention linked with the collection of alcohol harm data, such as an alcohol ‘brief intervention’, and a hospital-wide ‘key indicator for alcohol’ similar to that which is in place for smoking.

4. **Progress/Achievements/Activity**

Auckland Council have embraced the challenge of formulating an LAP for the Auckland region, and its formation has followed the statutory requirement to engage with the Medical Officer of Health, Police and District Licensing Inspectors for the region. Auckland Regional Public Health Service’s (ARPHS) Medical Officer of Health, along with her statutory partners, has engaged fully in this process with milestones as follows:

- Council’s issues and options paper: June 2013
- Statutory/other stakeholder meetings: June 2013 – April 2014
- Preferred Position Paper – first draft of LAP: September 2013
- Submissions on Preferred Position Paper by statutory stakeholders: 27th September 2013
- Oral submissions to Councillors: 19th September 2013 - 29th January 2014
• Proposed LAP approved by Council 13th May 2014
• Public submissions June 16th 2014 – July 16th 2014
• Provisional LAP Late 2014
• Appeals Late 2014
• Adoption/implementation LAP Early 2015.

5. Conclusion

We ask that CPHAC receives this report, supports our stance in advocating for further restrictions on trading hours, density and proximity of licensed premises in the Auckland region, than is currently being proposed in Council’s Proposed LAP, and supports further initiatives as outlined in the risks/issues section, above.

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3 Council’s Regional Strategy and Policy Committee approved draft LAP for public consultation.
16 July 2014

Submission on the Draft Auckland Council Local Alcohol Policy

1. Thank you for the opportunity for the Auckland Regional Public Health Service (ARPHS) to provide a submission on the Draft Local Alcohol Policy.

2. The following submission represents the views of the Auckland Regional Public Health Service and does not necessarily reflect the views of the three District Health Boards it serves. However, this submission has been formally endorsed by the Emergency Department Clinical Directors for hospitals in Auckland, Waitemata, Counties Manukau, and Waikato. Please refer to Appendix 1 for this endorsement and further information on ARPHS.

3. ARPHS understands that all submissions will be available under the Local Government Official Information and Meetings Act 1987, except if grounds set out under the Act apply.

The primary contact point for this submission is:

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Yours sincerely,

Dr. William Rainger
Service Manager
Auckland Regional Public Health Service

Dr. Denise Barnfather
Medical Officer of Health
Auckland Regional Public Health Service
Executive summary

1. ARPHS supports the overall intention of the draft Local Alcohol Policy (LAP) as a means to reduce alcohol related harms. Alcohol is a major source of a wide variety of harms to health. Alcohol is associated with over 200 diseases and is also associated with other harms including vehicle accidents, domestic violence and assault.

2. Alcohol is widely consumed in New Zealand, and often in a hazardous manner. Consequently alcohol is associated with between 600 and 1000 deaths each year in New Zealand. This has major social and economic costs. Alcohol is also strongly associated with health inequalities, particularly for young people and Māori and Pacific people.

3. Due to the major harms associated with alcohol consumption we strongly endorse greater restrictions on alcohol availability throughout the draft LAP. Our recommendations are based on policy measures that have been shown to work in reducing alcohol related harms. Our organisation also commissioned a survey that was designed to ensure that public opinion was captured, and has also been used to guide these recommendations. Public opinion strongly supports more restrictive provisions for alcohol licensing.

4. Our key recommendations for the Auckland Council Local Alcohol Policy to reduce alcohol related harms in the region are:

   **Broad Areas**
   - We support the priority overlays, but recommend greater restrictions.
   - Specifically, we recommend that the entire city centre, Broad Area A, be reclassified as a Priority Overlay Area in recognition of the high levels of alcohol-related disorder throughout the area and to prevent displacement of alcohol-related harm.

   **Density**
   - We recommend greater restrictions on the density and number of licensed premises.
   - Specifically, we recommend a freeze or sinking lid policy for on and off-licenses in Broad Area A, neighbourhood centres and all Priority Overlay Areas for the six-year duration of the LAP.

   **Proximity**
   - We recommend an exclusion zone near sensitive sites (including schools), to limit the proximity of alcohol retailing premises to vulnerable members of society.

   **Trading Hours**
   - We recommend further restricting trading hours for licensed premises, and strongly support consistent trading hours across the Auckland region to prevent migratory drinking and any associated harms.
   - Specifically, we are strongly opposed to extensions of trading hours for ‘best practice’, or other, operators.
   - For on-licensed premises, we support restricted trading hours of 10am – 1am for the whole Auckland region.
   - For off-licensed premises, we support restricted trading hours of 10am – 9pm for all premises, including supermarkets.
   - If consistent trading hours are not implemented, we advocate the use of a one-way door policy.

   **Discretionary Conditions**
   - We support discretionary conditions, but note that these are not an adequate substitute for the more effective means of reducing alcohol related harms summarised above.

   **Environmental Cumulative Impact Assessments**
   - We support the use of environmental cumulative impact assessments (ECIAs), but note the importance of Council ownership that is separate from the alcohol industry. This helps avoid any conflict of interest caused between the objective of the EICA, to reduce alcohol-related harm, and the industry’s economic imperative.
   - We note that the ECIA is not adequate to appropriately protect vulnerable populations.
**Integrated Dispersal Plans**

- ARPHS supports the use of integrated dispersal plans to reduce the potential for alcohol related harm by ensuring safe and efficient travel options for patrons of alcohol retailing premises.

**Evaluation**

- In order to monitor the ongoing effectiveness of the measures to reduce alcohol related harm in the LAP, we recommend ongoing evaluation.

**Consistency with the Unitary Plan**

- ARPHS recommends that the LAP and proposed Unitary Plan are consistent. The Unitary Plan proposes growth in many areas of Auckland and a greater mix of housing types. Policy should aim to reduce alcohol related harm in these future areas to ensure the effectiveness of the LAP.
- ARPHS believes that more restrictive policy limiting the availability of alcohol is needed to reduce alcohol related harms and effectively meet health-related targets in the Auckland Plan, as well as achieving the Mayoral vision of a highly liveable city.

**Introduction**

5. Alcohol related harm is of major importance to public health in the Auckland region. Thank you for the opportunity to submit on the Auckland Council Draft Local Alcohol Policy. We would also like to thank Council for the opportunities provided to the Medical Officer of Health (MOH) to contribute to this process.

6. We note that under section 78(4) of the Sale and Supply of Alcohol Act 2012 (SSOAA), LAPs must be created in consultation with the Medical Officer of Health. "The authority must not produce a draft policy without having consulted the Police, inspectors, and Medical Officers of Health". As such, this submission forms part of our statutory role in the development of Auckland’s LAP.

7. There is a substantial scientific knowledge base for policy makers on the effectiveness and cost effectiveness of policy interventions that reduce alcohol related harm. Our policy submission is based on this scientific evidence of proven measures to reduce harm, as well as public health ethics, and research on community opinion regarding the LAP.

8. Reducing alcohol related harms is an important part of improving health outcomes in Auckland. We note that the Auckland Plan strategic targets provide the guiding imperative for all of Council’s other policies and plans. We have outlined ways in which Council can meet many of these targets, by reducing alcohol related harms through the LAP, in Appendix 5 of this document.

**Alcohol use in New Zealand**

9. While all alcohol consumption is potentially harmful, heavy drinking, both regular and irregular, presents the greatest risk for negative health outcomes related to alcohol. Heavy drinking remains a predominant feature of New Zealand’s drinking culture. Almost one-half (44%) of all alcohol consumed by adults is consumed in heavy drinking (binge drinking) episodes.

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3 Reducing alcohol related harms to health have been specifically identified as an area in which (central and local) governments have an important ethical duty to intervene. Please refer to the Nuffield Institute of Bioethics: [http://www.nuffieldbioethics.org/news/government-and-industry-not-doing-enough-our-health](http://www.nuffieldbioethics.org/news/government-and-industry-not-doing-enough-our-health)
Health impacts of alcohol

10. The consumption of alcohol is a major personal and public health issue in New Zealand. The harmful use of alcohol is considered to be one of the main risk factors for poor health globally. Alcohol is ranked among the top five preventable causes of morbidity and mortality worldwide.

11. Alcohol is a contributing cause of more than 200 illnesses, as defined by the World Health Organization (WHO) International Classification of Diseases.

12. In New Zealand, alcohol is responsible for 600 to 1000 deaths per year (additionally, many more New Zealanders live with disability due to alcohol).

13. Alcohol is classified as a class one carcinogen. The primary carcinogen in alcoholic beverages is ethanol.

14. Alcohol consumption is linked with a wide number of cancers including the following:
   - Mouth
   - Oesophagus / stomach
   - Colo-rectum
   - Liver
   - Female breast.

15. The 2014 World Cancer Report (WCR) has recently stated that there is no ‘safe limit’ for alcohol consumption.

Alcohol related harms

16. As well as the direct harm to health from alcohol consumption, alcohol also harms health in other ways including alcohol related injuries, assaults, violence, road accidents and other crime.

17. The New Zealand Police report that alcohol is a major contributor to crime statistics. Alcohol is associated with:
   - 50% of all serious violent crime
   - 20% of sexual offending
   - 33% of all family violence
   - 33% of all police apprehensions.

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10 IARC Group 1 carcinogen: The agent (alcohol) is carcinogenic to humans. The exposure circumstance entails exposures that are carcinogenic to humans. This category is used when there is sufficient evidence of carcinogenicity in humans.
14 The World Cancer Report (WCR) is issued by the International Agency for Research on Cancer (IARC). The WHO is IARC’s parent organization.
17 Ibid.
18 Ibid.
19 NZ Police 2010.
18. The Ministry of Transport have reported that 26% of drivers involved in fatal crashes were recorded as having had alcohol\textsuperscript{21}.

19. The ADHB adult emergency department (ED) at Auckland hospital finds that approximately 30 - 50% of overnight attendances, especially during weekends, are related to alcohol use\textsuperscript{22}. Auckland hospital ED estimates that this amounts to an annual cost of $NZ 1.38 million\textsuperscript{23, 24}.

20. Globally around 20% of hospitalisations are associated with alcohol use\textsuperscript{25}. In the 2005/2006 year, gross hospital related costs for alcohol related admissions in New Zealand were estimated at NZD$126 million\textsuperscript{26}. Overall, alcohol related harms impose a major burden on the health system in Auckland.

21. As outlined earlier in this submission, all levels of alcohol consumption are a risk to health, and the risk increases with increasing consumption. Further details on harms related to alcohol can be found in Appendix 8 of this document.

\textbf{Alcohol and health inequalities}

22. Alcohol is a major contributor to health inequalities. Reducing alcohol related harm is an important factor in improving health inequalities\textsuperscript{27}. Other details on how alcohol related harm disproportionately affects the most disadvantaged can be found in Appendix 6 of this document. We have also outlined in Appendix 7 of this document some of the many requirements for the SSOAA (2012) including consideration both of minimising alcohol related harms and the health of the residents in the local area.

23. Reducing alcohol related harms to health have been specifically identified as an area in which both central and local governments have an important ethical duty to intervene\textsuperscript{28}. We also note that reducing health inequalities are part of Auckland Council's key strategic targets under the Auckland Plan\textsuperscript{29}.

\textbf{Economic costs}

24. The estimated economic cost of alcohol related harm in New Zealand was estimated at NZD$4.8 billion in one year alone (2005/06)\textsuperscript{30}.

25. The World Health Organization also identified that:

\textit{The mortality and prolonged disability associated with NCDs have a sizeable economic impact on households, industries and societies, both via the consumption of health services and via losses in income, productivity and capital formation}\textsuperscript{31}.

26. Alcohol related harm and disease contribute significantly to the overall non-communicable disease (NCD) burden in Auckland. NCDs, including those associated with alcohol, pose a

\textsuperscript{21} Ministry of Transport. 2006-2008 data.
\textsuperscript{22} Dr Anil Nair, Clinical Director, Adult Emergency Department, Auckland Hospital. 4th February 2014. Local Alcohol Policy Recommendations: oral presentation to Auckland Councillors. Auckland Regional Public Health Service.
\textsuperscript{23} Ibid.
\textsuperscript{24} This estimate is similar to that found in other Australian hospitals. Descallar, J., Muscatello, D. J., Weatherburn, D., Chu, M. and Moffatt, S. (2012). The association between the incidence of emergency department attendances for alcohol problems and assault incidents attended by police in New South Wales, Australia, 2003-2008: a time-series analysis. Addiction, 107: 549-556.
\textsuperscript{28} Nuffield Institute of Bioethics: http://www.nuffieldbioethics.org/news/government-and-industry-not-doing-enough-for-health
\textsuperscript{29} Please refer to Appendix 3 of this document for our summary of areas in which Council can improve health outcomes in line to better reach its Auckland plan targets through changes to the draft LAP document.
significant burden on economies and businesses. This was highlighted in a global survey of business leaders from around the world carried out by the World Economic Forum, where chronic disease was identified as one of the leading threats to global economic growth. Conversely, economic growth in health-harming industries such as global alcohol production, fast food and tobacco, are leading causes of global disease burdens.

**Need for separation of alcohol industry from local government policy process**

27. We urge Council to prioritise public health and community wellbeing ahead of the economic interests of the alcohol industry in its policy decisions on the LAP under the SSOAA (2012).

28. The stated objective of the SSOAA (2012) is to minimise alcohol related harms, rather than to minimise economic impacts on the alcohol industry.

29. The Global Alcohol Policy Alliance issued a statement of concern opposing the role of alcohol producers in the development of alcohol related public policy. This stated that:

> ‘Unhealthy commodities industries such as the global alcohol producers should have no role in the formation of national and international public health policies’.

30. Similarly, we wish to emphasise the need for evidence based restrictions in order to reduce alcohol related harm, rather than relying on the ineffectual and laissez faire policy instruments generally favoured by alcohol industry interests.

31. We urge Council to keep in mind that local alcohol policies are designed to enable community input into liquor licensing decisions and are the main legislative tool to reduce the availability of alcohol and associated alcohol related harm.

**Purpose of LAPs under the Sale and Supply of Alcohol Act**

32. The key principles of the Act include the need to minimise alcohol related harms. Alcohol related harms outlined in the Objects of the Act 4(2) include:

> “(2) For the purposes of subsection (1), the harm caused by the excessive or inappropriate consumption of alcohol includes —

(a) any crime, damage, death, disease, disorderly behaviour, illness, or injury, directly or indirectly caused, or directly or indirectly contributed to, by the excessive or inappropriate consumption of alcohol; and

(b) any harm to society generally or the community, directly or indirectly caused, or directly or indirectly contributed to, by any crime, damage, death, disease, disorderly behaviour, illness, or injury of a kind described in paragraph (a).”

33. We note that local alcohol policies were developed under the Sale and Supply of Alcohol Act (SSOAA 2012) to better cater to community concerns regarding the over-provision of alcohol retailing outlets in their local areas.

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35 More than 500 public health professionals, health scientists and NGO representatives from 60 countries signed this joint Statement of Concern about the activities of the global alcohol producers.
37 Ibid.
34. The government has stated that one of the key benefits of the Sale and Supply of Alcohol Act is the greater provision for communities to influence the conditions surrounding alcohol availability in their local areas.\(^59\)

35. Therefore, we emphasise the need for the draft LAP to give strong weighting to community opinion regarding policy measures around the sale and supply of alcohol within the LAP.

Public opinion – Local Alcohol policy – ARPHS survey

36. As part of the process for preparing for the LAP, ARPHS commissioned a study of public opinion on local alcohol policies in the Auckland region in January 2014\(^40\). There were 800 randomly selected CATI (computer-assisted telephone interviewing) interviews undertaken with adults in the Auckland Council region.

37. Overall, the survey found that the majority of public opinion is in favour of more restrictions than are currently in force regarding the availability and supply of alcohol. The key findings of this survey can be found in Appendix 2 of this document. As per the SSOAA, we urge Council to pay special credence to the voice of community opinion in formulating the final Local Alcohol Policy.

38. In Appendix 9 of this document we have also illustrated the extremely high level of harm to wider society resulting from alcohol related harm. As such, we strongly emphasise that alcohol use should not only be considered as an individual choice. As a whole society must bear the burden of its harms, we strongly suggest that policies to regulate the sale and supply of alcohol should also reflect the wishes of the entire community.

Key findings

39. Overall, there was majority support for more restrictive alcohol policies in the Auckland region than those currently proposed in the draft LAP.

40. We note that the overall support for greater restrictions on the supply of alcohol in the Auckland region is also reflected in other surveys, such as the one undertaken by the Health Sponsorship Council in Appendix 3 of this submission.

ARPHS' SPECIFIC COMMENTS ON DRAFT LAP

LOCATION- BROAD AREAS

ARPHS recommendations on this Issue

41. ARPHS is supportive of the three defined areas proposed in the LAP; broad area A in the city centre, broad area B being the rest of Auckland, and the priority overlay. ARPHS is pleased to see that the priority overlay covers some areas across Auckland that are currently experiencing a high level of alcohol-related harm.\(^41\)


\(^{41}\) Page 3. NZ Police (2014). Final draft of New Zealand Police submission for the Auckland Council Local Alcohol Policy.
42. We support the areas that have been proposed and agree that these areas require additional restrictions in order to successfully reduce local alcohol related harms.

43. ARPHS recommends a freeze on both on and off-licenses for six years in broad area A, neighbourhood centres and the priority overlay areas (the length of the policy).

44. In broad area B, the priority overlay is proposed in 20 areas. We are particularly concerned with areas in the southern initiative region and we are pleased to see that these areas have been identified as a priority. In broad area B, the Priority overlay contains priority streets, and covers areas within 250 metres of these streets. We support this approach. We also support further restrictions in neighbourhood centres.

45. ARPHS, however, believes that further assessment is required around the impact that the priority overlay areas will have in neighbouring centres and we have concerns around displacement. The proposed priority overlay covers priority streets in broad area A (city centre). We are unsure as to the effectiveness of having a very small number of priority streets in the CBD and feel that this is highly likely to lead to displacement. The entire city centre is an area of concern to ARPHS, as the whole area has high levels of alcohol-related disorder\textsuperscript{42}.

46. ARPHS proposes that the entire city centre area (broad area A) be classified as a priority overlay area.

47. ARPHS has strong concerns regarding the inflexibility of the draft LAP. More flexibility is required to take into account demographic, economic and land use changes over time. The dynamics of areas are likely to change within the six year period of the policy, and this risk is magnified without a proper forecast risk assessment of the impact of the proposed policy at neighbourhood levels. Additionally, there must be a process in place in order to add or remove areas to the priority overlay when required.

48. On account of this, ARPHS recommends annual reviews by Council of the priority overlay areas in order to ensure that they are appropriate and are reducing alcohol related harm without causing displacement. In addition, it is crucial that the impacts of the policies the draft LAP proposes are understood and appropriate mitigation is factored into the LAP itself.

DENSITY

Research findings:

Association between density of on-license premises and alcohol harms

49. There is strong evidence linking the numbers and density of licensed premises and alcohol related harms\textsuperscript{43, 44, 45, 46}. This association is especially pronounced in younger people\textsuperscript{47}.

50. International research has linked increasing numbers of licensed alcohol retailing premises to increased assaults, drink driving, domestic violence, homicide, suicide and child abuse\textsuperscript{48}. Research in Newcastle, Australia, has linked higher numbers of licensed alcohol retailing...

\textsuperscript{42} Page 3, NZ Police (2014). Final draft of New Zealand Police submission for the Auckland Council Local Alcohol Policy.


\textsuperscript{44} Livingston, M. (2012). Implications of outlet density, type and concentration on alcohol consumption & harm. Seminar presentation, Centre for Addiction and Mental Health, Toronto, April 25, 2012.


\textsuperscript{46} Ibid.


premises to higher levels of assault, domestic violence, chronic harms and high risk drinking amongst young people.\textsuperscript{50}

51. This is also consistent with New Zealand research which also links higher numbers of licensed premises with higher rates of alcohol related criminal offending.\textsuperscript{52}

52. A New Zealand based 2013 study found that\textsuperscript{51}: Licensed club density and other on-license density are significantly positively related to many of the categories of police events.
- Bar and nightclub density has the largest effects, and are significantly positively associated with all categories of police events and with motor vehicle accidents.
- Supermarket and grocery store density generally has statistically significant and positive effects on increased police events, but are also significantly negatively related to motor vehicle accidents.

Effectiveness of controls on alcohol density and alcohol related harms:

53. Density controls are strongly advocated in New Zealand and International literature as an effective measure to reduce alcohol related harms\textsuperscript{52},\textsuperscript{53},\textsuperscript{54}.

54. Restricting access to retailed alcohol is also identified by the WHO and the World Economic Forum as one of the most cost effective measures to reduce alcohol related harms\textsuperscript{55}.

Community survey – density and alcohol related harms

55. There was strong community support for no further increase in on-licenses in the CBD or in local communities.
- ‘Not increase any other on-licenses in the CBD’ (between 72% and 83%). There was significantly less support for ‘retain the status quo’ (between 52% and 64%).
- ‘Not increase the number of on-licenses in local communities’ (between 66% and 89%). There was significantly less support for ‘retain the status quo’ (between 56% and 60%).

ARPHS recommendations on this issue

On-licenses

56. ARPHS is very concerned that no density controls have been proposed for on-licenses within the draft LAP and that the environmental cumulative impact assessment (ECIA) is currently the only proposed tool to potentially reduce the number of on-licenses throughout the region.

57. ARPHS recommends the use of a freeze or sinking lid in broad area A, neighbourhood areas and all priority overlay areas for a six year period.

Off-licenses

Density of off-licenses in Auckland


58. ARPHS has found that the density of alcohol retailing premises in the CBD of the Auckland region is very high. Figure 1 below illustrates a high number of off-license premises are within 10 minutes walking distance of many residential addresses in the CBD area.

![Figure 1. GIS map of showing the walking distances of off-licensed premises in the CBD, Auckland](image)

### Research findings

**Off-licenses and alcohol related harms**

59. Off-licenses (including bottle stores and supermarkets) are strongly linked to increased alcohol related harms. A recent study undertaken by Otago University found that, of the alcohol related admissions to Christchurch Hospital Emergency Department, over 80% of alcohol affected patients had consumed alcohol from an off-license premise.

60. We note recent research from Palmerston North highlighting the role of off-licenses in youth alcohol consumption. Of survey respondents, 77% stated that they 'pre-loaded' from off-licensed premises before going on to on-licensed premises. Of the surveyed group, 47% reported having a negative experience on a typical weekend (involving pre-loading).

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57 Alcohol related admissions comprised 30% of the ED department admissions for the study period. More than 80% of the alcohol affected group had been ‘binge drinking’. Source: [http://www.otago.ac.nz/news/news/otago063639.html](http://www.otago.ac.nz/news/news/otago063639.html)


59 The off-licence preloading for this group was mainly from liquor stores (79%) or supermarkets (35%). From: UMR Research (2013). 'Pre-loading of alcohol and associated harm in Palmerston North. A quantitative and qualitative study of the general public'. [http://www.pnsab.co.nz/images/custom/pre-loading_of_alcohol_and_associated_harm_in_palmerston_north__umr_research.pdf](http://www.pnsab.co.nz/images/custom/pre-loading_of_alcohol_and_associated_harm_in_palmerston_north__umr_research.pdf)

60 The most common negative experiences were ‘doing something they later regretted’ (36%), ‘partner / relationship negatively affected by drinking’ (30%), and ‘injuring or hurting themselves or someone else while drunk’ (24%). Many negative experiences recorded higher incidence across pre-loaders with 42% claiming to have done ‘something they later regretted while drunk’. From: UMR Research (2013). 'Pre-loading of alcohol and associated harm in Palmerston North. A quantitative and qualitative study of the general public'. [http://www.pnsab.co.nz/images/custom/pre-loading_of_alcohol_and_associated_harm_in_palmerston_north__umr_research.pdf](http://www.pnsab.co.nz/images/custom/pre-loading_of_alcohol_and_associated_harm_in_palmerston_north__umr_research.pdf)

Off-license density and alcohol related harms

61. The availability of alcohol is linked to many negative health indicators for children, including child abuse. A longitudinal study found a relationship between the density of alcohol retailing outlets and alcohol related domestic violence, including violence towards children.\textsuperscript{62} While this association was found for both on and off-licensed premises, the effects were particularly severe for off-licensed premises, highlighting the increased need for density controls on off-license premises.

Effectiveness of reducing off-licenses

62. As with licensed premises, research indicates that policies to reduce off-license density controls are strongly associated with reductions in alcohol related harms.

63. Summary analyses of studies show a clear association between reduced density (of both on and off-license premises) and reduced alcohol consumption and alcohol related harms.\textsuperscript{63} An 18 year Canadian study found a significant association between reductions in off-license premises' density and reductions in alcohol consumption.\textsuperscript{64}

64. New Zealand studies also show a strong association between off-license density and alcohol related harms, for instance a 2013 study found that increasing off-license density, in particular, supermarket and grocery store density, has a significant relationship to increased alcohol related crime, and police events (although it is negatively related to motor vehicle accidents).\textsuperscript{65}

Community attitudes from ARPHS survey

Off-license density

65. There was extremely strong community support for no further increases in the number of off-licenses. There was, however, different opinions regarding the types of off licenses.  
- 'Not increase the number of off-licenses' (between 91% and 95% did not want increases for the different types of off-license).
- 'Retain the status quo for supermarkets selling alcohol' (63%), 'large chain liquor stores' (52%) and 'wine stores/ small bottle stores' (52%).
- There was no majority option for grocery stores selling alcohol, with 49% wanting 'less', 45% 'the same', 4% 'more' and 1% undecided.

ARPHS recommendations on this issue

66. We support the temporary freeze on off-licenses in broad area A, neighbourhood areas and the priority overlay areas. We strongly recommend a freeze for six years (the length of the policy) rather than 24 months. However, the concept of a rebuttable presumption against the issue of a new license after the 24 month period and the requirement of an ECIA after this time are worthwhile if the six year period is not approved.

67. ARPHS recommends strong density controls on off-license premises in order to effectively reduce alcohol related harms.

\textsuperscript{65} Cameron, M., Cochrane, W., Gordon, C., Livingston, M., (2013). 'The Locally-Specific Impacts of Alcohol Outlet Density in the North Island, New Zealand'. Research report commissioned by the Health Promotion Agency of New Zealand. University of Waikato.
68. We would like to see the introduction of a freeze or sinking lid policy for broad area A, neighbourhood areas and the priority overlay in order to effectively reduce the number of off-licenses in these areas.

LOCATION: PROXIMITY

Research findings

69. We note that the World Health Organization has stated that reducing zoning and liquor outlet density near schools and youth venues has been identified as a key strategy for reducing alcohol related harm for young people, particularly those in disadvantaged groups.

70. Proximity to sensitive sites such as schools poses several issues in relation to alcohol related harms. This includes increased exposure to alcohol advertising including signage to vulnerable populations including young people. Signage and advertising of alcohol is strongly associated with increased drinking in younger people, as well as earlier initiation of drinking.

71. Internationally, policy restrictions on alcohol retailing premises near sensitive sites have been undertaken to reduce alcohol related harms. For example, local Council’s in Poland have designated sites (such as schools, churches, sports facilities and bus/train stations) that must not have alcohol outlets within a minimum distance. Controls on alcohol retailing premises near sensitive sites (e.g. schools, hospitals, churches/places of worship) have also been established in New York, Paris, England and Wales.

Community attitudes from ARPHS survey

Buffer zones near schools

72. With the exception of supermarkets (57% thought they should be allowed), most people did not want off-licenses near schools and likewise for ‘taverns and large bars’ and ‘small neighbourhood bars’. Thirty-five percent of participants surveyed did not want off-licenses of any type near schools.

ARPHS recommendations on this issue

73. We acknowledge that proximity to sensitive sites will be taken into account during the ECIA process. ARPHS, however, wants to see the inclusion of buffer zones around schools as a policy tool in its own right.

74. We support the definition of sensitive sites that has been proposed (ECEs, schools including primary and secondary, and addiction treatment facilities) but believe that further sites could also be added to this, including rest homes.

75. ARPHS recommends that off-licenses that will be located anywhere near schools are closed between the hours of 3pm and 4pm on days that schools are in operation. If buffer zones are not approved ARPHS recommends a robust notification process whereby all residents near sensitive sites are actively notified of any license applications.

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MAXIMUM TRADING HOURS AND ONE-WAY DOOR POLICY

Maximum trading hours – on-licenses

Research findings

Trading hours

76. Research identifies the trading hours of alcohol outlets as a key factor influencing the physical availability of alcohol, and a key policy mechanism with which to regulate alcohol supply and consumption\textsuperscript{71, 72}.

77. Trading hours, especially later trading hours, are strongly associated with increased consumption and alcohol related harms\textsuperscript{73}.

"There is strong and reasonably consistent evidence from a number of countries that changes to hours or days of trade have significant impacts on the volume of alcohol consumed and on the rates of alcohol-related problems. When hours and days of sale are increased, consumption and harm increase and vice versa\textsuperscript{74}.”

Evidence - alcohol harm associated with increased trading hours

78. Evaluations of extended trading hours in other countries have consistently reported increases in alcohol-related harms and the temporal displacement of harms\textsuperscript{75}. In Ireland, an increase in trading hours resulted in increases in binge drinking, accident and emergency attendances, reports of disorder, vandalism and offences\textsuperscript{76}.

Evidence of benefits of restricting trading hours on reducing alcohol related harms

79. Several large summary reviews\textsuperscript{77, 78} have also found that restricting trading hours, especially later trading hours are associated with reductions in alcohol related harms. Similarly a 2007 study of restrictions on on-premise trading hours in Brazil found a significant decrease in the number of homicides\textsuperscript{79}.

80. Earlier opening hours are similarly related to increased alcohol related harms, as drinkers tend to drink for longer and consume more when licensed premises open earlier\textsuperscript{80}.

81. We note that figures recently released from the New Zealand Police indicate that following the February 2014 introduction of reduced closing hours from the Sale and Supply of Alcohol Act, there was an 11% reduction in reported serious assaults, public violence and disorder\textsuperscript{81}.


82. Consistency in trading times reduces the risk of ‘migratory drinking’ where drinkers move to other alcohol retailing venues. This is associated with a range of likely alcohol related harms including drink driving and car crashes.

Community opinions from ARPHS survey

Preferred closing time for CBD on-licenses

83. Maximum of 2am closing time for on-licenses in the CBD (61% did not want it any later), 1am for larger centres (60%) and midnight for the rest of Auckland (52%).

Preferred on-license closing time (if all of Auckland was the same)

84. If all parts of Auckland were to have the same closing time for bars and restaurants, public opinion favoured 1 am, with 56% preferring this option or earlier.

ARPHS recommendations on this issue

85. We applaud the Council’s decision to further restrict the standard maximum trading hours for all of Auckland.

86. We recommend, however, that the trading hours are reduced further due to clear evidence showing the impact of reduced hours on lowering levels of harm.

Need for consistency in trading hours

87. ARPHS proposes maximum hours from 10am – 1am closing for the entire Auckland region. ARPHS believes that having consistent trading hours for the region will prevent displacement issues.

88. ARPHS is strongly opposed to the concept of trial extensions of hours for best practice operators. Extensions up to two hours over the maximum standard hours will have a significant impact on alcohol-related harms in these areas.

One-way door policy

Research findings

89. We note that the evidence in support of one-way door policies is to some extent mixed. However, on the basis of the evidence available, we support one-way door policies as a measure to reduce alcohol related harms, in lieu of our preferred option of earlier and consistent closing times.

90. In New South Wales, instating a policy of 1am lockouts and 3am closing times resulted in a statistically significant 37% reduction in alcohol-related assaults, with an 11% decrease in the proportion of assaults occurring after 3am. There is also some evidence that indicates positive benefits of ‘one-way door’ policies in New Zealand. A trial of a ‘one-way door’ policy in Dunedin was associated with reduced alcohol related violence.

ARPHS community attitudes survey

91. The community attitudes survey indicated that the majority of respondents supported the 'one-way door policy', e.g. a 'lock out rule' for places closing later, which does not allow new people to enter a drinking location after the time at which on-licenses close in the rest of Auckland (66%).

ARPHS recommendations on this issue

92. As stated earlier, we emphasise that consistent trading hours are strongly our first preference. However if Council continues to propose staggered trading hours for the Auckland region we recommend inclusion of a mandatory one-way door policy in the City Centre two hours prior to closing in order to reduce the harms from migratory drinking.

Maximum trading hours – off-licenses

Research findings

93. Summary reports have indicated that reducing trading hours for off-licenses is a key strategy for reducing alcohol related harms. A 1998 study of restrictions on off-license trading hours in a small town in Western Australia identified corresponding reductions in alcohol consumption, criminal charges, alcohol-related hospital presentations and incidents of domestic violence. Reducing the opening hours of off licenses is also important in reducing alcohol consumption. A Swedish study found that the introduction of morning opening hours for alcohol retailing premises was linked to increased alcohol consumption.

ARPHS community attitudes survey

Maximum trading hours – off-licenses

94. We note that the majority of community support was for consistent and more restrictive trading hours for off-licenses. This included the following:
   - Having the same hours for all off-licenses (66% support).
   - Off-licenses stopping sales no later than 10pm (between 73% and 78% support depending on off-license type).
   - Off-licenses beginning sales no earlier than 10am (between 60% and 68% support).

ARPHS recommendations on this issue

95. ARPHS recommends a maximum closing time of 9pm for all off-licenses. We do not support an opening time of 9am.

96. We would like to see maximum trading hours of **10am - 9pm** for all premises, with no exceptions for supermarkets. The 10am opening time is particularly important for off-licenses in close proximity to institutions attended by vulnerable members of society, such as schools and rest homes.

DISCRETIONARY CONDITIONS

97. Host responsibility plays an important part in reducing alcohol related harms. We note that host responsibilities, including preventing, identifying and managing intoxicated and aggressive

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drinkers, is included amongst the suite of measures recommended in the WHO global strategy to reduce the harmful use of alcohol\(^89\).

98. However, host responsibility should not be seen as an adequate substitute for other effective policy instruments to reduce alcohol harm, such as reducing alcohol retailing premises and closing hours.

**ARPHS recommendations on this issue**

99. We are supportive of discretionary conditions varying with different license types. We also support some discretionary conditions being a requirement and more being required on a case-by-case basis.

100. We are particularly supportive of the requirement for all on and off-licenses to maintain a register of alcohol-related incidents.

101. ARPHS is also very supportive of certified managers being required to be on site for club licenses at busy times.

102. We support the introduction of mandatory host responsibility policies and training and restrictions on drinks prior to closing and that these should be mandatory for all relevant licenses.

**ENVIRONMENTAL AND CUMULATIVE IMPACT ASSESSMENTS (ECIA)**

**ARPHS recommendations on this issue**

103. ARPHS acknowledge the importance of the ECIA as a policy tool. We are encouraged by the ECIA process being a requirement for a number of new on and off-license applications, particularly those that are determined to be high risk. We support ECIAIs including matters of environmental risks, cumulative impacts and individual risks.

104. ARPHS recommends that the use of ECIAIs be extended further to be mandatory for all license applications.

105. Importantly, ECIAIs must be the responsibility of Council or an independent organisation. In addition, they must be conducted by those with the appropriate qualifications and experience in conducting environmental and health risk assessments.

106. While alcohol retailing premises can and should be asked to provide evidence of harm, assessment of this potential harm should be undertaken by an independent body, free from industry influence. Independent assessment of alcohol impact is essential in order to reduce the risk of potential conflicts of interest and bias in the reporting of likely alcohol related harms.

107. We acknowledge that proximity to sensitive sites will be taken into account during the ECIA process. ARPHS, however, wants to see the inclusion of buffer zones around schools as a policy tool in its own right. As mentioned previously, we note that the ECIA alone is not adequate to protect sensitive sites such as schools. We do not want our communities to be forced to squander their resources on endless re-litigation through the DLC process in order to protect their schools and their children from proximity to alcohol outlets. It seems particularly unfair and wasteful when taking into account the fact that poorer communities must fight this battle more often and more vigorously given the greater density of liquor outlets in poorer areas, while having fewer resources to engage in this battle.

ADDITIONAL COMMENTS

Integrated dispersal plans

Research findings

108. Evidence has indicated that inadequate transportation options for patrons leaving alcohol retailing venues is linked with increased alcohol related harms.\(^{60}\) Alcohol related harms are associated with the congregation of intoxicated people on the streets after venues close, and is linked to crime, for example, fights breaking out in overcrowded taxi ranks and bus queues.\(^{61}\)

109. We note that internationally ‘integrated dispersal plans’ are used as another means of reducing alcohol related harms.\(^{62}\) Dispersal plans include ensuring that lighting, cleaning and transportation systems are coordinated in order to ensure that people are able to travel safely home at night.

ARPHS recommendations on this issue

110. We suggest that Auckland Council consider the use of integrated dispersal plans and ensure that the Local Alcohol Policy closing times are aligned with the provision of safe public transportation systems.

111. We also note that as part of Auckland's continuing growth and development, the provision of safe transportation options needs to be considered for growth areas in order to protect against potential alcohol related harm in the future.

Unitary plan and ‘mixed use’

112. We note that the currently proposed Unitary plan will allow for a much greater variety of housing, and increased density in Auckland, particularly in the inner city and metropolitan areas of Auckland. This will increase population density in these areas, and will include an increasingly aged population. The well-being and safety of these residents from alcohol related harm also needs to be considered with regards to the liveability of Auckland, and particularly the CBD area.

ARPHS recommendations on this issue

113. We recommend that the LAP be tailored to consider the reduction of alcohol related harms in growth areas as defined by the Unitary plan (e.g. new subdivisions and areas with zoning changes under the Unitary plan).

Ongoing evaluation of effectiveness of Local Alcohol Policy

ARPHS recommendations on this issue

114. Ongoing evaluation of the Local Alcohol Policy is essential in order to gauge its effectiveness. ARPHS recommends robust evaluation procedures and an annual review of the Local Alcohol Policy.


A ‘Liveable city’ – for all

115. ARPHS notes that the liveable city is a key vision for Auckland Council. We applaud this vision. We also note that the argument has been raised (mainly by the alcohol industry in New Zealand) that more restrictive provisions on alcohol consumption will have a negative impact on Auckland’s tourism and night life.\textsuperscript{63, 64}

116. We contest this point on the basis that more restrictive alcohol policies increase health and well-being, personal safety, and are deemed desirable by the majority of our community. We also note that a wide variety of non-alcohol-related and health promoting forms of entertainment and social activities exist as alternatives to alcohol related entertainment.\textsuperscript{65}

\textit{Results of ARPHS community attitudes survey}

117. The ARPHS survey found that there was a clear preference for more non-alcohol focused entertainment in the Auckland CBD.

118. More specifically, in the CBD, 62% of Aucklanders wanted more ‘places providing shows and other entertainment, where the main focus is not on drinking’.

119. Many respondents stated that a reduction in bars and taverns would make them more likely to visit the CBD for shopping and to visit cafes and restaurants.

\textit{Alcohol related harms and liveability}

120. Further comments on the global liveability surveys can be seen in Appendix 4 of this document.

\textit{Reaching Auckland Plan targets through improved LAP policies}

121. ARPHS also notes that evidence based policies to restrict alcohol use will be a key means of reaching the targets of improving health outcomes that have been outlined in Auckland Council’s Auckland Plan. These are outlined in more detail in Appendix 4 of this document.

122. We note that all council policies and plans (including the Local Alcohol Policy) must give effect to the targets outlined in the Auckland Plan. To this effect we recommend that the LAP follow a more restrictive stance on the provision of alcohol in order to reach these aims.

\textit{ARPHS recommendations on these issues}

123. We recommend that Council supports its vision of Auckland as an aspirationally liveable city, and reaches its Auckland plan targets, by introducing more restrictive alcohol policies in the LAP to reduce alcohol related harm.

\textit{Conclusion}

124. Thank you for the opportunity to comment on Council’s draft Local Alcohol Policy. We urge Council to adopt our evidence based and publically endorsed recommendations on the LAP to substantially improve the health, safety and well-being of Aucklanders through reducing alcohol related harms in the Auckland region.

\textsuperscript{63} ‘Save our Nightlife’ campaign. Facebook. Accessed from: https://www.facebook.com/pages/Auckland-Save-our-Nightlife/852386628174056
\textsuperscript{65} Cultural activities, sports, artistic pursuits, social engagement, healthy food related activities are all forms of entertainment that can exist independently of alcohol consumption, both during the day and at night.
Appendix 1 – Endorsement of ARPHS submission on draft LAP

Date: 15th July 2014

ENDORSEMENT OF ARPHS SUBMISSION ON THE DRAFT LOCAL ALCOHOL POLICY

The submission is endorsed by the Emergency departments (ED) in the Auckland region and is also supported by the Clinical Director of Waikato Hospital.

The Auckland Local Alcohol Policy (LAP) provides a unique opportunity to reduce alcohol related harm in the Auckland population. It is important that the LAP addresses the concerns of health professionals who see first-hand the significant harm alcohol causes to our society.

There is a significant increase in the number of alcohol related attendances to EDs, particularly presenting after midnight. This places significant demand on the resources in the EDs and diverts care from other emergencies.

There is strong evidence that shows a restriction in the hours of sale of alcohol, or reduction in density of alcohol retail premises, results in a reduction in volume of alcohol consumed and on the rates of alcohol related presentations to Hospitals. The LAP should therefore have provisions to reduce the accessibility and availability of alcohol.

We would like to recommend the following changes to the LAP:

1. A reduction in the trading hours of off-licence premises from 10am to 9pm.
2. A reduction in the hours of trading of all on licenses from 9am to 1am.
3. A reduction in the number of on license and off-licence outlets serving alcohol.

Dr Anil Nair
Clinical Director, ED, Auckland Hospital

On behalf of
Dr Willem Landman, Clinical Director , ED, North Shore Hospital , Dr Vanessa Thornton, Clinical Director, ED , Middlemore Hospital ;Dr John Bonning, Clinical Director, ED, Waikato Hospital
Auckland Regional Public Health Service

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Auckland, Counties Manukau and Waitemata District Health Boards), with the primary governance mechanism for the Service resting with Auckland District Health Board.

ARPHS has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

ARPHS' primary role is to improve population health. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects on population health.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, outstanding infrastructure needs, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.
Appendix 2 – ARPHS survey on community attitudes towards alcohol restrictions

The following tables highlight some of the community survey results from our survey of community attitudes relating to local alcohol policies.

<table>
<thead>
<tr>
<th>TIME BARS AND RESTAURANTS SHOULD CLOSE IF SAME TIME FOR ALL OF AUCKLAND</th>
<th>Total Sample (n=800)</th>
<th>Those preferring different closing times (n=419)</th>
<th>Those preferring same closing time for all of Auckland (n=381)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 10 pm</td>
<td>2 %</td>
<td>1 %</td>
<td>4 %</td>
</tr>
<tr>
<td>10 pm</td>
<td>7 %</td>
<td>5 %</td>
<td>9 %</td>
</tr>
<tr>
<td>11 pm</td>
<td>7 %</td>
<td>5 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Midnight</td>
<td>22 %</td>
<td>21 %</td>
<td>23 %</td>
</tr>
<tr>
<td>1 am in the morning</td>
<td>18 %</td>
<td>20 %</td>
<td>15 %</td>
</tr>
<tr>
<td>2 am</td>
<td>18 %</td>
<td>18 %</td>
<td>17 %</td>
</tr>
<tr>
<td>3 am</td>
<td>11 %</td>
<td>14 %</td>
<td>8 %</td>
</tr>
<tr>
<td>4 am</td>
<td>2 %</td>
<td>3 %</td>
<td>1 %</td>
</tr>
<tr>
<td>5 am</td>
<td>1 %</td>
<td>1 %</td>
<td>1 %</td>
</tr>
<tr>
<td>6 am</td>
<td>1 %</td>
<td>1 %</td>
<td>1 %</td>
</tr>
<tr>
<td>7 am</td>
<td>0 %</td>
<td>0 %</td>
<td>0 %</td>
</tr>
<tr>
<td>After 7 am</td>
<td>0 %</td>
<td>0 %</td>
<td>0 %</td>
</tr>
<tr>
<td>Not close at all/open 24 hours</td>
<td>2 %</td>
<td>2 %</td>
<td>2 %</td>
</tr>
<tr>
<td>Same as now</td>
<td>2 %</td>
<td>1 %</td>
<td>2 %</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6 %</td>
<td>5 %</td>
<td>4 %</td>
</tr>
<tr>
<td>Refused</td>
<td>1 %</td>
<td>1 %</td>
<td>0 %</td>
</tr>
<tr>
<td>Total 1 am or earlier</td>
<td>56 %</td>
<td>52 %</td>
<td>61 %</td>
</tr>
</tbody>
</table>

PREFERRED NUMBER OF OFF-LICENCES

<table>
<thead>
<tr>
<th>PREFERRED NUMBER OF OFF-LICENCES</th>
<th>More</th>
<th>The same</th>
<th>Less</th>
<th>Don’t know/Refused</th>
<th>Total wanting no increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supermarkets selling alcohol</td>
<td>8 %</td>
<td>63 %</td>
<td>23 %</td>
<td>1 %</td>
<td>91 %</td>
</tr>
<tr>
<td>Large chain liquor stores</td>
<td>5 %</td>
<td>52 %</td>
<td>42 %</td>
<td>1 %</td>
<td>94 %</td>
</tr>
<tr>
<td>Wine stores and small bottle stores</td>
<td>7 %</td>
<td>52 %</td>
<td>39 %</td>
<td>1 %</td>
<td>92 %</td>
</tr>
<tr>
<td>Grocery stores selling alcohol</td>
<td>4 %</td>
<td>45 %</td>
<td>49 %</td>
<td>1 %</td>
<td>95 %</td>
</tr>
</tbody>
</table>

Base: Total sample (n=800)
### Preferred Number of On-Licences in Local Community

<table>
<thead>
<tr>
<th>PREFERRED NUMBER OF ON-LICENCES IN LOCAL COMMUNITY</th>
<th>More</th>
<th>The same</th>
<th>Less</th>
<th>Don't know/Refused</th>
<th>Total wanting no increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taverns and large bars</td>
<td>10</td>
<td>60</td>
<td>29</td>
<td>1</td>
<td>89</td>
</tr>
<tr>
<td>Small neighbourhood bars</td>
<td>17</td>
<td>56</td>
<td>25</td>
<td>1</td>
<td>82</td>
</tr>
<tr>
<td>Licensed cafes and restaurants</td>
<td>33</td>
<td>57</td>
<td>9</td>
<td>1</td>
<td>66</td>
</tr>
</tbody>
</table>

*Base: Total sample (n=800)*

### Preferred Number of On-Licences in CBD

<table>
<thead>
<tr>
<th>PREFERRED NUMBER OF ON-LICENCES IN CBD</th>
<th>More</th>
<th>The same</th>
<th>Less</th>
<th>Don't know/Refused</th>
<th>Total wanting no increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taverns and large bars</td>
<td>11</td>
<td>57</td>
<td>25</td>
<td>6</td>
<td>83</td>
</tr>
<tr>
<td>Small neighbourhood bars</td>
<td>14</td>
<td>59</td>
<td>22</td>
<td>5</td>
<td>81</td>
</tr>
<tr>
<td>Licensed cafes and restaurants</td>
<td>25</td>
<td>64</td>
<td>9</td>
<td>3</td>
<td>72</td>
</tr>
<tr>
<td>Night clubs</td>
<td>12</td>
<td>52</td>
<td>26</td>
<td>9</td>
<td>79</td>
</tr>
<tr>
<td>Places providing shows and other</td>
<td>62</td>
<td>29</td>
<td>6</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>entertainment, where the main focus is</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Base: Total sample (n=800)
Appendix 3 – Health Sponsorship Council survey of public support for restrictions on Alcohol in New Zealand

*Health Sponsorship Council of New Zealand survey results*

The following table highlights the strong desire for greater restrictions on the availability of alcohol in New Zealand[^86]. This survey similarly highlights majority support for reducing the availability of alcohol.

<table>
<thead>
<tr>
<th>Policy measure</th>
<th>Agree or strongly agree</th>
<th>Neutral</th>
<th>Total unopposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing the hours that alcohol can be sold</td>
<td>66%</td>
<td>18%</td>
<td>84%</td>
</tr>
<tr>
<td>Restriction on alcohol advertising or promotion seen or heard by young people</td>
<td>82%</td>
<td>14%</td>
<td>96%</td>
</tr>
<tr>
<td>Banning all alcohol advertising or promotion</td>
<td>50%</td>
<td>27%</td>
<td>77%</td>
</tr>
<tr>
<td>Number of liquor outlets</td>
<td>Too many</td>
<td>About right</td>
<td>Too few</td>
</tr>
<tr>
<td></td>
<td>65%</td>
<td>33%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Figure 2: Health Sponsorship Council survey of public support for greater restrictions on alcohol in New Zealand, 2010[^87].

[^87]: ibid.
Appendix 4 – Liveability (through reducing alcohol related harm)

‘Liveability’ is a core feature of the Auckland Council’s vision of the ‘World’s most liveable city’. ARPHS strongly supports this aim. We wish to support this aim by advocating for effective and evidence based measures to reduce alcohol related harm, as a means of ensuring that Auckland becomes a healthier, safer and more liveable city, for all Aucklanders.

Many of the core features of global liveability surveys relate to factors that can be improved through effective controls on alcohol related harm.

<table>
<thead>
<tr>
<th>Key concerns</th>
<th>Sydney (per cent)</th>
<th>Other Australian major cities (per cent)</th>
<th>Regional New South Wales (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care</td>
<td>44</td>
<td>49</td>
<td>50</td>
</tr>
<tr>
<td>Crime</td>
<td>34</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>Child in need</td>
<td>31</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>Transport</td>
<td>35</td>
<td>26</td>
<td>21</td>
</tr>
<tr>
<td>Poverty</td>
<td>31</td>
<td>22</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: Ipsos Australia 2013

Figure 3: IPOS Mind and Mood Survey. The Australian ‘Mind and Mood’ liveability report on Australian cities highlights a number of areas related to liveability that are linked to alcohol related health and safety outcomes. This survey highlighted that the top two concerns for residents in Australia were:

- Health care system
- Crime.

Both of these measures, are, as outlined earlier in our submission, affected by alcohol related harm.

Health care system:
In terms of the health care system in the Auckland region, the major impacts of alcohol related harm place a major strain on the health system in the Auckland region.

Crime/personal safety:
Personal safety and crime as we have also outlined earlier in this submission, crime is particularly closely related to alcohol use, with 50% of all serious violent crime and 33% of all police apprehensions in NZ associated with alcohol.

More traditional liveability indices tend to be developed with more focus on the needs of industry. These traditional indices, however, also focus on personal safety and crime. For example:

- Mercer Quality of Living Survey. Top features of liveability include: ‘Lack of crime’.
- Monocle’s most liveable cities Index. Top features of liveability: ‘Personal safety/crime’
- Economist’s Intelligence Unit Liveability index: Top features of liveability: ‘Low personal risk’.

We note that the Melbourne has a policy on ensuring a liveable city which highlights the need for ensuring time for recuperation for city residents. Restricting alcohol licencing times are a key feature of ensuring time for recuperation for inner city residents, in order to better ensure a good quality of life.

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99 Ibid.
101 NZ Police 2010.
Appendix 5 – Auckland Plan targets and ARPHS recommendations on LAP

We note that the Auckland Plan provides the overarching strategic framework for all of council’s policies and plans, which includes Auckland Council’s Local alcohol policy.

We also note that all Council policies and plans are intended to give support to these strategic objectives.

Given the extreme harm to health and personal safety caused by alcohol related harm, the strong need for stricter regulatory controls, and the strategic aims of the Auckland plan to improve the overall health and wellbeing of Aucklanders, we see options to improve health outcomes through changes to the LAP.

These support the Auckland plan targets in the following areas:

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Health outcomes; Auckland Plan targets</th>
<th>ARPHS LAP recommendations that contribute to these objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland’s</td>
<td>There will be no gaps in life expectancy between European, Māori, Pacific and Asian ethnicities by 2040.</td>
<td>Enacting controls on alcohol availability in order to minimise alcohol related harm, and reduce health inequalities – particularly in Southern Initiative areas.</td>
</tr>
<tr>
<td>people</td>
<td>Decrease the number of child hospitalisations due to injury by 20% by 2025.</td>
<td>Reduce availability and supply of alcohol through evidence based recommendations in submission.</td>
</tr>
</tbody>
</table>
|                | Ensure that the incidence of trauma from road crashes caused by alcohol, speeding or lack of restraints will be in line with nationally set targets by 2020. | • Reducing availability of alcohol. Ensuring consistent standards for closing times across the city in order to reduce migratory drinking.  
  • Aligning LAP with availability of public transportation options.  
  • Reducing opportunities for binge drinking. |
|                | By 2020 the number of breaches of the Domestic violence Act (1995) will have stabilised and by 2040 will have fallen by 40%. | Reduce availability and supply of alcohol through evidence based recommendations in submission.                             |
|                | Increase residents perceptions of safety in their neighbourhood from 68% in 2010 to 80% by 2030.       | Reduce availability and supply of alcohol through evidence based recommendations in submission.                             |
|                | Reduce the rate of total criminal offences per 10,000 population from 939 in 2010 to 800 in 2040.       | Reduce availability and supply of alcohol through evidence based recommendations in submission.                             |
| Transport      | Reduce road crash fatalities and serious injuries from 506 (2010) to no more than 410 in 2040.       | • Reducing availability of alcohol. Ensuring consistent standards for closing times across the city in order to reduce migratory drinking.  
  • Aligning LAP with availability of public transportation options.  
  • Reducing opportunities for binge drinking. |

Appendix 6. Alcohol related harms and their relationship to Health Inequalities

Figure 4: How inequalities in alcohol related harm compound over a life course\textsuperscript{104}.

Appendix 7. Sale and Supply of Alcohol Act (SSOAA) Purposes of the Act and local alcohol policies

The SSOAA

We seek here to outline several key features of the Act that relate to the conditions under which LAP should be created. This includes the requirement that under the SSOAA 2012, LAPs should aim to minimise alcohol related harms. Under the SSOAA, LAPs must also give regard to a number of issues including the nature and severity of current alcohol related harms, and the overall health indicators of residents within an area.

4 Object
(1) The object of this Act is that—
(a) the sale, supply, and consumption of alcohol should be undertaken safely and responsibly; and
(b) the harm caused by the excessive or inappropriate consumption of alcohol should be minimised.
(2) For the purposes of subsection (1), the harm caused by the excessive or inappropriate consumption of alcohol includes—
   (a) any crime, damage, death, disease, disorderly behaviour, illness, or injury, directly or indirectly caused, or directly or indirectly contributed to, by the excessive or inappropriate consumption of alcohol; and
   (b) any harm to society generally or the community, directly or indirectly caused, or directly or indirectly contributed to, by any crime, damage, death, disease, disorderly behaviour, illness, or injury of a kind described in paragraph (a).

“78 Territorial authorities must produce draft policy

- (1) A territorial authority that wishes to have a local alcohol policy must produce a draft policy.
  (2) When producing a draft policy, a territorial authority must have regard to—
     - (a) the objectives and policies of its district plan; and
     - (b) the number of licenses of each kind held for premises in its district, and the location and opening hours of each of the premises; and
     - (c) any areas in which bylaws prohibiting alcohol in public places are in force; and
     - (d) the demography of the district’s residents; and
     - (e) the demography of people who visit the district as tourists or holidaymakers; and
     - (f) the overall health indicators of the district’s residents; and
     - (g) the nature and severity of the alcohol-related problems arising in the district.
  (3) For the purposes of subsection (2), a district’s residents include people who have holiday homes there.
  (4) The authority must not produce a draft policy without having consulted the Police, inspectors, and Medical Officers of Health, each of whom must, if asked by the authority to do so, make reasonable efforts to give the authority any information they hold relating to any of the matters stated in subsection (2)(c) to (g).”
Appendix 8 – Summary of Alcohol related harms

Alcohol is responsible for 600 to 1000 deaths in New Zealand per year\textsuperscript{106,106} (additionally many more New Zealanders live with disability due to alcohol). In 2007, 802 deaths of New Zealanders under 80 years of age were attributable to alcohol consumption\textsuperscript{107}. Of these 43% were attributable to injuries, 30% were due to cancer and 27% were due to other chronic conditions\textsuperscript{108}.

Alcohol is also classified as a class one carcinogen\textsuperscript{109}. Alcoholic beverages contain at least 15 different carcinogens including; acetaldehyde, acrylamide, aflatoxins, arsenic, benzene, cadmium, ethanol, ethyl carbamate, formaldehyde, and lead\textsuperscript{110}. The primary carcinogen in alcoholic beverages is ethanol\textsuperscript{111}.

Alcohol is also classed as a neurotoxin\textsuperscript{112}. Heavy alcohol consumption is linked to brain damage. Some of these include black outs, memory impairment, alcohol related psychosis and damage to the developing brain in the new born child\textsuperscript{113}.

Alcohol related harms

The New Zealand police report that alcohol is a major contributor to crime statistics. Alcohol related harm is associated with:

- 50% of all serious violent crime\textsuperscript{114}
- 33% of all violence\textsuperscript{115}
- 20% of sexual offending\textsuperscript{116}
- 33% of all family violence\textsuperscript{117}
- 33% of all police apprehensions\textsuperscript{118}

The Ministry of Transport have reported that 26% of drivers involved in fatal crashes were recorded as having had alcohol\textsuperscript{119}.

Globally around 20% of hospitalisations are associated with alcohol use\textsuperscript{120}.

The ADHB Adult emergency department (ED) at Auckland hospital receives a significant amount of patients due to the direct or indirect effects of alcohol. This is primarily because of its location close to the CBD and its position as the regional trauma centre. About 30 - 50% of overnight attendances especially on weekends are related to alcohol use. The ED department also tends to have peaks in presentations over public holidays and major social events in the CBD and its surrounds\textsuperscript{121}. Please note that the official

\textsuperscript{108} Ibid.
\textsuperscript{109} Ibid.
\textsuperscript{110} ARC Group 1 carcinogen: The agent (alcohol) is carcinogenic to humans. The exposure circumstance entails exposures that are carcinogenic to humans. This category is used when there is sufficient evidence of carcinogenicity in humans.
\textsuperscript{112} Ibid.
\textsuperscript{113} The United States Department of Human and Health Sciences (2000). The 10th special report to the U.S. Congress on Alcohol and Health. 'The neurotoxicity of alcohol'. Accessed from: http://pubs.niaaa.nih.gov/publications/10report/chap02e.pdf
\textsuperscript{114} Examples include fetal alcohol syndrome, the most preventable type of developmental brain damage.
\textsuperscript{116} Ibid
\textsuperscript{117} Ibid.
\textsuperscript{118} NZ Police 2010.
\textsuperscript{119} Ministry of Transport. 2006-2006 data.
\textsuperscript{120} WHO. Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm. Copenhagen, Denmark: WHO Regional Office for Europe; 2009.
\textsuperscript{121} Dr Anil Nair, Clinical Director, Adult Emergency Department, Auckland Hospital. 4th February 2014. Local Alcohol Policy Recommendations: oral presentation to Auckland Councillors. Auckland Regional Public Health Service.
figures however tend to underestimate the impact of alcohol as attendances to ED of less than 3 hours are not coded.

Young people

Amongst youth aged 16-17 years, eight in ten (79.6%) people aged 16–17 years had consumed alcohol in the past year. Of these many young people experienced harm due to their own drinking, for example 15.0% had experienced injuries related to drinking.

Alcohol related inequalities

Figure 5 below indicates the strong association between alcohol use and the social gradient, with the most deprived group at three times greater risk of alcohol dependence compared with the most affluent group.

Figure 5: Socioeconomic deprivation and risk of dependence on alcohol, nicotine and other drugs.

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123 Ibid.

Appendix 9. Social and personal harms of alcohol related to other drugs

Alcohol is a drug with higher impacts to other people than any other recreationally used drug. The following study assessing drug harms to users and others, ranked alcohol as the most socially harmful drug.\textsuperscript{126} While other recreationally used drugs are also extremely harmful to human health and society, we would like to emphasise that the severity of harms related to alcohol are borne by the whole society, rather than just an individual choice, and therefore, policy recommendations should reflect the wishes of the entire community.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure6.png}
\caption{Overall harms of alcohol compared with other drugs.\textsuperscript{126}}
\end{figure}

\textit{Note:} Drugs are ordered in this graph based on their overall harm scores, showing the separate contributions to the overall scores of harms to users and harms to others. The weights after normalisation (0-100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for the criteria to others, 54). CW=cumulative weights. GHB=gamma hydroxybutyric acid. LSD=lysergic acid diethylamide.\textsuperscript{127}

\textsuperscript{127} Ibid.
5.1 Planning, Funding and Outcomes Update

Recommendation:
That the report be received.

Prepared by: Dr Debbie Holdsworth (Director Funding WDHB/ADHB), Simon Bowen (Director Health Outcomes WDHB/ADHB), Wendy Bennett (Manager Planning and Health Intelligence), Tim Wood (Funding and Development Manager Primary Care WDHB/ADHB), Ruth Bijl (Funding and Development Manager Women, Children and Youth WDHB/ADHB), Lita Foliaki (Manager Pacific Health Gain), Cliff La Grange (Manager Finance and Support Services), and William Rainger (ARPHS)

Glossary
A&C - Audit and Compliance
DHB - District Health Board
FTE - Full Time Equivalent – one FTE is the total number of hours a staff member would complete if they worked full time. This would range from 35 to 40 hours a week depending on the role being filled
GP - General Practitioner
MoH - Ministry of Health
PHO - Primary Health Organisation

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

2. Summary of activities

2.1 Planning
- Both ADHB and Waitemata DHB Annual Plans are with the Ministry of Health (MoH) awaiting Ministerial sign-off.
- Annual Reports for both ADHB and Waitemata DHB are underway - initial meetings with auditors completed and collation of data for measures has commenced
- Work underway to update Health Needs Assessment for both DHBs
- Planning underway for General Practitioner (GP) open day at Waitakere hospital and South Kaipara Festival – 20 September.

2.2 Fraud Hot Line Update
For over eight years Audit and Compliance, within the Ministry of Health, has operated the fraud hotline service with people being able to contact Audit and Compliance staff via the 0800 number to report their concerns during business hours. The Ministry has now contracted Crimestoppers to take all the 0800 fraud hotline calls providing a 24/7 service, with the call takers being specifically trained in assisting callers to elicit and record the best information to enable proper follow-up and investigation. Crimestoppers is used by many regulatory agencies in New Zealand including Police, Customs and Housing NZ. The service is completely
anonymous unless callers request their details to be recorded, with the regulatory agency only receiving information about the alleged wrong doing.

As of the first week in July, Crimestoppers started receiving 0800 fraud hotline calls on behalf of the Ministry of Health Audit and Compliance. The same 0800 424888 number that has always been used remains, so current posters and brochures in circulation remain valid and can continue to be used. New marketing material is currently being developed that will be available for circulation over the next few months. The key changes in messaging that will be used in the new marketing material is a move away from "fraud" and the name "Fraud Hotline" to a focus on encouraging people in the health sector or customers of health services to "give us a call" to discuss any concerns they may have. The hotline itself will be referred to as the "Health Integrity Line". A key reason for the name change has been feedback from customers of the old 0800 service that the word "Fraud" was potentially a barrier to people using the service/hotline, as often the callers were unsure of whether what they were concerned about (ie the behaviour they had seen or heard about) amounted to fraud in a legal sense. Ultimately we want people to contact the Health Integrity Line no matter what information they have and leave the decision as to whether their information is actionable or amounts to fraud or other criminal wrong doing to Audit and Compliance.

2.3 Primary Care

Provisional 2013/14 year end health target results, as reported directly by PHOs, are achievement of the smoking brief advice target for both Auckland and Waitemata DHBs and achievement of the more heart and diabetes check target for Auckland DHB. Waitemata PHO failed to achieve the more heart and diabetes check target which resulted in Waitemata DHB not achieving the target. Finalised results will be available in August.

Thank you to all PHOs for making a significant effort in helping in the achievement of these targets.

The Alliance Leadership Team has been appointed and meeting dates are now scheduled. The ALT membership is:

- A DHB Chief Executive (Ailsa Claire)
- PHO Chief Executives (Alliance Health+ - Alan Wilson, Auckland PHO - Barbara Stevens, National Hauora Coalition - Simon Royal, ProCare - Steve Boomert, Total Healthcare Mark Vella, Waitemata PHO - John Ross)
- PHO Clinical Directors (Alliance Health+ - Dr Jim Primrose, Auckland PHO – Dr Charlotte Harris, National Hauora Coalition – Dr David Jansen, ProCare – Dr Allan Moffitt, Total Healthcare - Dr Richard Hulme, Waitemata PHO – To be determined)
- A DHB Medical Director (Dr Andrew Brant)
- A DHB Nursing Director (Margaret Dotchin)
- DHB Primary Nursing Director (Jean McQueen)
- A DHB Allied Health Director (Sue Waters)
- A DHB Planning or Funding Director (Dr Debbie Holdsworth)
- A representative of Te Runanga O Ngati Whatua (Tereki Stewart)
- A representative of Te Whanau O Waipareira (John Tamihere)

Tim Wood, Deputy Director Funding, Auckland and Waitemata DHBs has been appointed interim Chair.
The first meeting is scheduled for Thursday 24th July. At this meeting the work programme will be presented for approval.

The first Regional Clinical Governance Forum meeting has been held. This was a well-attended forum and regarded as a success by those participating. The forum agreed to implement a proposed framework for reporting of performance data at a general practice level. It is anticipated that over time this framework will evolve in terms of both scope and depth of reporting. It is pleasing to see clinical leaders providing leadership in this important area.

2.4 Office Auditor General Report - DHBs: Availability and Accessibility of After-hours services

In 2010, The Office of the Auditor General (OAG) published a report about a performance audit looking at whether District Health Boards (DHBs) were effectively meeting government expectations about the availability and accessibility of after-hours services.

In 2010, the OAG found that after-hours services were available within 60 minutes’ drive for 99.7% of people. In general, people living in remote rural areas did not have these services available within 60 minutes’ drive. Although DHBs had good service coverage, most had not clearly identified or addressed transport and affordability barriers to accessing after-hours services.

The OAG has now completed a follow up review which is attached in Attachment 1 for the Committees’ information. The follow-up review showed that many DHBs have identified and/or addressed barriers and improved access. The introduction of free after-hours services nationally for children under six has also helped to improve access for these children. However, access problems (such as cost) remain for Māori, Pasifika, rural communities, and people living in the most deprived areas. There is still afterhours pressure on hospital emergency departments.

The OAG in the latest review encourage DHBs to continue to look for ways to make access to after-hours services easier and to improve the sustainability of those services. The OAG states “We recognise that DHBs need to work with primary health organisations and other after-hours service providers. There are some successful collaborations. We encourage DHBs and primary health organisations to consider these and other approaches that work well.” The follow up review shows that while the DHBs in Auckland have made progress since the 2010 review there are still some areas where improvements can be made.

The Auckland Regional After-Hours Network is continually working on improvements of the after-hours services. These improvements include: (i) working with St John, via the Clinical Hub, to direct patients to the most appropriate place for care, (ii) improving access to the telephone triage service, and (iii) introducing free visits for all under sixes at the Accident and Medical clinics in the network. Further refinements and improvements are being planned.

2.5 Primary Mental Health Project

One of the four over-arching goals in Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 is “building infrastructure for integration between primary and specialist services”. The expected result of this goal is to enhance co-ordination and integration between primary and specialist services, through addressing practical barriers to integration and developing infrastructure.
Both Auckland and Waitemata DHBs have stated 2013/14 Annual Plan actions that relate to this integration. There are also 2013/14 prioritised actions in the national *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* reporting template, which require regular reporting to the Ministry of Health. The key action was to begin to plan, in partnership with Primary Care, a collaborative Stepped Care model. We have initiated two projects, one in Tamaki and one the New Lynn Integrated Family Health Centre.

**New Lynn Integrated Family Health Centre (Totara Health)**

In the first half of the 2013/14 year, Procare Health Limited and Waitemata DHB came together to plan steps to improve the integration, responsiveness and performance of the Mental Health Services with a focus on primary care. Agreement was reached to develop and demonstrate a pilot ‘stepped model of care’ with the aim of using Totara Health as the locality. Totara Health quickly came on board as part of the project team, as did Auckland DHB. New Lynn has a shared border between the two DHBs, thus an ideal site for a joint project.

The objectives of the pilot were to:

- Develop an integrated model of Stepped Care with key stakeholders in order to provide Totara Health clients with the right intervention and the right level of intensity to maximise mental health
- Integrate primary care services with Procare primary mental health services (Procare Psychological Services), DHB secondary mental health and addiction services, NGO and community services
- Demonstrate how mental health providers and services can be joined up to provide more effective care for clients
- Support Totara Health staff to manage the mental well-being of their clients more effectively
- Increase the identification of Alcohol and Drug problems and support the provision of interventions using a stepped care approach
- Increase uptake and integration of resources like E Therapies
- Reduce levels of illness, through early treatment and prevention
- Demonstrate how a closer working relationship between primary and secondary care can be achieved, along with how this positively impacts client outcomes
- Provide a replicatable model that can be rolled out across the DHBs

**Progress to Date**

- The integrated Family Health Practice in New Lynn continues to host the project which aims to integrate the Secondary Mental Health Services of both ADHB and WDHB, with primary care.
- Malcolm Stewart (Clinical Psychologist) is the clinical lead for the project.
- Waitemata DHB Mental Health Services are developing a role to enable psychiatrist support for this model.
- DHB community mental health Primary Care Liaison nurses are based some of the time in Totara Health. This allows for timely intervention and support for clients both exiting and entering secondary care.
• Progress in identifying the needs of clients together with better understanding the interplay of the different domains has been made. At this point four key components are being integrated in order to deliver the clinical care required
  o GP assessment processes
  o Coordination/guidance processes
  o Primary/Secondary stepped care pathways
  o Community Resources
• The integration of each of these components in a trial is expected to be implemented in August/September 2014
• The project continues to address the complexities of mental health and drug and alcohol care and develop a safe and functional pathway for consumers.

Risks/Issues
As this is a pilot project, the model developed from this will need to be replicated in other sites. In order for the model to be sustainable and replicable, the project steering group will need to ensure the model and pathway is well documented and understood by all participating groups.

Tamaki Locality Project (Auckland DHB)
As part of the primary care localities approach to health service development and delivery, extensive consultation has been undertaken with the Tamaki community and the health professionals working within this community over the past two years. This engagement activity culminated with a series of workshops that were held in November 2013 and April 2014. In the interim period between the first workshop in November and the second workshop in April over 100 meetings were held with a variety of stakeholders concerned with the mental health of the Tamaki community. This consultation process delivered five questions that represented the identified needs of the stakeholders consulted. The five questions were:
  • What is stressing me out?
  • How can I learn to care for myself and others?
  • How can people living here help and support each other?
  • How can services work better together for me?
  • How can we support GPs better?

More than 100 community members and health professionals joined the April workshops, which were focused on creating solutions to meet the identified needs in the above questions. These gatherings produced over 750 ideas that were channelled into 32 proposed projects as part of the workshop process. Subsequently these 32 projects were grouped into three high level work streams.

These three work-streams are:

1. **Building mental health capability in primary care**
   Five proposed projects to provide greater support for General Practice.

2. **Effective navigation between primary care and the community through care navigators and peer support**
   Five proposed projects to provide a care navigation/peer support service that would act to support linkage between primary care and the community.
3. A physical, virtual and mobile community wellness hub

Eleven proposed projects, or one-third of all of the projects that were proposed, directly concerned the development of a community hub of one description or another that would support overall community wellness and access to health and social services.

Although the above set of ‘hub’ projects represent over one-third of the projects proposed through the workshop process, the content and scope of the above projects extend beyond the remit of what health is required to deliver. However the above mandate from the community represents an opportunity for health to lead an inter-sectorial project that can deliver a high value response to the needs identified by the Tamaki community and potentially a transformative approach to how communities engage with their health and well-being.

Throughout the consultation process, leaders from Auckland Council, WINZ, Housing New Zealand, Department of Internal Affairs (DIA) and the Tamaki Redevelopment Company, as well as the local MP have been consulted on the possibility of a hub idea being one of the eventual outputs from the engagement process. Very strong indications have been received that there is a real appetite existing within these organisations to support such an inter-sectorial initiative. Auckland Council has indicated that they can provide physical infrastructure as well as expertise and other resource for the initiative. Community hubs are an integral part of their Unitary Plan development and they have been awaiting an opportunity to engage with such an initiative. Tamaki Redevelopment Company has earmarked $100K in their 2014/15 budget to put towards a hub initiative. Senior planning and funding individuals from DIA are also keen to support this project.

It is anticipated that Health will bear the least significant burden of cost associated with the development of this project, with other parties contributing the capital expenditure and major resource application to the development, implementation and sustainability of the project. It does however offer Health the opportunity to lead a whole of government approach to addressing the social determinants of health.

Progress to Date

Using the three work-streams emerging from the consultation process, a dedicated project working group has been set up to define the model/s and to scope a programme of work, develop an implementation plan and deliver on an agreed series of projects that integrate across the three streams. This working group is made up of a diverse range of expertise from Auckland DHB Mental Health Services, Mental Health Planning and Funding, Mental Health NGO’s, Community leaders, PHO’s, Nursing, Consumers and Population Health.

The Ministry of Health has ear-marked implementation support group funding for this initiative that is available to be applied for within the 2014/15 year. A business case that articulates clearly what the funds are intended to be used for in developing primary care within localities needs to be developed to apply for this funding. It is intended that the application for this funding will proceed once the working group has had the opportunity to develop the model for service improvement.

Risks/Issues

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

2.6.1 Contracting
The focus of the Pacific Team in the May/June period has been contracting. A major piece of work in terms of contracting was reconfiguring a number of separate contracts into one integrated contract with Alliance Health Plus (AH+), who will then sub-contract with its Pacific providers. The new contract attempts to reflect a whanau/family approach where a package of care will be delivered to family/household members based on and tailored to the needs of the family/household and not just to an individual. The service will attempt to address both immediate health needs of family members as well as changes to household lifestyle. The process of contact review included consultation with service users facilitated by AH+.

The pricing of previous contracts was based on FTE costs. The pricing for the new contract is based on the cost of a package of care, number of families that will receive the package and the achievement of a minimum of two health outcomes per family identified as most needed and beneficial for that family.

Although we reached agreement with AH+ as to the cost of the packages of care and the number of families that they will deliver to, we will collaboratively learn whether the assumptions that we have based our pricing on are correct or not in the current year of service delivery and if they are not we will adjust the service specifications accordingly.

2.6.2 Service Development – Parish Nursing
As part of developing the parish nursing service in Waitemata, we are undertaking consultation with stakeholders. We have consulted with:
- Current ADHB parish nurses
- Enua Ola church health committee members from West Auckland
- Primary Care Associate Director of Nursing
- ADHB/WDHB Pacific Workforce Development Consultant.

We are consulting this week (mid-July) with:
- North Shore Enua Ola church health committees
- Pacific Integrated Healthcare.

At the end of the consultation, we will develop service specifications.

The intention is to contract with West Fono Health Trust to provide the parish nursing service in West Auckland and with Pacific Integrated Healthcare for North Shore and for the contract to be effective from 1 August 2014.

2.7 Women, Children and Youth Services

2.7.1 Immunisation Performance against the National Health Target
Performance against the national health target for immunisation is being exceeded by both Auckland and Waitemata DHBs. The target is 90% of eight months olds will have their primary course of immunisation on time by July 2014. The provisional quarter four results were:
- Auckland DHB 93% Total; Māori 84%; Pacific 96%
- Waitemata DHB 91% Total; Māori 87%; Pacific 94%
Compared to the previous quarter Waitemata DHB results decreased by 2% Total, 2% Māori and 1% Pacific. Auckland DHB results decreased by 5% for Māori, increased by 4% for Pacific and there was no change for the total population. Practice merges and introduction of the influenza vaccine on the National Immunisation Register may account for some delay in timeliness of immunisations.

**Current activity**

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

- Working with PHOs to provide targeted support to a merged Auckland practice with low coverage rates and high Māori population to encourage newborn enrolment, precalls and recalls and identify infants overdue for immunisation.
- Adding influenza vaccine on the National Immunisation Register for adults.
- Working with Auckland Regional Public Health and Counties Manukau DHB on a Regional Focused Control Response to the measles outbreak.
- Introduced the Immunisation Schedule change which includes the addition of the rotavirus vaccine from 1 July 2014.

**Other planned activity includes:**

- Working with primary care partners and the Māori health team to develop a multi-provider case review group to identify opportunities for collaboration and service improvements for Māori infants in West Auckland.
- Extending opportunistic immunisations through the in-patient services of both Starship and Waitakere paediatric hospitals.
- Developing early indicators of change in practice performance to support systematic early interventions.
- Maternity / PHO enrolment data-match audit proposal underway, outcomes will inform strategies to increase new born enrolments with primary healthcare.

### 2.7.2 Measles

The last confirmed Measles case in Auckland was the week of 1 June 2014. There is continued surveillance for measles, and ongoing efforts by local public health services, hospitals and primary health care practices in tracing cases and contacts. The DHBs are promoting resources to remind health professionals, patients and travellers of the importance of being immunised before overseas travel and to be alert for measles symptoms, especially on return from overseas.

### 2.7.3 B4 School Check

The B4 School Check target of 90% was achieved in Waitemata with a final coverage of 92% overall and 92% high needs. The Auckland B4 School Check programme achieved a final coverage of 80% overall and 76% high needs.

The PHO Alliance agreement to deliver the B4 School Check Programme in Auckland DHB ended on 30 June 2014 and Plunket began delivering the B4 School Check Auckland programme on 1 July 2014. The two providers have worked closely together to ensure a seamless transition. Plunket have also worked with the vision and hearing team to set up referral process to ensure children receive both components of the B4 School Check.
The coverage for Māori and Pacific children in both DHBs is lower than Other:

- Waitemata coverage is: 85% Māori, 81% Pacific and 95% Other
- Auckland coverage is: 65% Māori, 63% Pacific and 87% Other.

Achieving equity will be a focus of the programme for 2014/15. Activity to improve Māori and Pacific coverage will include joint home visits for the nurse and hearing and vision technician and exploring opportunities to provide the B4 School Check in Kohunga Reo and Pacific Language Nests.

2.8 Obesity

Auckland Regional Public Health Service has commenced the development of a coordinated, strategic and innovative region-wide approach to address obesity. A comprehensive paper on progress will be brought to the September CPHAC meeting, in the interim this briefing provides an overview of the work plan and progress made.

Initially this project has focused on strengthening existing programmes and is now moving towards building closer working relationships and collaboration with the range of potential partners involved. Progress achieved on respective priorities to date:

- Internal steering group established and regular meetings scheduled. Interagency planning group identified. Initial meeting scheduled for 29 July. Planning underway for a dedicated workshop with Auckland Council staff. Health Outcomes Grand Round established and inaugural presentation on addressing obesity in Auckland given by Prof Boyd Swinburn.
- On track to establish organisational nutrition environments policies in all DHBs by 31 December 2014.
- Promotion of healthy eating and physical activity to prioritised populations in workplaces and early childhood education settings has been prioritised. MoH milestones achieved for 2013-14 annual plan:
  - 105 workplaces engaged with HBC. (Heart Beat Challenge - Workplace Health )
  - 18 workplaces have achieved or renewed their award 2013/2014.
- Regional intersectoral health promotion network group established May 2014 for health promotion service providers in Early Childhood Education.
- Collaboration opportunities to be discussed at interagency meeting and in ongoing liaison with Auckland Council. Establishing links with Healthy Families NZ and other local initiatives.
- Strategies to improve healthy eating and physical activity have been promoted through policy submissions with five policy submissions in the last nine months giving significant focus to these issues. Innovative approaches to be discussed at upcoming interagency and Auckland Council meetings.

2.9 Unitary Plan Submission

Auckland Council has provided a third consultation opportunity on the Proposed Auckland Unitary Plan. The third round of submissions was only open to:

- Those who have previously submitted on the plan
- A person representing a relevant aspect of the public interest
• A person that has an interest in the Proposed Auckland Unitary Plan that is greater than the interest of the general public.

The submission enabled ARPHS to give targeted and strategic emphasis to the most important policy recommendations and greatly increase the overall potential for policy impact of the original submission. The submission consisted of:

• Briefly restating the importance of our original recommendations
• Highlighting the key recommendations of highest strategic importance
• Potentially noting other submissions on the Unitary plan from other stakeholders that it also supports (if time permits)

The full submission is attached to this report (Attachment 2).
District health boards: Availability and accessibility of after-hours services

Progress in responding to the Auditor-General’s recommendations

Published under section 21 of the Public Audit Act 2001.

June 2014
Summary

1.1 In 2010, we published a report about a performance audit looking at whether district health boards (DHBs) were effectively meeting government expectations about the availability and accessibility of after-hours services.

1.2 The 2010/11 Service Coverage Schedule requires DHBs to ensure that after-hours services are available within 60 minutes’ travel time for 95% of the population they service.

1.3 In 2010, we found that after-hours services were available within 60 minutes’ drive for 99.7% of people. In general, people living in remote rural areas did not have these services available within 60 minutes’ drive. Although DHBs had good service coverage, most had not clearly identified or addressed transport and affordability barriers to accessing after-hours services.

1.4 In 2013, we wrote to the Ministry of Health (the Ministry) and DHBs to find out how they had responded to our 2010 recommendations.

1.5 After-hours services remain available within 60 minutes’ travel time for at least 95% of the population.

1.6 Our follow-up review showed that many DHBs have identified and/or addressed barriers and improved access. The introduction of free after-hours services nationally for children under six has also helped to improve access for these children. However, access problems (such as cost) remain for Māori, Pasifika, rural communities, and people living in the most deprived areas. There is still after-hours pressure on hospital emergency departments.

1.7 We encourage DHBs to continue to look for ways to make access to after-hours services easier and to improve the sustainability of those services. We recognise that DHBs need to work with primary health organisations and other after-hours service providers. There are some successful collaborations. We encourage DHBs and primary health organisations to consider these and other approaches that work well.

1 District Health Boards: Availability and accessibility of after-hours services.

2 In our 2010 report, we defined after-hours services as being:
   - services for urgent or acute needs, and services that one might expect to receive from a general practitioner (or from a nurse who has appropriate medical back-up available);
   - services available at times when a patient might expect reduced access to their general practitioner, such as when local businesses are closed, and
   - those services contained in DHBs’ after-hours plans.
Scope and recommendations of our 2010 audit

1.8 Our 2010 performance audit looked at how DHBs planned after-hours services. We looked at whether DHBs had planned to ensure that an after-hours service was available within 60 minutes’ drive of at least 95% of their district’s population during a typical week. We also looked at the extent to which DHBs had identified any potential barriers, such as transport and affordability of after-hours services.

1.9 We recommended that DHBs:

• better identify, consider, and respond to affordability barriers when planning, funding, and providing after-hours services;
• where it is within their influence, better identify, consider, and respond to access barriers other than affordability – such as transport barriers; and
• comprehensively review and, where necessary, redesign their after-hours service networks to ensure that those networks will be more sustainable in the future (for those DHBs not already doing so).

Improvements since 2010

1.10 The Ministry and all the DHBs responded to our 2013 request for information about the progress they had made. Figure 1 summarises new initiatives and progress that the DHBs reported to us.
## Figure 1
District health boards’ new initiatives and progress since 2010

<table>
<thead>
<tr>
<th>District health boards</th>
<th>Affordability</th>
<th>Access</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Implemented free after-hours services for children under 6</td>
<td>Identified, considered, and/or responded to other affordability barriers</td>
<td>Identified and/or addressed other access barriers</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Canterbury</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>Auckland metro (Counties Manukau, Waitemata, and Auckland)</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>MidCentral</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Nelson-Marlborough</td>
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<td>Northland</td>
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<tr>
<td>Southern</td>
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<td>South Canterbury</td>
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<td>Tarāwhiti</td>
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<td>Waikato</td>
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<tr>
<td>West Coast</td>
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<td>Whanganui</td>
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<td>Capital and Coast</td>
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<td>Wairarapa</td>
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<td>Hutt Valley</td>
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<td>Lakes</td>
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<tr>
<td>Taranaki</td>
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</table>
Addressing affordability barriers

1.11 In 2012, free after-hours services for children under six were introduced nationally. Thirteen DHBs have also eliminated consultation fees for children under six during regular hours.\(^3\) Canterbury DHB and the Auckland Regional After-Hours Network told us that they plan to do the same. More than 95% of children under six now have access to free after-hours services. There are indications that the services are being used more.

1.12 However, apart from this initiative, progress with identifying and addressing barriers to access after-hours services has been limited.

1.13 The New Zealand Health Survey Annual Update of Key Findings 2012/13 reported that 7% of adults did not visit an after-hours medical centre because of cost.\(^4\) The cost barrier particularly affects people in rural and deprived areas. However, only three DHBs reported collecting information to help identify affordability barriers. This matters because people who delay getting treatment are more likely to have poorer health outcomes. If complications arise because of delayed treatment, the costs are likely to be higher. Other economic effects include loss of earnings and payment of health-related social benefits.

Addressing other access barriers

1.14 Hospital emergency departments continue to bear some burden from after-hours services. In 2011, a survey of 11 countries found that 40% of “sicker” New Zealand adults reported finding it difficult to get after-hours care without going to an emergency department.\(^5\) This is a smaller proportion than in Australia or Canada. However, in the United Kingdom, 21% of respondents reported similar difficulties. This suggests that DHBs can improve access to after-hours care.

1.15 Our survey of DHBs shows that they have focused largely on diverting people from inappropriately accessing emergency services.

1.16 The Primary Response in Medical Emergencies (PRIME) service provides a quick response to people who are seriously ill or injured in rural areas. The PRIME service uses specifically trained rural general practitioners and/or rural nurses to support the ambulance service.

1.17 Since 2010, DHBs have been using nurse-led telephone advice more. All DHBs that responded to our request for information use telephone advice as part of their

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\(^3\) Regular hours are defined as between 8am and 5.30pm.

\(^4\) This is for the period from 1 July 2011 to 30 June 2012.

\(^5\) The Commonwealth Fund (2011), 2011 Commonwealth Fund International Health Policy Survey, available at www.commonwealthfund.org. Sicker adults are those aged 18 and older who rated their health as fair or poor, who reported receiving medical care for serious chronic illness, injury, or disability in the past year, or who had had surgery or had been hospitalised in the past two years.
after-hours service. From April to June 2013, 65.3% of calls to Healthline were outside regular hours. Private telephone advice services are also being used more.

1.18 The Ministry is developing a national “telehealth” service. Streamlining the approach to telehealth would mean that advice could be provided more consistently and reduce confusion about which number to call. Telephone advice can reduce the number of face-to-face consultations when it is safe to do so, easing after-hours workloads. However, it is not suitable for patients who need to see a general practitioner or a nurse.

1.19 Seven DHBs have proposed or taken other steps to address transport problems. These steps include home visits, redirecting patients to accident and medical centres or primary care providers, and extended health shuttle services. Whanganui DHB told us that its patients can use after-hours services in MidCentral DHB (Palmerston North) if the services are closer to them.

1.20 Our original audit highlighted the need for DHBs to consider the availability of pharmacy services during after-hours periods. In their responses to our follow-up, only two DHBs identified, or said they have plans to address, barriers to access after-hours pharmacy services. Although our audit did not cover the availability of diagnostic services, two DHBs are working to improve access to after-hours diagnostic services.

Improving the sustainability of after-hours services

1.21 Since 2010, several after-hours initiatives have begun to improve the sustainability of after-hours services through the use of networks. In 2011, the Auckland metro DHBs set up the Auckland Regional After-Hours Network. This is a network of DHBs, primary health organisations, and accident and medical clinics that aims to address the need for co-ordinated after-hours care in Auckland.

1.22 The Southern After-Hours Initiative is a collaboration between Southern Primary Health Organisation, Southern DHB, and general practices. Midlands Health Network’s Patient Access Centre triages patients over the phone by taking calls diverted from general practitioners in parts of Waikato.

1.23 In Waimakariri, after-hours services were reconfigured to provide an integrated response. The response includes extended general practice hours, nurse-led telephone triage, the hospital’s emergency department, the local paramedic service, the St John Ambulance Service, taxis, and a 24-hour surgery (see Figure 2).

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6 The Auckland metro DHBs are Auckland DHB, Waitemata DHB, and Counties Manukau DHB.
1.24 Some DHBs plan to address the sustainability of after-hours services — for example, by integrating family health centres or reviewing workforce problems. The After Hours Primary Health Care Working Party identified staff availability as one of the biggest problems affecting the sustainability of an after-hours service.

1.25 Increasingly, after-hours services are being consolidated. Various arrangements have emerged, from co-locating with hospital emergency departments to merging
several after-hours providers. These arrangements allow resources to be shared between primary and secondary care, and between after-hours service providers. Consolidating after-hours services can help reduce the workloads for staff on call for extended periods. This is particularly true in rural areas.

1.26 DHBs continue to share roster arrangements. For example, in Nelson, a network of practices share rosters to provide after-hours services from a dedicated facility. However, some general practitioners work alone. Relying on a single general practitioner to provide after-hours services is risky and unsustainable in the long term.

1.27 We saw limited progress in addressing challenges to workforce and financial sustainability. DHBs are still working to identify better after-hours workforce models. After-hours fees are inconsistent, and there can be a perverse incentive to go to the emergency department of a hospital because it is free.
22 July 2014

Submission on feedback to proposed Unitary plan.

1. Thank you for the opportunity for the Auckland Regional Public Health Service (ARPHS) to provide a submission on the feedback to the proposed Unitary plan.

2. The following submission represents the views of the Auckland Regional Public Health Service and does not necessarily reflect the views of the three District Health Boards it serves, though we have consulted with them through the Auckland Inter-sectoral Health Group (AIHG). Please refer to Appendix 1 for more information on ARPHS.

3. ARPHS understands that all submissions will be available under the Local Government Official Information and Meetings Act 1987, except if grounds set out under the Act apply.

The primary contact point for this submission is:

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jane.dudley@adhb.govt.nz

Yours sincerely,

Sunil Kushor
Acting Service Manager
Auckland Regional Public Health Service

Dr. Richard Hoskins
Medical Officer of Health
Auckland Regional Public Health Service
Introduction

1. Thank you for the opportunity to submit on the feedback document on the Unitary plan.

2. We reiterate the strong importance of all of our recommendations for health contained in our earlier Unitary plan submissions.

3. In particular we wish to highlight the importance of our recommendations on the Unitary plan in the following areas as outlined below.

Specific ninth strategic objective for Health within the Regional Policy statement

4. We request that a health objective be added as a specific goal in the Regional Policy Statement. ARPHS proposes that a ninth objective be added within the Regional Policy Statement (RPS) and that it focus on ‘Enabling improved health, wellbeing and safety for all Aucklanders’.

5. This should include:
   - Both communicable and non-communicable diseases
   - Social determinants of health
   - Environmental health
   - Health inequalities
   - Particular focus on Māori health.

6. ARPHS recommendations on this issue:

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<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Text associated with recommendations</th>
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<tbody>
<tr>
<td>6100-4</td>
<td>Add a ninth objective to RPS to read ‘Enabling improved health, wellbeing and safety for all Aucklanders’.</td>
</tr>
<tr>
<td>6100-2</td>
<td>Advance the health related strategic aims of the Auckland Plan through the PAUP including (i) Māori health; (ii) Child injury; (iii) Southern initiative targets - Health and Safety, Housing; (iv) Physical activity; (v) Environmental goals; (vi) Greenhouse emissions and human induced climate change; (vii) Increased provision of housing; (viii) Housing affordability; (ix) Water network; (x) Transport; (xi) Urban design and transport. Refer to Appendix 7 of the submission for details [pg. 125-128/134].</td>
</tr>
<tr>
<td>6100-3</td>
<td>Add a specific section on ‘Health and Wellbeing’ within the overall objectives. Include reference to: (i) fundamental human ‘right to health’, as well as a standard of living that ensures the social determinants of health as expressed in the United Nations Declaration of Human Rights (UNDHR); (ii) standard of living that ensures the social determinants of health are encompassed within equal rights expressed within Tiriti o Waitangi; (iii) improve poverty, minority stress and other social determinants of health; (iv) an overview of communicable diseases (such as those relating to poverty and climate change); (v) an overview of non-communicable diseases (such as those relating to urban design, tobacco and alcohol use); (vi) an overview of Environmental disease - including housing, recreational water access, hazardous substances; (vii) a specific section on Māori health (viii) holistic frameworks as used by Mana Whenua be integrated into health impact assessments. Refer to page 25-26, 29/134 of the submission for details.</td>
</tr>
</tbody>
</table>
Māori health frameworks and Mana Whenua consultation

7. ARPHS recommends the prioritisation of Mana Whenua consultation and Māori health frameworks through:
   - Extensive use of holistic Māori health frameworks (Te Whare Tapa Whā and Te Pae Māhutonga).
   - Ensuring extensive Mana Whenua engagement in order to ensure the best possible health outcomes.

8. ARPHS recommendations on this issue:

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<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Text associated with recommendations</th>
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<tbody>
<tr>
<td>6100-14</td>
<td>Retain section B5.2.</td>
</tr>
<tr>
<td>6100-15</td>
<td>Add reference to the Te Whare Tapa Whā and Te Pae Māhutonga frameworks and provide encouragement to using these models in decision making.</td>
</tr>
<tr>
<td>6100-13</td>
<td>Ensure Māori terminology is used consistently throughout the PAUP, to clarify the plan is referring to Mana Whenua's role, rather than the interests of taurahere Māori or Mataawaka.</td>
</tr>
</tbody>
</table>

Overall aim of phased reduction in vehicle dependency

9. ARPHS advocates that an overall objective of a phased approach to actively reduce vehicle dependency in the Auckland region should be included within the plan.

10. The objective of a phased reduction of vehicle dependency should be added to all relevant objectives, policies and regulatory methods within the proposed Unitary plan.

11. We recommend that this objective also include:
   - Prioritising active transport (walking and cycling) over private passenger transport on roads.
   - Greatly improving infrastructure options for active transport and transport, including:
     - Phased reduction of MPRs and other private vehicle oriented infrastructure.
     - Prioritizing zoning and urban planning that facilitates active and public transport usage.
     - Increased cycle lanes and networks (especially off-road cycle lanes, and near schools).
     - Improving cycle parking and facilities.
     - Increasing walking access and safety provisions for pedestrians.

12. ARPHS recommendations on this issue:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Text associated with recommendations</th>
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<tbody>
<tr>
<td>6100-18</td>
<td>Add 'A phased approach to reducing vehicle dependency' to the objectives, policies and regulatory methods in the RPS.</td>
</tr>
<tr>
<td>6100-36</td>
<td>Prioritise cycling and walking, rather than private passenger transport on roads.</td>
</tr>
<tr>
<td>6100-22</td>
<td>Add 'A phased approach to reducing vehicle dependency' to the objectives,</td>
</tr>
<tr>
<td>6100-17</td>
<td>Provide a rationale for car parking requirements that balances the environmental impacts, impacts on human health and the positive impacts of car usage with its policies relating to car usage.</td>
</tr>
<tr>
<td>6100-16</td>
<td>Retain increased emphasis on increasing public transport and walking and cycling.</td>
</tr>
<tr>
<td>6100-26</td>
<td>Transport Retain the RPS aims around encouraging pedestrian movement.</td>
</tr>
<tr>
<td>6100-27</td>
<td>Reconsider how pedestrians may more easily and safely cross busy highways and access facilities such as schools, junctions and crossing points for pedestrian on matters of safety, convenience and the needs of the mobility impaired e.g. kerb ramping.</td>
</tr>
<tr>
<td>6100-29</td>
<td>Increase the provision for bicycle parking [3.2,Table 5] and reduce provision for car parking [3.2,Table 3] in workplaces and other facilities as a means of promoting active transportation.</td>
</tr>
<tr>
<td>6100-30</td>
<td>Increase the provision of 'end of trip' facilities [3.2(3)] such as showering spaces, to encourage the use of active transport options.</td>
</tr>
<tr>
<td>6100-31</td>
<td>Amend the unisex shower provision [3.2(3),Table 6] to provide separate showering facilities.</td>
</tr>
<tr>
<td>6100-32</td>
<td>Delete the use of 'minimum parking requirements' for car parking (with the exception of disabled and emergency parking etc.).</td>
</tr>
<tr>
<td>6100-37</td>
<td>Separate cycle traffic from vehicle transportation paths to protect cyclists from injury and to encourage cycling.</td>
</tr>
<tr>
<td>6100-39</td>
<td>Incorporate provisions to provide a greater portion of dedicated off road cycle ways.</td>
</tr>
<tr>
<td>6100-38</td>
<td>Provide dedicated off road cycle ways for only bicycles as forms of access to schools.</td>
</tr>
</tbody>
</table>

**Improving housing quality in the Auckland region**

13. ARPHS strongly supports improvements to housing quality for all new housing in the Auckland Region.

14. We strongly recommend improved and mandatory quality standards improvement to the quality of all new housing in the Auckland region.

15. This includes:
   - Mandatory quality standards for all new housing developments of all sizes, housing extensions and alterations.
   - Mandatory insulation needs to ensure minimum air temperatures that are within the World Health Organization guidelines (indoor air temperature of a minimum of 18°C for adults and 21°C for housing for children, elderly and immune compromised).
   - Auditing and compliance standards for the proposed green building standards for insulation are needed to avoid any potential new leaky buildings and related health issues.
   - Mandatory use of quality guidelines for housing that promote health in wide variety of areas. These include:
     - Housing design and quality that minimises the potential for heat related illnesses.
     - Avoids hazardous building materials.
     - Separating household waste water
     - Ensuring culturally appropriate housing.
### 16. ARPHS recommendations on this issue:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Text associated with recommendations</th>
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<tbody>
<tr>
<td>6100-66</td>
<td>Retain the aims to improve housing quality and affordability, especially for the vulnerable, high deprivation and Southern Initiative Areas and Māori and Pacific people.</td>
</tr>
<tr>
<td>6100-67</td>
<td>Include provision for culturally appropriate housing for Māori and Pacific people in residential developments.</td>
</tr>
<tr>
<td>6100-68</td>
<td>Retain the use of mandatory Homestar guidelines and other design and quality requirements that influence human health.</td>
</tr>
<tr>
<td>6100-69</td>
<td>Ensure a minimum air temperature of 18 degrees for adults and 21 degrees Celsius for children, the immune-compromised and the elderly for the implementation of the Homestar insulation requirements.</td>
</tr>
<tr>
<td>6100-70</td>
<td>Ensure the implementation of Homestar insulation requirements follow compliance standards and be independently audited to avoid leaks and to ensure healthy housing requirements.</td>
</tr>
<tr>
<td>6100-71</td>
<td>Require the mandatory Homestar guidelines be used for all new housing.</td>
</tr>
<tr>
<td>6100-72</td>
<td>Ensure all that new buildings be subject to design in all areas that influence health, wellness and safety, in order to ensure good design standards.</td>
</tr>
<tr>
<td>6100-73</td>
<td>Retain the definition of 'Retained affordable housing'.</td>
</tr>
<tr>
<td>6100-74</td>
<td>Amend the definition of 'Retained affordable housing' by resetting the median income threshold level relevant to all ethnic groups (for the ethnic group with the lowest median income threshold), in order to provide equitable access to retained affordable housing.</td>
</tr>
<tr>
<td>6100-75</td>
<td>Extend the provision of retained affordable housing by reducing the requirement for affordable housing to be provided for only 15 or more dwellings (i.e applies to developments with less than 15 dwellings or vacant sites) [Rule1.1(1)]</td>
</tr>
<tr>
<td>6100-79</td>
<td>Add mandatory design guidelines for housing and other design related aspects of the Auckland Design Manual that affects health and safety outcomes.</td>
</tr>
</tbody>
</table>

### Green space and open space

17. ARPHS strongly supports the inclusion of more green and open space and overall increased access to recreational areas, particularly in higher density housing areas.

18. ARPHS recommends both retention and enhancement of open and green spaces. This needs to incorporate the following features:
   - Free facilities, especially in Southern initiative areas.
   - Increased space where there are increased population projections.
   - Culturally appropriate / gender considerations - recreational access.
   - Recreational access for all elderly and disabled people.
   - Converting current car parking areas into green and open space.
19. ARPHS recommendations on this issue:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Text associated with recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>6100 - 116</td>
<td>Ensure the development of 'green space' be allocated a more central position in spatial planning policy.</td>
</tr>
<tr>
<td>6100 - 117</td>
<td>Retain and enhance vegetation cover in open spaces.</td>
</tr>
<tr>
<td>6100 - 118</td>
<td>Ensure adequate access to open space and in particular green open space for Mixed Housing and Terrace Housing and Apartment Building zones.</td>
</tr>
<tr>
<td>6100 - 119</td>
<td>Ensure accessible open space to the elderly and disabled.</td>
</tr>
<tr>
<td>6100 - 120</td>
<td>Provide a mixture of private and communal/public open space to meet the different needs of the community.</td>
</tr>
<tr>
<td>6100 - 121</td>
<td>Acknowledge and remediate any health risks associated with intensification within the PAUP. Refer to page 80/134 of the submission for details.</td>
</tr>
<tr>
<td>6100 - 122</td>
<td>Retain the requirement for assessing the quantity, quality and location of public open space.</td>
</tr>
<tr>
<td>6100 - 123</td>
<td>Provide a clear method for identifying indicative public open space that includes all relevant public health concerns such as: (i) a range of open space types; (ii) equitable access for all people, both genders, ethnicities and be free; (iii) vulnerable status of open space (natural hazards, air quality, traffic and industry); (iv) role of open space as evacuation sites; (v) open space on contaminated land should be managed and remediated to safe levels.</td>
</tr>
<tr>
<td>6100 - 124</td>
<td>Include a formula to calculate open space requirements over time.</td>
</tr>
<tr>
<td>6100 - 125</td>
<td>Require a management plan (meeting the Ministry for the Environment Contaminated Land Guideline no.1 reporting requirements) for all new public open space on contaminated land.</td>
</tr>
<tr>
<td>6100 - 126</td>
<td>Clarify the expectations for vesting public open space.</td>
</tr>
<tr>
<td>6100 - 127</td>
<td>Provide opportunities to convert some areas previously used for car parking to green space and open space areas, as part of an overall policy of a phased recuition in car parking.</td>
</tr>
<tr>
<td>6100 - 128</td>
<td>Provide measures that promote equal access to open recreational space for both men and women.</td>
</tr>
<tr>
<td>6100 - 129</td>
<td>Adopt the use of safety considerations (crime prevention through environmental design - CPTED) within recreational areas, and extend to areas such as the Southern Initiative area.</td>
</tr>
<tr>
<td>6100 - 130</td>
<td>Ensure equitable access to recreational areas for all people (gender, culture, age, disability status) through urban design features and that these considerations be required as part of the assessment of future open space and recreational areas under the PAUP.</td>
</tr>
</tbody>
</table>

**Climate change - mitigation**

20. ARPHS strongly supports the prioritisation of climate change mitigation in the Unitary plan. We support the prioritisation of climate change mitigation in the Auckland plan we and recommend that all parts of the Proposed Unitary plan support this aim.

21. ARPHS particularly requests alterations to the proposed Unitary plan including:
- Phased reduction of vehicle dependency and a strong prioritisation of active and public transportation.
- Reducing methane emissions from waste.
- Reducing emissions related to agricultural land use (e.g. nitrogen / excessive use of agricultural fertiliser).
- Localised food production.
- Incentives for sustainable buildings.
- Incentives for renewable energy activities.

22. ARPHS recommendations on this issue:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Text associated with recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>6100-167</td>
<td>Ensure the PAUP provisions are consistent with the climate change mitigation measures identified in the Auckland Plan.</td>
</tr>
<tr>
<td>6100-168</td>
<td>Add strong policies around the main activities associated with greenhouse gas emissions (including synthetic green house gas emissions) in order to reduce the emissions profile in the Auckland region.</td>
</tr>
<tr>
<td>6100-21</td>
<td>RPS - Climate change. Add 'A phased approach to reducing vehicle dependency' to the objectives, policies and regulatory methods in the RPS.</td>
</tr>
<tr>
<td>6100 - 169</td>
<td>Encourage the use of active transport (walking and cycling) as well as public transport.</td>
</tr>
<tr>
<td>6100 - 170</td>
<td>Reduce overall car dependence through policies on the management of parking provisions and increasing zoning for mixed use and smart growth strategies for better urban design.</td>
</tr>
<tr>
<td>6100 - 172</td>
<td>Reduce methane emissions through effective disposal of green waste (e.g. through organic waste disposal and 'zero waste' options).</td>
</tr>
<tr>
<td>6100 - 171</td>
<td>Reduce agricultural emissions (e.g. by aiming to reduce nitrogen related emissions through changes in agricultural land use activities).</td>
</tr>
<tr>
<td>6100 - 173</td>
<td>Localise food production (e.g. through community gardens and fruit tree plantings).</td>
</tr>
<tr>
<td>6100 - 175</td>
<td>Incentivise renewable energy production (e.g. incentives for solar panels on housing).</td>
</tr>
<tr>
<td>6100 - 176</td>
<td>Provide strong requirements and incentives for more efficient and sustainable building standards.</td>
</tr>
<tr>
<td>6100 - 177</td>
<td>Add specific projected climate health related effects. Refer to Appendix 4 to the submission for details on page 115-117/134.</td>
</tr>
</tbody>
</table>

Health Impact Assessment (HIA) in all Council activities

23. ARPHS suggests that Auckland Council utilise health impact assessment tools (HIA) as a means of assessing impacts to health of all activities within the plan. We recommend that these also include holistic health frameworks such as Te Pae Māhutonga.

24. ARPHS recommendations on this issue:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Text associated with recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>6100-8</td>
<td>Develop a Health Impact Assessment (HIA) tool in close collaboration with Auckland Regional Public Health Service (ARPHS) to assess impacts to health of activities within the PAUP.</td>
</tr>
<tr>
<td>6100-15</td>
<td>Add reference to the Te Whare Tapa Whā and Te Pae Māhutonga frameworks and provide encouragement to using these models in decision making.</td>
</tr>
</tbody>
</table>
Formalised system of intersectoral engagement

25. Health and Council intersectoral planning ARPHS recommends a system of formalised engagement between Council, CCOs and the health sector.

26. We suggest that this involve including ARPHS and a Medical Officer of Health on Council decision making in areas that affect public health outcomes in order to ensure expert guidance on public health related decision making.

27. We further recommend that Council collaborates with ARPHS to further the health related targets/objectives in the Auckland plan and to ensure that these are achieved through the rules and objectives of the Unitary plan.

28. We see particular opportunities to improve the broader health issues related to land use planning such as car usage and obesity.

29. ARPHS recommendations on this issue:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
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</tr>
</thead>
<tbody>
<tr>
<td>6100-5</td>
<td>Introduce a system of formalised engagement with the health sector, including Auckland Regional Public Health Service (ARPHS) and the Ministry of Health on issues of discretion in areas that affect public health outcomes and to ensure expert guidence on public health related decision making.</td>
</tr>
<tr>
<td>6100-1</td>
<td>Add new issue - Provide greater consideration of the wider health issues encompassed in land use planning (e.g. car usage and obesity), which are in line with the health related impacts expressed in the principles of the RMA included in Council policy decision making.</td>
</tr>
</tbody>
</table>

Restrictions on fast food outlets (FFO’s)

30. ARPHS recommends restrictions on fast food outlets through zoning restrictions throughout the plan. We suggest that zoning restrictions on fast food outlets be instated with priority in high deprivation and Southern Initiative areas.

31. This should include:
   - Limiting FFO proximity to schools
   - Limiting density of FFOs
   - Limiting hours of operation.

32. ARPHS recommendations on this issue:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
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</thead>
<tbody>
<tr>
<td>6100-49</td>
<td>Restrict fast food outlets close to schools, parks and low socio-economic areas by (i) setting minimum distances between schools and fast food outlets; (ii) limiting density of fast food outlets in any neighbourhood or restrict their proximity to one another; (iii) applying restrictions to location / hours of operation; with prioritising the above in high deprivation and</td>
</tr>
</tbody>
</table>
restrictions on alcohol retailing premises

33. ARPHS recommends that all measures be taken to ensure that the Unitary plan supports the local alcohol policy (LAP) in all areas.

34. This includes:
   - Ensuring the ability for communities to lodge applications regarding alcohol licenses in all areas.
   - Minimising alcohol related harms by restricting on and off licence alcohol retailing premises, especially near residential areas and sensitive areas.
   - Restricting the density of alcohol retailing premises.

35. ARPHS recommendations on this issue:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
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</tr>
</thead>
<tbody>
<tr>
<td>6100-58</td>
<td>Retain provisions within the PAUP that reduce alcohol related harms in the community.</td>
</tr>
<tr>
<td>6100-59</td>
<td>Remove any referral to 'no-complaint covenants' within the PAUP that limits an individual's ability to lodge submissions to liquor licence applications or renewals to matters subject to the Sale and supply of Alcohol Act (e.g. Albany Centre precinct). Refer to page 57/134 of the submission for details.</td>
</tr>
<tr>
<td>6100-60</td>
<td>Retain control 3.1 [activities within 30m of a residential zone] that makes taverns in Business zones within 30m of a residential zone being classified as a restricted discretionary activity.</td>
</tr>
<tr>
<td>6100-61</td>
<td>Include zoning restrictions to curb alcohol related harms on other types of facilities that sell alcohol (e.g. restrict off-licence facilities, such as bottle stores around tertiary education centres).</td>
</tr>
<tr>
<td>6100-62</td>
<td>Differentiate between off licence premises that have socially beneficial uses (e.g. supermarkets that provide food, and provide an after hours alternative to fast food and takeaway options), and premises that exist primarily for the sale of alcohol (e.g. bottle stores). Consideration of supermarkets which do not sell alcohol or for limited hours, should also be noted.</td>
</tr>
<tr>
<td>6100-63</td>
<td>Ensure that the PAUP enables and enhances the Local Alcohol Policy (LAP) to achieve a reduction in alcohol related harm.</td>
</tr>
<tr>
<td>6100-64</td>
<td>Include restrictions on clusters of alcohol retailing premises.</td>
</tr>
</tbody>
</table>

Supported residential care facilities

36. ARPHS asks that supported residential care be catered to under the plan through ensuring notice to the following features:
   - Sizing
   - Location
   - Transport options
   - Suitable consent status.
37. **ARPHS recommendations on this issue:**

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Text associated with recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>6100-98</td>
<td>Amend the activity table classification for 'supported residential care' from a Discretionary and a Non-complying activity to a Restricted Discretionary activity.</td>
</tr>
</tbody>
</table>

**Urban design and land use that promotes the best health outcomes**

38. We recommend health promoting forms of urban design, due to the evidence linking good urban design to better health outcomes.

39. ARPHS recommends the following priorities for urban design and zoning:
   - Increased zoning requirements and incentives for developers for new well designed (smart growth), mixed use and higher density ‘brownfields’ housing developments rather than ‘green fields’ redevelopment.
   - Urban design features that promote physical activity and health
   - For both brownfields and green fields developments; ready access to social infrastructure, health care and places of work.
   - Ensuring access to information on contaminated land for developments.
   - Ensuring housing affordability for all new developments by ensuring that housing is well located in order to reduce transportation costs (near work places, social infrastructure and transport networks).
   - All new developments need to be located away from natural hazard areas and coastal inundation areas.

40. **ARPHS recommendations on this issue:**

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Text associated with recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>6100-106</td>
<td>Provide for well designed ‘brownfields’ developments' that are close to amenities and transport centres.</td>
</tr>
<tr>
<td>6100-104</td>
<td>Increase incentives for ‘smart growth’ and brownfields’ forms of residential development over single site renewal through council led initiatives such as: (i) Expedited consent processes for brownfield developments; (ii) Additional height: or density controls (where these do not impact on public health); (iii) Rate credits or grants (e.g. reduced rates for well designed / sustainable developments); (iv) Fee reductions or waivers.</td>
</tr>
<tr>
<td>6100-103</td>
<td>Provide more zoning for well designed (smart growth) mixed use and higher density forms of ‘brownfields’ residential developments over ‘greenfields’ developments, in peripheral locations.</td>
</tr>
<tr>
<td>6100-109</td>
<td>Amend the 'Transport networks' section, so that the street pattern is designed to ensure that all dwellings and employment locations are within the 500m walk Public Transport Plan target for access to the public transport network.</td>
</tr>
<tr>
<td>6100-170</td>
<td>Reduce overall car dependence through policies on the management of parking provisions and increasing zoning for mixed use and smart growth strategies for better urban design.</td>
</tr>
<tr>
<td>6100 - 199</td>
<td>Recognise 'urban heat island' effects and that appropriate adaption and mitigation measures be provided such as (i) increased mandatory insulation;</td>
</tr>
</tbody>
</table>
(ii) ventilation and cooling requirements for dwellings and work places; (iii) inclusion of urban design considerations; (iv) Increased green space; (v) encouraging the use of light colours and reflective materials for roofs and pavings to maximise reflectivity; (vi) Adopt the practice of biophilic design; (vii) Encourage green roof initiatives in urban areas.

6100-107  Clarify how urban structure encourages the provision of local social, economic and cultural facilities.

6100-243  Ensure urban design and zoning provisions [in the Activity table] enable health services and primary healthcare facilities to be located within the communities they serve. [Refer to page 14/134 of the submission for details].

6100-113  Clarify the use of the term 'brownfields', so that it is not confused with the term used for contaminated land.

6100-114  Require supporting documents highlighting the potential contamination of greenfield sites for any new developments, for structure plans.

6100-76  Provide more affordable housing by increasing zoning requirements for well designed, mixed use and higher density housing.

6100-77  Review the residential development threshold of 5 or more dwellings, so as not to act as a perverse incentive to reduce the numbers of possible dwellings being created (due to lower requirements for smaller developments).

6100-78  Remove excessive minimum parking requirements (e.g where adequate disabled and emergency access is available and where adequate transportation or active transport networks are available) to remove financial barriers to small scale housing developments.

6100-182  Add a policy of managed retreat from areas subject to flooding and inundation risks and that new developments not be built in these locations.

6100-112  Include a summary document setting out the social infrastructure required, a Health Impact Assessment (HIA) and a high level summary of the discussions that have taken place with District Health Board planning and funding locality teams, in structure plan requirements.

6100 - 131  Include assessment criteria for all new developments to ensure that disabled access is provided, in order to provide universal disabled access, throughout the PAUP.

Support for stakeholder submissions

41. We wish to support the recommendations of the following recommendations of other submitters on the pan.

Hapai Te Hauora

42. We support Hapai Te Hauora in their submission on the Unitary plan (submission number 6735). In particular we support the following recommendations on the plan.

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Name of submitter</th>
<th>Theme</th>
<th>Subtopic</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>6735-11</td>
<td>Hapai Te Hauora</td>
<td>Mana Whenua</td>
<td>B5.2 Mana Whenua values Mātauranga &amp; tikanga</td>
<td>Amend to align with the spiritual needs of tangata whenua including a connection to the land and acknowledgement of local Mana Whenua and Māori connection with the location.</td>
</tr>
<tr>
<td>6735-10</td>
<td>Hapai Te Hauora</td>
<td>RPS Mana Whenua</td>
<td>B5.1 Recognition</td>
<td>Recognise whānau, hapū and Māori community participation in all stages</td>
</tr>
<tr>
<td>Recommendation number in feedback document</td>
<td>Name of submittter</td>
<td>Theme</td>
<td>Subtopic</td>
<td>Summary</td>
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</tr>
<tr>
<td>6735-4</td>
<td>Hapai Te Hauora</td>
<td>RPS Urban growth</td>
<td>B2.1 Providing for growth in a quality compact urban form</td>
<td>Recognise opportunities for whānau to access good quality, affordable housing.</td>
</tr>
<tr>
<td>6735-15</td>
<td>Hapai Te Hauora</td>
<td>Residential zones</td>
<td>Residential D1.1 General objectives and policies</td>
<td>Ensure quality of housing in areas of high Māori populations of Papakura, Manurewa, Clendon, Massey and Henderson.</td>
</tr>
</tbody>
</table>

**Waitemata District Health Board**

43. We support the following provisions within the Waitemata District Health Board submission (submission number 4467) on the Unitary plan.

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Name of submittter</th>
<th>Theme</th>
<th>Subtopic</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>4467-19</td>
<td>Waitemata District Health Board</td>
<td>Residential zones</td>
<td>Residential Activity Table</td>
<td>Increase the Gross floor area for the Permitted Activity 'Supported residential services [care]' from 200m² to 350m² in Rule 1.1 Activity Table.</td>
</tr>
<tr>
<td>4467-18</td>
<td>Waitemata District Health Board</td>
<td>Definitions</td>
<td>Existing</td>
<td>Amend the definition of 'Supported residential services [care]' to read '...fulltime care for the aged or people involved in rehabilitation. The facility must be certified under the Health and Disability Services (Safety) Act 2001 and comply...includes...- Accessory nursing and medical care, - Mental health services and rehabilitation, - Drug/alcohol services and rehabilitation, - Other disabilities...'</td>
</tr>
</tbody>
</table>

**Supported residential care**

44. We also support the following recommendations by Navigate (Mental Health and Addiction Provider Group) on their submission on the plan (number 5373).

<table>
<thead>
<tr>
<th>Recommendation number</th>
<th>Submitter</th>
<th>Topic</th>
<th>Specific topic</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>5373-2</td>
<td>Navigate</td>
<td>Definitions</td>
<td>Existing definitions</td>
<td>Amend the definition of care centres as follows: Facilities used for any one or...</td>
</tr>
<tr>
<td>Code</td>
<td>Navigate</td>
<td>Definitions</td>
<td>Existing definitions</td>
<td>Action</td>
</tr>
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</tr>
<tr>
<td>5373-3</td>
<td>Navigate</td>
<td>RPS Urban growth</td>
<td>B2.1 Providing for growth in a quality compact urban form</td>
<td>Amend the definition of Supported residential care as follows: Facilities used to provide accommodation and full-time care for aged or disabled people, or people with mental health, addiction illness or intellectual disability.</td>
</tr>
<tr>
<td>5373-13</td>
<td>Navigate</td>
<td>Residential zones</td>
<td>Residential l1.10-11 Assessment &amp; l1.12 Special info. req.</td>
<td>Add the following to Rule 10.1 'Matters of discretion': 2. Supported residential care more than 400m2 GFA. The matters over which discretion should be reserved are: intensity and scale; noise, lighting and hours of operation.</td>
</tr>
<tr>
<td>5373-14</td>
<td>Navigate</td>
<td>Residential zones</td>
<td>Residential l1.10-11 Assessment &amp; l1.12 Special info. req.</td>
<td>Add the following to Rule 10.2 'Assessment criteria': 2. Supported residential care more than 400m2 GFA. The recommended assessment criteria are the intensity and scale of the activity, in particular the number of people involved and traffic generated by the activity, size and location of buildings and associated car parking should be compatible with the planned future form and character of the area/zone. For supported residential care and care centres, the site should be on an adequate size and road frontage to accommodate the activity. In particular, sufficient space will need to be provided for a safe pick-up and drop-off area; Noise and lighting from the activity should not adversely affect the amenity of surrounding residential properties. In determining this consideration will be given to the location of any potentially noisy activities e.g. outdoor play areas associated with a care centre, and any proposed measures to mitigate noise including screening or other design features.</td>
</tr>
</tbody>
</table>
Access to kai moana

45. We would also like to make particular support for Ngati Ata’s submission (submission number 5255) in support of mangrove vegetation management for access to customary use (e.g. for access to kai moana gathering areas).

46. While we restate our general support for the ecosystem services of mangroves and that these should not be removed without suitable reason, we support the permitted removal of mangroves for customary uses by manawhenua, including the collection of kai moana.

47. ARPHS supports the following recommendation:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Submitter</th>
<th>Topic</th>
<th>Text associated with recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>5255-73</td>
<td>Te Ara Rangatu O Te Iwi O Ngāti Te Ata Waiohua Trust Board</td>
<td>Vegetation Management and SEAs.</td>
<td>Retain Control 2.5 'Vegetation alteration or removal for customary use' and identify activities not complying to be restricted discretionary activities and include new assessment criteria to this effect.</td>
</tr>
</tbody>
</table>

Alcohol health watch

48. We also wish to support Alcohol health watch (AHW) on their submission on the proposed plan (submission number 5995).

49. This includes the following recommendations to reduce alcohol related harm in the Auckland region.

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Submitter</th>
<th>Topic</th>
<th>Subtopic</th>
<th>Text associated with recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>5995-2</td>
<td>Alcohol Health Watch</td>
<td>Business (excluding City Centre)</td>
<td>Business D3 Business Zones / D3.1 General objectives and policies</td>
<td>Ensure that the PAUP works in unison with the Local Alcohol Policy and any other alcohol related harm reduction work to maximise the controls that they have available to contribute to the reduction of alcohol related harm.</td>
</tr>
<tr>
<td>5995-3</td>
<td>Alcohol Health Watch</td>
<td>General Chapter G</td>
<td>General provisions G2.4 Notification</td>
<td>Amend to require public notification for all resource consent applications for liquor based</td>
</tr>
<tr>
<td>Recommendation number in feedback document</td>
<td>Submitter</td>
<td>Topic</td>
<td>Subtopic</td>
<td>Text associated with recommendations</td>
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</tr>
<tr>
<td>7392-3</td>
<td>New Zealand Green Building Council</td>
<td>RPS Issues</td>
<td>B1 Introduction - Issues of Regional significance</td>
<td>Retain the issues of regional significance. Recognise that sustainability of the built environment is an inherent component of each of these issues.</td>
</tr>
<tr>
<td>7392-4</td>
<td>New Zealand Green Building Council</td>
<td>RPS Urban growth</td>
<td>B2.2 A quality built environment</td>
<td>Retain the approach which seeks to promote quality buildings.</td>
</tr>
</tbody>
</table>

*New Zealand Green Building Council*

50. We also wish to support the following recommendations by the New Zealand Green Building Council submission (number 7392).
<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Submitter</th>
<th>Topic</th>
<th>Subtopic</th>
<th>Text associated with recommendations</th>
<th>ARPHS stance on this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>318-5</td>
<td>Minister of the Environment</td>
<td>Sustainable Development</td>
<td>C7.7/H6.4 Sustainable design</td>
<td>Remove the mandatory Homestar sustainable building requirements, or encourage their use as a voluntary tool.</td>
<td>Due to the major impacts of housing on health, we oppose this recommendation. ARPHS is strongly in favour of the mandatory use of the Homestar requirements for housing as a means to improve health outcomes.</td>
</tr>
<tr>
<td>318-12</td>
<td>Minister of the Environment</td>
<td>Sustainable Development</td>
<td>C7.7/H6.4 Sustainable design</td>
<td>Remove the mandatory office star sustainable building requirements, or encourage their use as a voluntary tool.</td>
<td>Due to the major impacts of housing on health, we oppose this recommendation. ARPHS is strongly in favour of the mandatory use of the green star requirements for offices as a means to improve health outcomes.</td>
</tr>
</tbody>
</table>

51. ARPHS opposes the following recommendations from the Minister for the Environment submission on the plan (submission number 318).

52. ARPHS also opposes the submission of DB breweries (submission number 4868). This is on the basis of the major harm caused by alcohol in the Auckland region.
53. ARPHS _opposes_ the submission of Restaurant brands (submission number 4449) on the basis of the major harms to health that fast foods in particular cause to health and their role in the current role obesity epidemic.

54. In particular, we oppose the following recommendations:

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Submitter</th>
<th>Topic</th>
<th>Subtopic</th>
<th>Text associated with recommendations</th>
<th>ARPHS stance on this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>4449-42</td>
<td>Restaurant Brands Limited</td>
<td>Business (excluding City Centre)</td>
<td>Business I.3.1 Activity table 1 for Centres, Mixed Use, Gen. Bus. &amp; Bus. Park zones</td>
<td>Amend the activity table so that 'drive-through facilities' change from a restricted discretionary activity to a permitted activity in the Metropolitan Centre zone.</td>
<td>ARPHS opposes this recommendation on the basis of the harms to health arising from fast food outlets.</td>
</tr>
<tr>
<td>4449-43</td>
<td>Restaurant Brands Limited</td>
<td>Business (excluding City Centre)</td>
<td>Business I.3.1 Activity table 1 for Centres, Mixed Use, Gen. Bus. &amp; Bus. Park zones</td>
<td>Retain the restricted discretionary activity status for 'drive-through facilities' in the Light Industry zone.</td>
<td>ARPHS opposes this recommendation on the basis of the harms to health arising from fast food outlets.</td>
</tr>
<tr>
<td>4449-44</td>
<td>Restaurant Brands Limited</td>
<td>Business (excluding City Centre)</td>
<td>Business I.3.1 Activity table 1 for Centres, Mixed Use, Gen. Bus. &amp; Bus. Park zones</td>
<td>Retain the permitted activity status for 'food and beverage' in all business zones.</td>
<td>ARPHS opposes this recommendation on the basis of the harms to health arising from fast food outlets.</td>
</tr>
</tbody>
</table>

55. ARPHS also _opposes_ the following from the New Zealand Transportation Agency (NZTA) submission (submission number 1725).

56. Vehicle related emissions are a major contributor to air pollution which has serious, negative impacts on air quality in the Auckland region. Therefore, we are opposed to reducing

<table>
<thead>
<tr>
<th>Recommendation number in feedback document</th>
<th>Submitter</th>
<th>Topic</th>
<th>Subtopic</th>
<th>Text associated with recommendations</th>
<th>ARPHS stance on this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1725-83</td>
<td>The New Zealand Transport</td>
<td>Transport</td>
<td>Transport Auckland - wide C1.2</td>
<td>Review the use of the defined term 'high traffic generating'</td>
<td>ARPHS opposes this recommendation</td>
</tr>
</tbody>
</table>
Conclusion

57. Thank you for the opportunity to submit on the feedback document of the proposed plan. We see the proposed Unitary plan as a major means to improve health outcomes in Auckland. Our evidence based recommendations provide a means to achieve these outcomes.

58. We note that improving health outcomes in the Auckland region are major targets for the Auckland plan, to which the Unitary plan must give effect. In order to meet these health related outcomes we recommend that council takes up our recommendations on areas in which to improve the plan, in order to substantially improve health outcomes in the Auckland region.
Appendix 1 - Auckland Regional Public Health Service

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Auckland, Counties Manukau and Waitemata District Health Boards), with the primary governance mechanism for the Service resting with Auckland District Health Board.

ARPHS has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

ARPHS' primary role is to improve population health. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects on population health.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, outstanding infrastructure needs, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.
7.1 **Long Term Conditions**

**Recommendation:**
That the report be received.

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

**Glossary**

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

1. **Executive Summary**

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

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

Over the last two years the DHBs have focused on reducing the incidence of cardiovascular disease and prevalence of smoking by:
- Identifying the individual heart and diabetes risk of our eligible population
- Identifying people who are currently smoking
• Providing brief advice to people who are currently smoking.

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

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

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

2. Introduction/Background

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

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

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

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

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

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

2.1 Diabetes prevalence

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

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

The following tables based on information from the VDR as at December 2013 show:
• 45% of Auckland DHB population with diabetes is non-European/other.
• 27% of Waitemata DHB population with diabetes is non-European/other.
• The percentage of Maori with diabetes is the same in both DHBs at 7%.
• Pacific people have the next highest prevalence after European.
• Only 1% of the population with diabetes is enrolled with a PHO outside of the metro Auckland area.
• 58% of the people with diabetes are enrolled with ProCare Networks Limited practices and 22% are enrolled with a Waitemata PHO practice.

The 2013 VDR reports an 8% growth in the population with diabetes for each DHB compared to the previous year. This is an increase of 2,048 people with diabetes in Auckland DHB and 2,320 people with diabetes in Waitemata DHB.
Figure 2: PHO enrolled population in total

<table>
<thead>
<tr>
<th>PHO</th>
<th>European/Other</th>
<th>Māori</th>
<th>Pacific</th>
<th>Indian</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Health Plus Trust</td>
<td>2%</td>
<td>5%</td>
<td>14%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Auckland PHO Limited</td>
<td>7%</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>East Health Trust</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>National Maori PHO Coalition Inc.</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>ProCare Networks Limited</td>
<td>57%</td>
<td>59%</td>
<td>59%</td>
<td>62%</td>
<td>58%</td>
</tr>
<tr>
<td>Total Healthcare Charitable Trust</td>
<td>0%</td>
<td>1%</td>
<td>4%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Waitemata PHO Limited</td>
<td>27%</td>
<td>18%</td>
<td>9%</td>
<td>10%</td>
<td>22%</td>
</tr>
<tr>
<td>Total Metro Auckland PHOs</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td>PHOs Outside Metro Auckland</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figure 3: Auckland DHB Diabetes Population by Ethnicity

<table>
<thead>
<tr>
<th>PHO</th>
<th>European/Other</th>
<th>Māori</th>
<th>Pacific</th>
<th>Indian</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>14180</td>
<td>1783</td>
<td>5790</td>
<td>3944</td>
<td>25697</td>
</tr>
<tr>
<td>% ethnicity</td>
<td>55%</td>
<td>7%</td>
<td>23%</td>
<td>15%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figure 4: Waitemata DHB Diabetes Population by Ethnicity

<table>
<thead>
<tr>
<th>PHO</th>
<th>European/Other</th>
<th>Māori</th>
<th>Pacific</th>
<th>Indian</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>20917</td>
<td>2064</td>
<td>3717</td>
<td>2147</td>
<td>28845</td>
</tr>
<tr>
<td>% ethnicity</td>
<td>73%</td>
<td>7%</td>
<td>13%</td>
<td>7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

2.2 Services to improve diabetes care and patient outcomes

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

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

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

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

3.1 Providing patient centred care

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

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

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

3.2 Services Available in Auckland and Waitemata DHB

3.2.1 Diabetes Annual Review

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of Diabetes Annual Reviews</th>
<th>Diabetes Prevalence</th>
<th>Percent Achieved</th>
<th>2013/14 Target</th>
<th>Difference From Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>492</td>
<td>808</td>
<td>61%</td>
<td>90%</td>
<td>-29% ▼</td>
</tr>
<tr>
<td>Pacific</td>
<td>1839</td>
<td>2708</td>
<td>68%</td>
<td>90%</td>
<td>-22% ▼</td>
</tr>
<tr>
<td>Other</td>
<td>3716</td>
<td>8309</td>
<td>45%</td>
<td>90%</td>
<td>-45% ▼</td>
</tr>
<tr>
<td>Total</td>
<td>6047</td>
<td>11825</td>
<td>51%</td>
<td>90%</td>
<td>-39% ▼</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2.3 Diabetes Self-Management Education (DSME)
The service focuses on providing self-care and diabetes education to people with type two diabetes and family or whanau. The programme is available to people:
• Within the first two years following their diagnosis of type two diabetes.
• Who have established diabetes with poor control, HbA1c ≥ 64 mmol/mol.
• Identified as being at significant risk of another diabetes related health complication.

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

The providers also work together to run cultural specific courses, allowing for people from other areas to attend rather than running multiple courses for the same culture. The current capacity for each provider is:
• ProCare Networks Limited (Waitemata DHB) provides courses for 405 people (not specifically focused on a population group), 45 for Maori, and 60 for Pacific people per annum
• Waitemata PHO provides courses for 404 people (not specifically focused on a population group), 44 for Maori, and 60 for Pacific people per annum
• Auckland PHO (All Auckland DHB PHOs) provides courses for 160 people per annum
• West Fono provides courses for 240 Pacific people per annum.

There is a body of evidence that DSME is effective when patients are engaged. It is estimated that 4% of the total diabetic population would benefit from this service each year. When the need is calculated on this basis, the current contracted volumes for Waitemata should meet this need and further investment is required for ADHB. However in both DHBs, this service is underutilised. It is noted that for the current services:
• Low numbers of referrals are received from general practice.
• The providers advertise their services extensively within the sector and in local press.

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

Additionally, the Northern Region Diabetes Network has been working with service providers to implement quality processes to ensure self-management programmes are of a consistent quality and applicable to patient need. The group is also working to develop a tool to evaluate the effectiveness of the programme in achievement of health gain for the people who attend.
3.2.4 Retinal Screening
Screening for diabetic eye disease provides early detection and treatment plans for people with eye disease. Information from screening can also provide medical staff with information on the effect diabetes is having on the blood vessels throughout the body. Retinal screening has been provided within the two DHBs for more than a decade. The services align with the National Grading and Referral Guidance for Retinal Screening. The service provides photo screening with a quality programme for grading of photographic images of the retina. If a person is not suitable for photo screening they will be referred for slit lamp studies of the retina or referred for treatment.

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

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

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

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

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

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

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

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

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

**Figure 8: Auckland and Waitemata DHBs Community Podiatry Service Capacity Requirements (Packages of Care - a full assessment and up to three treatments)**

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

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

### 3.2.6 Cardiovascular and Diabetes Risk Assessment and Management (CVD/DRAM)

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

**Eligibility and Prevalence**

The Health Target eligible population is defined as:

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

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

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

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3 The Assessment and Management of Cardiovascular Risk; Evidence-based best practice guideline, December 2003
General practitioners are able to refer to the DHB funded programmes for self-management education and Green Prescription to support lifestyle change.

**Screening and Monitoring in Action**

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

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

<table>
<thead>
<tr>
<th>Cardiovascular risk</th>
<th>Lifestyle</th>
<th>Drug therapy</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established CVD</td>
<td>Intensive lifestyle advice (diet, physical activity, smoking cessation) simultaneously with drug treatment</td>
<td>Strong evidence of benefit from BP-lowering, statins and antplatelet therapy in this group</td>
<td>Risk factor monitoring initially at 3 months, then as indicated</td>
</tr>
<tr>
<td>CVD risk calculated</td>
<td>Intensive lifestyle advice (diet, physical activity, smoking cessation) simultaneously with drug treatment</td>
<td>Strong evidence of benefit from BP-lowering, statins and antplatelet therapy in this group</td>
<td>Annual review or as clinically indicated</td>
</tr>
<tr>
<td>&gt;20%</td>
<td>Specific individualised lifestyle advice (diet, physical activity, smoking cessation)</td>
<td>Good evidence demonstrating benefit from BP-lowering and/or statin therapy in this group. The absolute benefits will be smaller at lower levels of combined risk, with increasing benefit of treating both BP and lipids for those with higher five-year combined risk.</td>
<td>As clinically indicated, with more intensive focus for higher combined risk patients</td>
</tr>
<tr>
<td>10% to 20%</td>
<td>Lifestyle advice (diet, physical activity, smoking cessation)</td>
<td>Evidence of benefit from BP-lowering and statin therapy in this group is unclear; use a shared decision-making approach to consider benefits and harms of treatment of modifiable risk factors</td>
<td>Offer further CVD risk assessment in 5 to 10 years</td>
</tr>
<tr>
<td>&lt;10%</td>
<td>Lifetime advice (diet, physical activity, smoking cessation)</td>
<td>Evidence of benefit from BP-lowering and statin therapy in this group is unclear; use a shared decision-making approach to consider benefits and harms of treatment of modifiable risk factors</td>
<td>Offer further CVD risk assessment in 5 to 10 years</td>
</tr>
</tbody>
</table>
• Incorporating HbA1c in the 5 yearly CVDRA assessments. This helps identify Maori, Pacific and Indian men with signs of diabetes
• Screening of Lipids (blood cholesterol) and HbA1c as routine care for most of the enrolled population 40+ or earlier with known other risk factors (ethnicity/early onset - family history)
• Close monitoring of people who are already identified as being pre-diabetic as a result of routine yearly bloods. This monitoring includes bloods tests every 3-6 months and lifestyle advice
• Confirmation of positive blood tests results for diabetes – (Symptomatic HbA1c ≥50mmols/mol or Asymptomatic two HbA1c ≥50mmols/mol) the patient will be seen by their general practitioner for a comprehensive clinical assessment. This will determine what type of diabetes the person has, type 1 (LADA) or type 2. The general practitioner in conjunction with the practice team will then:
  o complete further blood tests [GAD,IA2 markers],
  o confirm the diagnosis of diabetes
  o admit to hospital if required for people with type 1 diabetes
  o review or introduce diabetes and cardiovascular medications as appropriate.

The patient will also be seen by the practice nurse and an action plan with goals will be set. This may include all or some of the following depending on what is negotiated with the patient:
• Understanding what diabetes is and what the patient is concerned about
• Lifestyle factors that can impact on diabetes including eating habits and physical activity
• Medications to manage blood glucose and prevent secondary complication
• When, how and why to do blood glucose monitoring
• Referral to diabetes self-management programme
• Referral for retinal screening.

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

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

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

3.3 Long Term Condition Services for Maori

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

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

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

3.4 Pacific Health

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

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

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

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

4. Moving Forward

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

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

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

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

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

Recommendation

That the report be received.

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

Glossary

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

1. Executive Summary

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

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

2. Background

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

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

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

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

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

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

3. Progress/Achievements/Activity

3.1 Locality Planning

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

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

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

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

3.2 Health Literacy

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

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

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

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

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

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

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

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

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

Plans are underway for the South Kaipara Festival of Health and Wellbeing on 20 September 2014. This is being organised by Health Link North in conjunction with the Auckland North
4. Conclusion

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

Recommendation:

That the report be received.

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

Glossary

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

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

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

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

2. **Primary Care Scorecard**

**How to read the scorecard**

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

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

**Summary Performance Against Targets**

**Priority One Targets**

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

**Service Delivery Targets**

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

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

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

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

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

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

**Immunisation Health Target Q3 2013/14**

<table>
<thead>
<tr>
<th>Target</th>
<th>90 percent of eight months olds will have their primary course of immunisation on time by July 2014 (Auckland DHB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>95 percent of eight months old will have their primary course of immunisations on time by July 2014 (Waitemata DHB)</td>
</tr>
</tbody>
</table>

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

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

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

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

Auckland DHB 86.2% (131,106 people assessed).
- Total coverage ↑2.9% from quarter two.
- Coverage for Māori ↑0.3% (to 80.7%) and decreased for Pacific ↓1.0% (to 84.4%).
  - Auckland DHB leads the country for Māori coverage and is second in New Zealand for Pacific coverage.

Waitemata DHB 80.8% (113,893 people assessed).
- Total coverage ↑4.4% from quarter two.
- Coverage for Māori ↑2.8% (to 74.3%) and for Pacific ↑1.8% (to 78.5%).

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

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

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

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

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

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

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

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

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

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

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

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

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

All PHOs are prioritising high needs populations in their programmes to support people to quit smoking. They are all achieving a higher rate of advice and support to quit to their Māori and Pacific populations than the total population in both DHBs (see table below for actual results).
### Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 30/07/14

<table>
<thead>
<tr>
<th></th>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>76.2%</td>
<td>68.7%</td>
</tr>
<tr>
<td>Pacific</td>
<td>72.2%</td>
<td>68.1%</td>
</tr>
<tr>
<td>Total Population</td>
<td>67.1%</td>
<td>64.1%</td>
</tr>
</tbody>
</table>

Results for each PHO are as follows:

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

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

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

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

Diabetes annual reviews

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

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

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

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

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

Waitemata DHB

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

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

**Auckland DHB**

- Auckland VDR population is 23,649.
- 67% of the total population have had a DAR.
- 73% of the total population have an HbA1c of <64 mmol/mol.
- The number of annual reviews remains the same this quarter. However there has been a 2% increase in good diabetes control as measured by HbA1c over the last quarter. We would expect to see an improvement in reported volumes once general practices move to the use of an ‘advanced form’ for diabetes within their patient management system.
- All four PHOs continue to implement their DCIP plans. The PHOs have been focused on ensuring people have their annual review. This includes meeting their PHO Performance Programme targets. The annual review includes a plan of care for the next year noting what medical and self-care activities will be worked on. This approach encourages general practice to work to improve diabetes control.

**Primary mental health**

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

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

**Waitemata DHB**

- Work is ongoing with the Waitemata PHOs, to ensure the stepped care model is fully implemented, and the target population prioritised. A draft project implementation plan has been completed in partnership with Pro Care, Waitemata DHB and Auckland DHB for establishment and refinement of a collaborative stepped care model, pilot in the New Lynn Integrated Family Health Care Centre. Pilot to be evaluated and approved for roll out by June 30, 2015.
- Work to increase integration between primary, secondary and NGO services is continuing. A pilot test for the collection of base-line data for the number of consult-liaison sessions delivered to primary is complete. Full testing with Child and Adolescent Mental Health Services (CAMHS) started in April 2014.
2013/14 Q3 volumes are as follows:

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

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

Auckland DHB

2013/14 Q3 volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland PHO</th>
<th>ProCare</th>
<th>AH+</th>
<th>NHC</th>
<th>Youthline</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>168</td>
<td>216</td>
<td>9</td>
<td>165</td>
<td>27</td>
<td>585</td>
</tr>
<tr>
<td>Māori</td>
<td>46</td>
<td>274</td>
<td>3</td>
<td>30</td>
<td>2</td>
<td>355</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>20</td>
<td>183</td>
<td>17</td>
<td>20</td>
<td>3</td>
<td>243</td>
</tr>
<tr>
<td>Asian</td>
<td>55</td>
<td>75</td>
<td>2</td>
<td>71</td>
<td>5</td>
<td>208</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>64</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td>95</td>
</tr>
<tr>
<td><strong>Q3 Total</strong></td>
<td><strong>304</strong></td>
<td><strong>812</strong></td>
<td><strong>32</strong></td>
<td><strong>293</strong></td>
<td><strong>45</strong></td>
<td><strong>1,486</strong></td>
</tr>
<tr>
<td><strong>Q3 Expected Total</strong></td>
<td><strong>105</strong></td>
<td><strong>385</strong></td>
<td><strong>89</strong></td>
<td><strong>86</strong></td>
<td><strong>38</strong></td>
<td><strong>703</strong></td>
</tr>
</tbody>
</table>

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

Regional after hours network

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

- Work continues on the development for the After Hours business case. The aim is to have this available for Boards to consider in July 2014.
- There has been an independent evaluation of the After Hours Network. This has been undertaken by Dr Tim Tenbensel, Health Systems, School of Population Health, Faculty of Medical and Health Sciences, The University of Auckland. It is expected the report will be available soon to inform the business case.
- The table provided in Appendix 1 provides an over view of the utilisation of the After Hours Network services through to 31 March 2014.
- The following table shows the current opening hours of each of the 11 A&M clinics and the fees charged for eligible patients.
Note: The Government’s policy of free GP visits and prescriptions for children under six, including free after-hours care, will be extended to children under 13 from 1 July 2015.

**Access to Diagnostics-Radiology**

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

**Wait times**

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

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

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

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

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

Equity of access

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

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

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

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

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

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

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

e-Referrals

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

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

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

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

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

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

- The West Auckland Diabetes working group continue to support three priorities with a focus in New Lynn initially;
  1. The implementation of the Quality Improvement Team (QIT). Recruitment for a Registered Nurse is in progress with the position advertised for a third round again in May. Once in post, the nurse will be on working with practices across West Auckland to improve diabetes care with a focus on improving care for Māori and Pacific populations.
  2. The development of an integrated diabetes model of care. Four clinics and lunchtime educational sessions have been held in Totara Health, New Lynn since the pilot began in October 2013. Practice GPs and nurses are invited to attend the consultation with the specialist to support upskilling. These have not been well attended so far by clinicians within the Integrated Family Health Centre (IFHC). Therefore alternate options are being considered for patients within the wider cluster such as virtual clinics or chart reviews, the use of care plans and shared care tool and nurse specialist clinics. There are now Diabetes Nurse Specialists offering clinics within Whānau House, Henderson and Totara Health, New Lynn. The Whānau House service is for Māori patients only and work is underway to support wider integration with primary care and other service providers.
  3. Facilitation of network development to support improved diabetes care. Without a Clinical Director in post there has been little interaction with the surrounding GP practices although they are invited to the lunchtime educational sessions. Some of the DHB services operating out of Totara Health Services are continuing to use the clusters as their referral mechanism. These linkages will hopefully be strengthened through the QIT workplan. There has also been some work by an independent facilitator with a subset of New Lynn cluster practices to look at a number of diabetes performance initiatives which is to be progressed next year. This will work in parallel to the QIT.

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

Greater Auckland Integrated Health Network

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Primary Care Nursing

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

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

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

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

### 5. Primary care operational issues

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

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

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

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

The above two initiatives aim to increase the health gain of our high needs population and ensure a consistent population health outcome.
The purpose of the PPP report is to provide information on how a PHO performs against the nationally consistent indicators. This performance programme is soon ending. This will be replaced by the Integrated Performance and Incentive Framework (IPIF).

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

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

The graph below shows ‘Ischaemic CVD Detection’ across Auckland and Waitemata DHB PHOs. All PHOs met this target in quarter three and most PHOs are significantly exceeding the target for high needs populations.
The graph below shows ‘Diabetes Detection’ target for Auckland and Waitemata DHB PHOs. All are now meeting or exceeding the target of 90%, but performance for Waitemata PHO has declined significantly since last year.

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

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

PHO enrolment data

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

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

The graph below shows ‘Immunisation Coverage for 2 year olds’. Procare Auckland, NHC (high needs) and Waitemata PHO (total population) are not meeting the target in quarter three, although all PHO’s performance has increased on last year.
Ethnicity of ADHB Residents enrolled with a PHO

- Other
- Asian
- Pacific
- Maori

% split by ethnicity

PHO (total number of enrollees)

Ethnicity of WDHB Residents enrolled with a PHO

- Other
- Asian
- Pacific
- Maori

% split by ethnicity

PHO (total number of enrollees)
### Appendix 1: After Hours Network Report: Summary year to date (Period ending March 2014)

<table>
<thead>
<tr>
<th>Location</th>
<th>YTD 2010-11</th>
<th>YTD 2011-12</th>
<th>YTD 2012-13</th>
<th>YTD 2013-14</th>
<th>Adjusted for no. of available afterhours</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>5,930</td>
<td>6,586</td>
<td>6,559</td>
<td>6,333</td>
<td>7,305</td>
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<tr>
<td>Central</td>
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<td>4,162</td>
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<td>South &amp; East</td>
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<td>23,154</td>
<td>25,146</td>
<td>26,256</td>
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<tr>
<td>Total ex West</td>
<td>32,252</td>
<td>33,794</td>
<td>36,967</td>
<td>37,771</td>
<td>38,363</td>
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<tr>
<td>West</td>
<td>7,916</td>
<td>7,935</td>
<td>8,105</td>
<td>9,067</td>
<td>9,583</td>
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<tr>
<td>Auckland</td>
<td>40,170</td>
<td>41,239</td>
<td>44,236</td>
<td>46,459</td>
<td>48,226</td>
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### Auckland After Hours Network Report

<table>
<thead>
<tr>
<th>Location</th>
<th>YTD 2010-11</th>
<th>YTD 2011-12</th>
<th>YTD 2012-13</th>
<th>YTD 2013-14</th>
<th>Adjusted for no. of available afterhours</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>7,778</td>
<td>8,300</td>
<td>8,328</td>
<td>8,649</td>
<td>8,835</td>
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<td>Central</td>
<td>6,287</td>
<td>7,528</td>
<td>8,002</td>
<td>7,594</td>
<td>4,932</td>
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<td>South &amp; East</td>
<td>11,782</td>
<td>12,256</td>
<td>12,425</td>
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<tr>
<td>Total ex West</td>
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<td>25,838</td>
<td>26,738</td>
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<td>26,317</td>
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<tr>
<td>West</td>
<td>5,002</td>
<td>4,838</td>
<td>4,951</td>
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<tr>
<td>Auckland</td>
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<td>30,676</td>
<td>31,666</td>
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### Medical A&M Afterhours

<table>
<thead>
<tr>
<th>Location</th>
<th>YTD 2010-11</th>
<th>YTD 2011-12</th>
<th>YTD 2012-13</th>
<th>YTD 2013-14</th>
<th>Adjusted for no. of available afterhours</th>
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<tbody>
<tr>
<td>North</td>
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<td>13,386</td>
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<td>15,062</td>
<td>12,12%</td>
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<td>Central</td>
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<td>10,694</td>
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<td>South &amp; East</td>
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<td>40,214</td>
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<td>Total ex West</td>
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<td>61,213</td>
<td>64,580</td>
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<tr>
<td>West</td>
<td>12,610</td>
<td>12,431</td>
<td>11,130</td>
<td>14,795</td>
<td>14,724</td>
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<td>Auckland</td>
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<td>71,975</td>
<td>75,922</td>
<td>76,008</td>
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### Medical ED Afterhours Under 6

<table>
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<th>YTD 2012-13</th>
<th>YTD 2013-14</th>
<th>Adjusted for no. of available afterhours</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Central</td>
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<td>2,600</td>
<td>2,578</td>
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<tr>
<td>South &amp; East</td>
<td>13,253</td>
<td>13,818</td>
<td>14,067</td>
<td>17,045</td>
<td>15,020</td>
</tr>
<tr>
<td>Total ex West</td>
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<td>West</td>
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<td>5,481</td>
<td>5,850</td>
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<tr>
<td>Auckland</td>
<td>25,888</td>
<td>26,276</td>
<td>26,104</td>
<td>30,010</td>
<td>30,215</td>
</tr>
</tbody>
</table>
8. Resolution to Exclude the Public

Recommendation:

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

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

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minutes of the Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting with Public Excluded 30/04/14</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Confirmation of Minutes As per resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&amp;D Act.</td>
</tr>
<tr>
<td>2. Co-opted member appointment</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]</td>
</tr>
</tbody>
</table>