Community and Public Health Advisory Committees Meeting

Wednesday, 25th November 2015

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
25th November 2015

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
Chris Chambers - ADHB Board member
Sandra Coney - WDHB Board member
Warren Flainty - 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
Elsie Ho - Co-opted member
Rev Featunai Liuaana – Co-opted 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: Rev Featunai Liuaana and Elsie Ho

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

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

1  AGENDA ORDER AND TIMING

2  CONFIRMATION OF MINUTES

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3.30pm  6  GENERAL BUSINESS

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 25/11/15
## Auckland and Waitemata District Health Boards
### Community and Public Health Committees
#### Member Attendance Schedule 2015

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<th>NAME</th>
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* # absent on Board business
^ leave of absence
*+ attended part of the meeting only
+ ex-officio member

# absent
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<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
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| Lester Levy      | Chair - Auckland District Health Board  
Chairman - Auckland Transport  
Independent Chairman - Tonkin & Taylor  
Chief Executive - New Zealand Leadership Institute  
Professor of Leadership - University of Auckland Business School  
Trustee - Well Foundation (ex-officio member)  
Member – State Services Commission’s Performance Improvement Framework Review Panel                                                                                       | 11/09/15     |
| Max Abbott       | Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology  
Patron - Raeburn House  
Advisor - Health Workforce New Zealand  
Board Member - AUT Millennium Ownership Trust  
Chair - Social Services Online Trust  
Board Member - The Rotary National Science and Technology Trust                                                                                                           | 19/03/14     |
| Jo Agnew         | Professional Teaching Fellow - School of Nursing, Auckland University  
Trustee Starship Foundation  
Casual Staff Nurse - ADHB                                                                                                                                                        | 01/03/14     |
| Peter Aitken     | Pharmacist  
Shareholder/Director, Consultant - Pharmacy Care Systems Ltd  
Shareholder/Director - Pharmacy New Lynn Medical Centre                                                                                                                         | 15/05/13     |
| Judith Bassett   | Nil                                                                                                                                                                                                                                     | 09/12/10     |
| Chris Chambers   | Employee - Auckland District Health Board (wife employed by Starship Trauma Service)  
Clinical Senior Lecturer- Anaesthesia Auckland Clinical School  
Associate - Epsom Anaesthetic Group  
Member - ASMS  
Shareholder - Ormiston Surgical                                                                                                                                               | 20/04/11     |
| Sandra Coney     | Elected Member - Chair: Waitakere Ranges Local Board, Auckland Council                                                                                                                                                                 | 12/12/13     |
| Warren Flaunty   | Member - Henderson - Massey and Rodney Local Boards, Auckland Council  
Trustee (Vice President) - Waitakere Licensing Trust  
Shareholder - EBOS Group  
Shareholder - Green Cross Health  
Director - Westgate Pharmacy Ltd  
Chair - Three Harbours Health Foundation  
Director - Trusts Community Foundation Ltd                                                                                                                                 | 26/11/14     |
| Lee Mathias      | Chair - Counties Manukau District Health Board  
Chair – Unitec  
Director – Health Innovation Hub  
Director – healthAlliance  
Director – New Zealand Health Partnerships  
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  
Advisory Chair - Company of Women Ltd                                                                                                                                              | 02/09/15     |
| Robyn Northey    | Project management, service review, planning etc - Self-employed Contractor  
Board member - Hope Foundation Northern Region  
Trustee - A+ Charitable Trust                                                                                                                                                     | 18/07/12     |
Register of Interests continued...

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<tr>
<th>Name</th>
<th>Position</th>
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<tr>
<td>Christine Rankin</td>
<td>Member - Upper Harbour Local Board, Auckland Council</td>
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<td>Director - The Transformational Leadership Company</td>
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<td>Allison Roe</td>
<td>Member - Devonport-Takapuna Local Board, Auckland Council</td>
<td>02/07/14</td>
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<td>Chairperson - Matakana Coast Trail Trust</td>
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<td>Gwen Tepania-Palmer</td>
<td>Chairperson - Ngatihine Health Trust, Bay of Islands</td>
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<td>Life Member - National Council Maori Nurses</td>
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<td>Alumni - Massey University MBA</td>
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<td>Director - Manaia Health PHO, Whangarei</td>
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<td>Board Member - Auckland District Health Board</td>
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<td>Committee Member - Lottery Northland Community Committee</td>
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Co-opted Members

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<th>Name</th>
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<tr>
<td>Elsie Ho</td>
<td>Associate Professor - School of Population Health, University of Auckland</td>
<td>03/09/14</td>
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<td>Member - Waitemata DHB Asian Mental Health and Addiction Governance Group</td>
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<td>Member - Problem Gambling Foundation of New Zealand Advisory Board</td>
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<td>Trustee – New Zealand Chinese Youth Trust</td>
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<td>Rev Featunai Liuana</td>
<td>Chairperson – Congregational Christian Church Samoa Sandringham Trust</td>
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<td>Board Trustee – Congregational Christian Church Samoa Trust</td>
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<td>Chairperson – Mothers and Daughters Health – HVAZ and Alliance Health Plus</td>
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<td>Committee Member – Working Group for Pacific Health Action Plan (ADHB and WDHB)</td>
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<td>Deputy Chairperson – Working Group Pacific Family Violence (ADHB and WDHB)</td>
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<td>Member – MIT Pasifika Students Forum</td>
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<td>Secretary - Negotiation Committee – EFKSNZ Trust</td>
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<tr>
<td>Dr Tim Jelleyman</td>
<td>Clinical Chair - Child Health Network, Northern Regional Health Plan</td>
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<td>Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland</td>
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<td>Member-Board of Kaipara Medical Centre</td>
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<td>Community Paediatrician, Waitakere Hospital</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 14th October 2015

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 14th October 2015 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 14 October 2015

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

PART I - Items considered in Public Meeting

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Max Abbott (WDHB Deputy Chair) (present from 2.30 p.m.)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Chris Chambers (ADHB Board member)
Lee Mathias (ADHB Deputy Chair)
Robyn Northeys (ADHB Board member) (present from 2.05 p.m.)
Allison Roe (WDHB Board member)
Rev Featunai Liuaana (Co-opted member)

ALSO PRESENT:

Ailsa Claire (ADHB, Chief Executive)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Tim Wood (ADHB and WDHB, Deputy Director Funding)
Ruth Bijl (ADHB and WDHB, Funding and Development Manager, Child, Youth and Women’s Health)
Karen Bartholomew (ADHB and WDHB, Public Health Physician)
Craig Heta (ADHB and WDHB, Portfolio Manager, Maori Health)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Lynda Williams, Auckland Womens Health Council
Tracy McIntyre, Waitakere Health Link
Brian O’Shea, ProCare
Lorelle George, Comprehensive Care/Waitemata PHO
Rowan Quinn, Radio New Zealand

APOLOGIES:

Apologies were received and accepted from Lester Levy, Sandra Coney, Warren Flaunty, Christine Rankin, Elsie Ho, Tim Jelleyman and Dale Bramley.

WELCOME:

The Committee Chair gave a warm welcome to all those present.
KARAKIA: The Committee Chair led the meeting in the Karakia.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no declarations of interests relating to the agenda.

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 02\textsuperscript{nd} September 2015 (agenda pages 7-17)

Resolution (Moved Judith Bassett/Seconded Jo Agnew)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 02\textsuperscript{nd} September 2015 be approved.

Carried

Matters Arising (agenda page 18-19)

No issues were raised.

2.05p.m – Robyn Northey present.

3 DECISION ITEMS

There were no decision items.

4. INFORMATION ITEMS

4.1 Auckland DHB Integrated Child and Youth Mental Health and Addiction Direction 2013-2023 Update (agenda pages 20-41)

Hilary Carlile (Project Manager), Tim Wood (Chair of Child and Youth Mental Health and Addictions Direction Implementation Governance Group, Acting Funding and Development Manager, Mental Health and Addictions), Sarah Gray (Public Health Physician, Auckland DHB) and Shreya Rao (youth representative) were present for this item.
Shreya Rao spoke of her role representing young people who use these services across Auckland DHB, assisting the Steering Group in developing the scorecard and in considering issues affecting the wellbeing of young people.

Hilary Carlile provided context for the report. Matters that she covered included:

- The vision is to assist children, young people and their families to experience and enjoy good mental health and wellbeing.
- From the young people involved in this work it is clear that enjoying wellbeing is important, as well as getting help when difficulties are being experienced.
- The principles being followed in this project included meaningful co-design with young people; responsiveness; recognising diversity; importance of community; and intervening earlier.
- When they had presented to CPHAC in October 2014, the Committee had requested them to develop a scorecard to measure the impact of implementing the Direction. The team involved had been working hard on this and had produced the draft scorecard shown in the agenda report; however this is an ongoing work in progress. As with any scorecard the key issue is what the right data to measure is. They had tried to develop measures for each of the areas of the Direction. The status bar in the scorecard shows for each measure whether it is a hard measure (green), still being worked on (amber) or requiring a lot of work (red). They are still working on the reliability of data and considering what new data they want to include.
- ‘Look Up’, the Youth Innovation Forum occurring on 16 October (described on page 22 of the agenda) provides an opportunity to learn and experience. It will explore a range of technology options including wellbeing applications as well as clinically based applications like SPARX. There is a wide range of other aspects including a chill out zone with four psychiatrists available and an area for service innovation, to encourage people to express their ideas of what makes them feel great.

Shreya Rao advised that the Forum will also be promoting the approach of the Mental Health Foundation to addressing social stigma when people become unwell and discussing interventions by which young people can help support their peers.

Hilary Carlile advised that Michelle Atkinson (who had presented to CPHAC in October 2014 on the Direction) was currently returning from the Youth Mental Health Conference in Montreal, where she had won the prize for the best youth focused poster. She had played a key role in developing the ‘Look Up’ Forum.

Matters covered in discussion and response to questions included:

- ‘Look Up’ on 16 October will be the first such event. One of the aims is to find out what young people and those working with them want next. If there is support for another Forum, that would happen.
- Questions were raised as to whether youth suicide is a useful measure and whether it should be so prominent in the scorecard. In response, Tim Wood commented that youth suicide is a key issue and to monitor it is critically important. A key consideration in placing it first in the score card is keeping it at the front of their minds; they needed to keep challenging themselves on
the issue and keep discussing it. Even if they could not change the trend, that did not negate the need to have it at the forefront.

- In response to a question on utilising other game type applications (in addition to SPARX), Hillary Carlile advised that there are many such products on the market and they need to be focused in what they provided at 'Look Up'. Overseas, many products had been found to be useful.
- Ailsa Claire acknowledged the work of all those involved and noted how this work reflected key values of Auckland DHB including the wish to co-design and also understand the needs of the people using its services. She asked if it would be feasible to have more user surveys, to get more quantitative information. In response Shreya Rao advised that Auckland DHB is starting to track real time feedback.
- With regard to addressing the issue of workforce diversity, Tim Wood noted that this issue still had to be worked through by the group. It would be brought back subsequently. Ailsa Claire commented that this was part of the wider organisational issue of how to develop the ethnic mix of the workforce generally. Work done in this youth mental health area would help contribute to that. Hilary Carlile noted the importance of actively starting in schools to get young people thinking about careers in health. A project focused on Pacific young people had illustrated the benefits of this.
- Rev. Liuaana suggested that perhaps the approach taken focused too much on the end results in mental health. In response, Hilary Carlile said that the challenge is to collect that earlier data and to make sure it is good data; there is not currently good data on what is happening from a wellbeing perspective in schools. Shreya Rao suggested that the issue is about going out and talking to young people, who don’t necessarily want to discuss mental health issues. The ‘Look Up’ Forum provided an informal way to start those conversations.
- In response to a question as to whether the timing of the ‘Look Up’ Forum in October was good in view of the pressure of upcoming examinations, Tim Wood suggested that it may be useful for young people to have these discussions at a time when they are under extra stress. It is hoped that the Forum will help in coping with such stress.

The Committee Chair thanked the presenters for the work done to date and encouraged them in the direction being taken. Challenges will remain, but, as Ailsa Claire had pointed out, it is very important to get the values of youth included in shaping co-design and development of support for young people.

2.30p.m – Max Abbott present.

Resolution (Moved Lee Mathias/Seconded Peter Aitken)

That the Community and Public Health Advisory Committee:

a) Receives the report.

b) Notes the approach taken to develop the Auckland DHB outcomes framework and scorecard and the progress made.

Carried
4.2 Mental Health and Addictions Update – 2014/15 Actions (agenda pages 42-63)

Jean-Marie Bush (Portfolio Manager, Mental Health and Addictions), Tim Wood (Acting Funding and Development Manager, Mental Health and Addictions) and Ruth Williams (Chair of the Waitemata Stakeholder Network) were present for this item.

Tim Wood introduced the report. Matters that he covered included:

- The report focuses on the work of the Funder with the Mental Health NGO sector and the Provider Arm. The two DHBs are at different stages of developing collaborative arrangements with the NGO sector. The Waitemata Stakeholder Network has been very well embedded over a long period, develops a plan every five years, and works through that. At Auckland DHB the corresponding process is at a much earlier stage of development and Innovate has had only a few meetings to date and is very much in a formative stage, however there is a very high level of enthusiasm from everyone involved to progress this approach.

- The work done with the Waitemata Stakeholder Network tends to “sit under the radar” in that they look at the issues coming up and how they can be resolved collectively.

- The report includes an update on the work being done to develop an employment strategy for people with mental health conditions, to improve employment opportunities. The document shown in the report, developed as a collaborative project, is still very much a draft and is going through a consultation and approval process with stakeholders.

- With regard to Support Hours, the report notes that discussions are continuing with NGOs on how this approach might be refined going forward.

Ruth Williams commented that one of the most important roles of the Stakeholder Network is consulting with the community.

Matters covered in discussion and response to questions included:

- It was suggested that as the DHBs are amongst the biggest employers in the region, it would be worthwhile for them to look at how they approached employment of people with mental health conditions. Tim Wood advised that the discussion had not occurred, but it would be good to have it.

- With regard to the Mental Health and Employment Strategy, it was suggested that the list of proposed “Everyone’s Business Champions” (page 59 of the agenda) might be strengthened by the inclusion of some business people and potential employers, useful also in showing the perspective of employers.

- Jean-Marie Bush advised that Auckland DHB has a contract to help people with mental health conditions find jobs; Waitemata DHB does not have a specific contract for that. Ruth Williams confirmed that the NGOs are involved in links to business and looking for job connections.

- Questions were asked about at what point does an employee have a responsibility to advise his or her employer about mental health issues and at what point does the employer need to know? In response Jean-Marie Bush advised that these questions are often asked and support workers are quite skilled at working on these matters. There is a lot of support given to people on that.
The Committee Chair acknowledged the authors of the report and expressed appreciation of the vignettes that had been included; it was very useful to see matters through the eyes of those people that use the service. She thanked those involved for the work they had done and the partnering approach, which helped to strengthen the service itself. She thanked Ruth Williams for attending the meeting; the stakeholder groups are very important.

Resolution (Moved Judith Bassett/Seconded Lee Mathias)

That the report be received.

Carried

4.3 Child, Youth and Women’s Health (agenda pages 64-72)

Ruth Bijl (Funding and Development Manager - Child, Youth and Women’s Health), Natalie Desmond (Senior Programme Manager - Child Health), Pam Hewlett (Programme Manager - Women’s Health) and Dr Karen Bartholomew (Public Health Physician) were present for this item. Apologies were conveyed from Dr Tim Jelleyman (WDHB Community Paediatrician) and Dr Alison Leversha (ADHB Community Paediatrician).

Ruth Bijl introduced the report, highlighting some key points. This included advising that results for the immunisation health targets for the first quarter had been received since the report was written and these confirmed that Auckland DHB had reached the 95% target for immunisation at eight months, a major achievement. She also noted that Auckland Girls Grammar School is delighted to have a new school based service established there. She had visited the school to look at possible locations and the school is extremely supportive.

Natalie Desmond commented on the immunisation results. The results for Auckland DHB are very pleasing, with the only area behind target being Maori at 90%. They are working on early engagement with Maori babies through primary care. For Waitemata DHB there are longstanding issues of a high decline rate as well as delays in immunising. The figure was 93% for the previous quarter, however there had been a very good start to the current quarter with 95% already achieved, a very positive sign.

The meeting was advised that whooping cough remains an issue, with new cases each month. Work continues with ARPHS on this issue. This illness is always around and protection from it is important.

Dr Karen Bartholomew commented on the improvement in the cervical screening rate for both DHBs (pages 71-72 of the agenda). While this was a small percentage increase, it represented a great deal of work by the PHOs and a large number of additional women screened.

Brian O’Shea (Procare) endorsed comments by Natalie Desmond and Karen Bartholomew on how well the PHOs and DHBs are working together to achieve targets.
Matters covered in discussion and response to questions included:

- With regard to oral health enrolments at one year, results are poor. It is acknowledged that there is a great deal of work to be done on this. As shown by the graphs on page 70 of the agenda, oral health for Pacific children is particularly poor. A strategy is being worked on to change hearts, minds and behaviour on this. Rev. Liuaana also noted that at a recent symposium on the effects of sugar, advice had been given that if oral decay is not dealt with from ages 0-6, then there is a much bigger chance of developing diabetes. He commented that it is positive to see that a strategy is being developed for Pacific children.

- The issue of health literacy was raised and whether the various programmes are tied up together. Ruth Bijl advised that it is understood how important it is that different providers give consistent messages to young people and their parents.

- The previous suggestion that the public health nurse role needs review was re-iterated.

- With regard to breastfeeding, Pam Hewlett advised that at both DHBs the joint midwifery well child group is supporting training on this issue and improving the consistency of information provided to women.

- Lee Mathias raised the need to persuade the Ministry of Health to strengthen the breastfeeding target in view of evidence supporting exclusive breastfeeding and therefore put forward the following motion.

**Resolution** (Moved Lee Mathias/Seconded Allison Roe)

That it be recommended to the Auckland and Waitemata District Health Boards:

That the Board lobby the Ministry of Health for it to change the six month breastfeeding target to read: “exclusive breast feeding” and set the target at 75%; and for the target to be included for well child providers.

**Carried**

Cervical Screening – Consultation by the Ministry of Health on HPV Screening as part of the screening pathway (page 72 of the agenda)

Karen Bartholomew advised that the DHBs will put in a submission on this. As the closing date for feedback to the Ministry is 23 October it was agreed that the draft submission be circulated by e-mail to Board members for comment before being submitted.

The Committee Chair acknowledged the work of the team and thanked the presenters.

**Resolution** (Moved Lee Mathias/Seconded Jo Agnew)

That the Community and Public Health Advisory Committee note results against key child, youth and women’s health indicators, with accompanying commentary.

**Carried**
4.4 Proposed Building (Pools) Amendment Bill 2015 (agenda pages 73-76)

Dr David Sinclair (Senior Medical Officer, Auckland Regional Public Health Service Medical Team) was present for this item.

Simon Bowen introduced David Sinclair to the Committee and noted that it was intended to have a more detailed paper go to the two Boards.

David Sinclair summarised the paper, including the main proposals in the Bill, concerns with them and the process being followed.

David Sinclair confirmed that ARPHS will be preparing a submission on the Bill and will be looking for the DHBs’ support. As this is a Government Bill there will need to be consultation with the Ministry of Health. The closing date for submissions is 6 November and the proposed submission will be circulated to Board members prior to being submitted.

Resolution (Moved Robyn Northey/Seconded Max Abbott)

That the Community and Public Health Advisory Committee:

a) Receive this report.

b) Note ARPHS is continuing to liaise with other agencies about the draft Bill.

Carried

5. STANDARD REPORTS

5.1 Planning, Funding and Outcomes Update (agenda pages 77-87)

Debbie Holdsworth (Director Funding) and Simon Bowen (Director Health Outcomes) presented this item.

Matters that were highlighted or updated included:

- Final approvals of the Annual Plans for both DHBs.
- Annual Reports for both DHBs are nearing completion.
- Waitemata DHB’s Health Services Plan will be coming to its next Board meeting.
- The responses to the various questions raised at the previous CPHAC meeting provided in the ARPHS section of the report.

Matters covered in discussion and response to questions included:

- With regard to the Asian International Benchmarking Report (referred to on page 80 of the agenda), Wendy Bennett (Manager-Planning and Health Intelligence) advised that this looked at a range of other countries where data is available on health outcomes. Some of these are Asian countries; some are non-Asian countries with Asian populations. Simon Bowen noted that this data needs to be looked at to see what it tells us and how it should be interpreted; internationally what does best experience look like? Lee
Mathias advised that Counties Manukau DHB has useful information on Asian populations’ health broken down by ethnicity and country of origin. Simon Bowen said that he will contact Counties Manukau DHB on this.

- The Committee Chair suggested that it would be useful to receive an update on the work being done with Community Nurses in Pacific Health; it is important to make sure that there are the necessary resources to meet the high needs there. She also suggested that it would be useful to see a table of work aligned to the Pacific Health Action Plan. Jo Agnew suggested that it would also be useful to have an analysis of whether some of the things being done in Pacific Health should be replicated for other ethnicities. Rev. Liuaana commented that it will be important to see data from Enua Ola, HVAC etc. A paper on Pacific Health was requested for the early part of 2016. Debbie Holdsworth noted that Lita Foliaki had reported to CPHAC at its July meeting and had been asked to develop a Pacific scorecard; they hoped to have that soon.

- The Committee Chair suggested developing a road map to inform the scorecard, just to understand the interlocking arrangements between the various groups reaching out into the community, for example Pacific Health and Oral Health – covering how these work together and where there may be gaps.

- For Maori Health, the Committee Chair noted that it was good to see the programme to support pregnant mothers become and stay smokefree; also the framework being developed for phase two cardiac rehabilitation in the community.

Resolution (Moved Robyn Northey/Seconded Lee Mathias)

That the report be received.

Carried

6 General Business

There was no general business.

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

The meeting concluded at 3.28p.m.
### Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 17th November 2015

<table>
<thead>
<tr>
<th>Meeting Ref</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPHAC 10/06/15</td>
<td>5.1</td>
<td>Primary Care Update: to include reporting on Primary Mental Health reconfiguration on an ongoing basis.</td>
<td>Tim Wood</td>
<td>CPHAC 25/11/15</td>
<td>Included in Primary Care Update, Section 4.4.</td>
</tr>
</tbody>
</table>
| CPHAC 22/07/15 | 5.1 | Issues of Homelessness and Deprivation: 
- An approach to be made to the Well Foundation to see if it would support a project to raise awareness and funding to help assist with these issues. 
- Ongoing updates to be provided to CPHAC on the Western Caravan Park. 
- Report to be provided to CPHAC on the broader housing issues in Auckland with recommendations about any actions the DHBs could take to address them. | Simon Bowen | CPHAC 25/11/15 | Refer report 3.1 on this agenda – Housing in Auckland. |
| CPHAC 14/10/15 | 4.3 | Cervical Screening – Consultation by the Ministry of Health on HPV Screening as part of the Screening Pathway – draft submission to be e-mailed to Board members for comment prior to submission. | Karen Bartholomew | | Actioned. |
| CPHAC 14/10/15 | 5.1 | Pacific Health – Update report requested for CPHAC for early 2016. | Lita Foliaki | CPHAC 03/02/16 or 16/03/16 | |
3.1 Housing in Auckland

Recommendation

That it be recommended to the Auckland and Waitemata District Health Boards:

That the Board:

1. Note that the health sector has a stake in the housing needs of Aucklanders.

2. Agree that ARPHS and the DHBs continue to work with Auckland Council and Auckland Social Sector Leaders Group to address issues of housing.

3. Agree that DHBs actively support and promote schemes to improve housing quality such as the home insulation schemes.

4. Agree that consideration of the impacts of the special housing areas is undertaken as part of the Auckland and Waitemata primary and community services plan.

5. Note ARPHS will maintain a watching brief on housing issues within the Auckland Region and will consider engaging in projects with significant potential for health gain where it has capacity and expertise to do so.

Prepared by: Dr Julia Peters (Clinical Director – Auckland Regional Public Health Services), Dr David Sinclair (Public Health Medicine Specialist)
With contribution from: Jude Woolston (Manager Healthy Housing - Counties Manukau DHB), Ruth Bijl (Funding & Development Manager Women, Children & Youth – Waitemata and Auckland DHBs), Alison Leversha (Community Paediatrician)
Endorsed by: Simon Bowen (Director Health Outcomes Waitemata and Auckland DHBs)

Glossary

AWHI - Auckland Wide Housing Initiative
BRANZ - Building Research Association
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
FACE - Financial Entitlement Assessment
HNZC - Housing New Zealand Corporation
IRRS - Income Related Rent Subsidy
MBIE - Ministry of Business, Innovation and Employment
MSD - Ministry of Social Development
RMA - Resource Management Act
SHA - Special Housing Area

1. Executive Summary

The housing situation in Auckland is of considerable concern for central and local government, health and social sectors, the Auckland population and the regional economy. Government initiatives such as Reserve Bank loan requirements, Special Housing Areas, the Auckland Unitary
Plan, social housing policy reforms, changes in the construction industry and planning regulation will have effects over a number of years.

The health sector bears a proportion of the impacts and costs associated with housing. Poor quality, crowded housing is a causal factor for a range of infectious and respiratory illnesses, allergies, injury, and mental health and social issues. It contributes to persistent health inequalities that impact across the life course.

Key aspects of the Auckland housing situation and impacts on community’s health outlined in this paper include:

- **Pressures on housing in Auckland**: Include population changes (such as ageing, internal and external migration, household characteristics); economic factors (such as employment, household income, investment patterns, debt and loan regulations); and property development factors (e.g. constraints on land, planning and construction industry, and profitability).

- **Supply and overcrowding**: At least 200,000 people (15% of Auckland’s population) live in crowded housing. The existing shortfall (more than 20,000 housing units, mostly for households on low incomes) is unlikely to resolve over the next decade. Demographic change is also altering demand and supply patterns.

- **Affordability**: House price and rental inflation have outstripped increases in income for most households. Increased debt and financial pressures on households can lead to compromises such as reducing spending on necessities and services; moving to lower quality housing (cold and damp); overcrowding; relocating to areas of cheaper housing but increased transport costs. A high-debt housing market is economically unstable.

- **Quality**: Auckland’s rental housing stock is frequently uninsulated and commonly damp. Households with lower incomes are more likely to live in poorer conditions.

- **Tenure**: Patterns are changing, with reducing home ownership and increasing renting. Insecure housing tenure has a destabilising impact on families and communities making it difficult to maintain social cohesion, for children and whanau to thrive and for health and education services to do their best for families. There are complex issues for some groups such as people with chronic mental illness.

The health sector has no direct levers on housing supply or quality, but has been involved in several housing related initiatives across the region.

Current projects include the Auckland Wide Housing Initiative programme on reducing the impact of rheumatic fever, involvement in the Tamaki Regeneration Project including development of a health assessment framework, service provision and support in the Western Park Village in Ranui and policy work on homelessness and overcrowding with Auckland Council, MSD, MBIE and other government agencies. The Healthy Housing and Warm ‘n’ Well programmes (which included improving insulation and heating) have finished.

The health sector also has a responsibility for identifying families who are suffering adverse health effects secondary to housing related issues, to link them wherever possible to available social and housing initiatives and to advocate for improvements.

There are potential adverse demographic and economic consequences associated with the current housing situation as people re-locate to other regions.
2. Overview

The Auckland housing situation is of widespread concern due to issues with supply, crowding, transiency and severe housing deprivation, including homelessness, affordability issues (including rising prices and high debt to equity ratios (despite historical low interest rates), poor quality and declining home ownership rates.

At all levels of government there are concerns that the Auckland housing market needs a carefully planned response and that the current situation poses an economic risk.¹

This paper gives a brief overview of (1) health impacts of housing; (2) population factors affecting the Auckland housing situation; (3) supply pressures; (4) crowding and homelessness; (5) affordability; (6) housing quality; (7) changes in tenure; and (8) current strategies to address Auckland’s housing situation.

3. Housing and Health

Access to safe and secure housing and shelter is widely recognised as a key determinant of health. The health sector has a legitimate interest in this issue both at a population level and as regards vulnerable and high risk groups. Figure 1 shows a commonly used model of the main determinants of health.

Figure 1: Dahlgren and Whitehead (1991)

Inadequate housing (including damp and cold), crowding and severe housing deprivation have a direct detrimental effect on physical and mental health and are a significant cause of illness, disability and premature mortality. Poor housing conditions are associated with a wide range of health conditions including respiratory infections, gastro-enteric illnesses, asthma, lead poisoning, injuries, and mental illnesses.

The epidemic of meningococcal disease which affected New Zealand for over a decade from the 1990s was clearly linked with overcrowding.

Rheumatic fever is linked with overcrowding, and reducing rheumatic fever episodes by two thirds by 2017 is one of the ten Better Public Service targets. A description of the AWHII rheumatic fever programme is included below in Section 8.

Earlier this year, the Auckland Coroner\(^2\) reported on the death of a two year old girl living in a substandard Housing New Zealand house in Otara as follows:

> I am of the view that the condition of the house at the time, being cold and damp during the winter months, was a contributing factor [to the illness which caused the child’s death]...

> The house in question is described as very cold and not getting much sunshine. There were no carpets and only floorboards. ... The family had requested a transfer to a better house given the living conditions and were currently on a waiting list.

> Housing NZ made available to the family a heater. Unfortunately the heater required a lot of electricity [resulting in] extremely high power bills [which the] family could not afford.

> When it rained, there was a leak in the hallway ceiling.

In his view the house was “unhealthy for this family”. A sibling had developed rheumatic fever.

Secure and affordable housing improves the ability of households in greatest need to provide a stable environment for themselves and their children with consequent improvements in health, employment and educational outcomes. A lack of affordable and adequate housing for low income individuals and families contributes to persisting inequalities in health with an impact across the life course.

4. Population factors

According to the 2013 Census, Auckland residents comprised one third of New Zealand’s total population with a usually resident population of 1,415,550 people. Auckland is the fastest growing and most ethnically diverse region of New Zealand.

Auckland’s population is also ageing. This affects housing patterns through the development of retirement villages and increased demand for smaller 1- and 2- person housing units for older people. Ethnic diversity and changes in where people from different communities live and work is affecting housing demands and patterns (e.g. for house size and quality) in many parts of Auckland. These factors are described in detail in a recent Statistics NZ report on housing in Auckland.

Aucklanders are more likely to live in a complex household. Complex households are defined as those containing a family and other people; more than one family; a group of unrelated people; or a group of related people who do not form a family, such as siblings. 30% of Aucklanders lived in a ‘complex household’ in 2013 compared with 19% for those living in the rest of NZ. Maori, Pacific peoples, and those of Asian ethnicity living in Auckland were much more likely to live in complex households than those of NZ European/Other ethnicities. In 2013, nearly half of Pacific peoples, about 40% of people of Maori and Asian ethnicities lived in a complex household, compared with about one in five people of European or other ethnicity.

5. Supply pressures

There were 473,451 occupied dwellings in Auckland at the time of the 2013 Census and a total of 33,360 unoccupied dwellings across the region (little changed from the 2006 Census).

The number of building consent issued in Auckland nearly halved following the 2008 financial crisis, to around 3,000 consents in 2009. This has increased to nearly 7,000 consents in 2014, but is still well short of the more than 12,000 consents in 2004.

Estimates from several government and community housing organisation sources indicate a housing shortfall of about 20,000 dwellings in Auckland. This situation is expected to persist well in to the future despite the current surge in development. The main shortfall is in reasonable quality housing for households on lower incomes. Current economic and industry characteristics favour construction of higher priced housing over that for lower income households. Government policy settings are based on the expectation that households on lower incomes will continue to occupy older houses, but that this will gradually improve as older stock is replaced. Housing NZ is intending to expand its stock gradually, by about 1,000 units a year plus replacement in Auckland.

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3 Census 2013 Auckland Usual Residents Snapshot, Auckland Regional Public Health Service, July 2014
5 Ibid, Goodyear R & Fabian A
6 Auckland Dwellings and Households: Initial Results from the 2013 Census. Auckland Council, May 2014
7 Housing Affordability: Outlook and Opportunities, MBIE 25 November, 2014
6. Crowding and homelessness

Crowding is a persistent problem in Auckland. Crowding is an indicator of housing affordability as people having difficulty affording accommodation may share with others as a way to reduce overall housing costs. A Statistics NZ report on Housing in Auckland\(^8\), based on the 2013 Census, noted not only the marked change in the Auckland housing market since the 1990’s but also the persistence of crowding, stating that Auckland is:

‘now distinct from most other areas in New Zealand…. Home ownership rates have fallen and are lower than elsewhere in New Zealand...What has remained largely unchanged, however, are levels of household crowding. While crowding fell in other regions in New Zealand, there has been very little change in crowding rates in Auckland, which remain among the highest in the country...Auckland also shows little spare capacity in dwelling stock... and has experienced growth in the number of households living in ‘other private’ dwellings, which include motor camps, mobile dwellings and improvised dwellings’ (although the data on these groups is limited).’

Ministry of Health estimates from the 2013 Census indicated around 200,000 people in the Auckland region (approximately 15%) live in crowded housing (using the Canadian National Occupancy Standard), including over 20% of the population in Counties Manukau DHB area.

There are concerning levels of severe housing deprivation, including homelessness, in Auckland. The most comprehensive analysis of this situation was completed by the University of Otago, based on the 2006 Census data.\(^9\) On Census night 2006, around 15,000 Aucklanders were defined as being in severe housing deprivation or homeless (includes being without shelter, in temporary accommodation such as motor camps and boarding houses), sharing accommodation and occupying uninhabitable structures. Around 5% (approximately 2,250 in the previous Auckland City area) were living on the streets or improvised/mobile dwellings. At the extreme end of this spectrum, Auckland Council estimated that around 150 people were sleeping rough in the CBD in 2014.

Those most likely to be in severe housing need or homeless include children and young people with sole parents, males, Maori, people with mental health and addiction issues and those recently released from prison who have no place to go.

Maps showing areas of household crowding in Auckland are included in Appendix One.

7. Affordability

The average house value in the Auckland region is currently $896,676.00 with inflation running at 22% over the past year.\(^10\) The current ratio of median house price to median income is 9.6:1.\(^11\)

Whilst it is accepted that ideally households should not pay more than 25% of their disposable income on housing, estimates are that low income households (the bottom 20%) are likely to be paying 40% of their disposable income on rent.\(^12\)

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\(^11\) Housing Supply, choice and affordability. Chris Parker, Chief Economist, Auckland Council, September 2015
As housing costs are generally a fixed expense, high housing costs leave less money for other items essential to good health including a nutritious diet, education, transport, heating and health services.

8. **Housing quality**

New Zealand houses are cold by international standards with one third of New Zealand homes below the World Health Organisation recommended minimum indoor winter temperature of 18°C. Damp, cold and mouldy houses are among the most common health hazards of poor housing and people living in them are more likely to have respiratory conditions, depression and other mental health problems. Damp houses are difficult to heat, and problems are exacerbated by using unflued gas heaters and poor ventilation. Insulation requirements for new houses were only introduced in 1978.

A survey by the Building Research Association (BRANZ) in 2010 found 34% of rental housing was considered damp and 73% had mould, compared with owner-occupied housing where 24% were considered damp and 53% had mould.

Programmes and research in NZ on retrofitting houses with insulation, heating and improving ventilation have found reduced childhood hospital admissions for housing related illnesses of over 25%, reductions in wheezing (40%), days off school (50%), days off work (over 35%) and GP visits (over 20%), as well as significant power savings. Benefit to Cost estimates for one of these programmes was assessed at 3.9:1 (i.e. highly favourable).

9. **Tenure**

Home ownership levels are decreasing in Auckland, in large part because of reduced affordability. Between 2006 and 2013, decreases in home ownership were documented in most Auckland Local Board areas. The lowest levels of home ownership were in Waitematā (39% ownership in 2013), Ōtara-Papatoetoe (46% ownership in 2013), Manurewa (55% ownership in 2013), and Māngere-Ōtāhuhu (42%). Since 2001, the percentage of households renting privately in Auckland has increased, while the percentages renting from Housing New Zealand or a local authority have fallen.

The 2012 Household Incomes Report identified that nationally 70% of children from low income households live in rental accommodation – 20% in Housing New Zealand Corporation (HNZC) properties and 50% in private rentals.

Transiency is a significant issue for those in rental accommodation. At the time of the 2013 Census, 35% of people in households in Auckland who rented had lived there for less than one year compared with 14% of those who owned their home or held it in a family trust. For children in rented homes, 28% of five - nine year-olds and 25% of 10-14 year-olds had moved at least once

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within the last year (compared with 12% and 10.5% for children in these age groups who lived in homes that were owned or in a family trust)\textsuperscript{14}

There are severe inequalities in home ownership in Auckland with rates of home ownership of 24% for Maori, 17% for Pacific and 36% for those earning <$20,000.00 per annum. \textsuperscript{15}

10. Strategies to address housing need in Auckland

The housing sector is extremely complex with a large number of central and local government agencies involved in addition to the private (developers, architects, planners, engineers, tradespeople, suppliers, banks) and not for profit sectors (Salvation Army, Habitat for Humanity etc.). New housing developments have complex infrastructure requirements and intensification increases demand on existing infrastructure.

Central Government agencies involved include the Treasury, Ministries of Social Development, Business, Innovation and Employment and the Housing New Zealand Corporation. The Reserve Bank has macro-economic tools that can be used to place controls on the market. The central government’s approach to the Auckland housing situation can be categorised according to two major headings: housing affordability and supply; and social housing reform.

Auckland Council is also closely involved and established a Housing Project Office in 2013. It is leading implementation of its Housing Action Plan and is working with the government on the identification, assessment and facilitation of approvals for Special Housing Areas (SHA). The Auckland Council is also in the process of hearings related to the Proposed Auckland Unitary Plan and, with Auckland Transport, major developments in transport infrastructure.

10.1 Special Housing Areas and the Housing Accord

Legislation passed in 2013 allows councils and central government to enter into Housing Accords to facilitate cooperation between local and central government on housing issues. As part of the accord, SHAs can be identified which need to meet a number of criteria such as housing density and height, and may include requirements for a proportion of “affordable” houses. In the Auckland Unitary Plan, one model of “affordable” housing is that it is priced at less than 75% of the median price for houses in its category or in the development. This would generally be done by building smaller units with less expensive fittings. In exchange, planning and other development requirements are simplified.

Although nearly 100 SHAs have been identified, the scheme is still in its early stages so only about 100 houses have been completed. The SHAs are expected to deliver several thousand units sooner than they would have otherwise, although the effectiveness of SHAs will not be known for several years. There are concerns about adequacy and funding of infrastructure and local community facilities in SHAs.

10.2 Housing affordability

Initiatives to improve housing affordability and supply include:

\textsuperscript{14} Ibid, Goodyear & Fabian
\textsuperscript{15} Housing Supply, choice and affordability. Chris Parker, Chief Economist, Auckland Council, September 2015
• Changes to Reserve Bank rules around mortgage lending (for both owner-occupied and rental housing)

• Supporting first home buyers through the Kiwisaver Homestart deposit subsidy; Kiwisaver first home withdrawal and ‘welcome home loans’

• Changes to land use regulation and future Resource Management Act (RMA) amendments to promote and expedite residential developments

• Increasing housing supply through the Housing Accord with Auckland Council and Special Housing Areas Act;

• Proposals to develop excess Crown Land and HomeStart for new build.

10.3 Social housing reform programme

The Government commenced its Social Housing Reform programme in 2012. Whilst the government remains by far the major provider of social housing in Auckland (over 30,000 properties in the Auckland Region), the Housing Reform Programme aims to reduce reliance on central government as the main provider of social housing. In regards to social housing provision this has included (but is not limited to):

• Introduction of reviewable tenancies for all new and existing Housing New Zealand tenancies (as of 1 July 2014) and those tenancies managed by registered social housing providers (non-government organisations and agencies) receiving Income Related Rent Subsidy (IRRS).

• Passage of the new Social Housing Reform (Housing Restructuring and Tenancy Matters Amendment) 2013 legislation has enabled registered Class 1 Social Housing Providers to access IRRS for new tenants.

• The Housing Restructuring and Tenancy Matters Amendment Act also enabled the transfer of housing needs assessment from HNZC to the Ministry of Social Development (MSD) as of April 2014 (including the responsibility of allocating of IRRS and reviewing tenancies).

The Government has a stated intention to grow the community housing sector and to that end is actively looking to transfer some HNZC houses to the non-governmental sector, linked with changes to income-related rents for affected tenants. To date, most community housing agencies have declined to be involved, and nor are they in a position to have substantial building or purchasing programmes themselves.

The Government has also recently announced a two million dollar temporary increase in emergency housing funding for up to 30 families, for a maximum of 12 weeks, starting in 2016 and running for two years16.

10.4 Rental housing quality

Earlier this year the Government announced changes to requirements for rental accommodation. These include compulsory smoke detectors (from 1 July 2016), and minimum standards for insulation (from 1 July 2016 in social housing and 1 July 2019 for private rental housing). In addition,

landlords will be required to inform prospective tenants about insulation and other issues. There are a number of exemptions from the insulation requirements.

This proposal falls well short of the Rental Warrant of Fitness proposal which was successfully trialled by several local authorities in 2013-14.

10.5 Health Sector Activities

Current projects include the AWHII programme on reducing the impact of rheumatic fever, involvement in the Tamaki Regeneration Project including development of a health assessment framework, service provision and support in the Western Park Village in Ranui and policy work on homelessness and overcrowding with Auckland Council, MSD, MBIE and other government agencies. The Healthy Housing and Warm ‘n’ Well programmes (which included improving insulation and heating) have finished.

10.6 Western Park Village in Ranui

The park is situated on ten acres and offers 60 caravans and another 60 units (including cabins, small units, trailer homes and powered sites). Residents pay rent and may incur additional charges for cleaning, linen, appliance hire, or use of a washing machine, dryer or shower. Accommodation is very basic and particularly cold and damp in winter. There are poor quality cooking and toilet facilities and limited communal space and areas for children to play. The park is privately owned and the current owners live onsite.

At any one time there are around 300 people, including up to 50 children, living in the park. A high proportion of the residents are Maori. People can rent on a casual basis – but the average length of stay is approximately a year. The costs of the caravans and units are relatively high ranging from $195 per week for a small unit with a hand basin to $480 per week for a 3 bedroom unit. Given that most of the residents are on benefits for many residents there is very little money left over after they have paid for rent.

The people residing within the Western Village Caravan Park are amongst the most vulnerable in our district. Many residents live a day to day existence and battle to meet basic human needs and there is a concentration of health and social issues amongst the residents. Families with young children live alongside single people of all ages, people with a history of incarceration or who are on bail, people living with mental health and/or addiction problems, and people who have experienced discrimination and family violence.

A number of Waitemata DHB staff have raised concerns about the conditions in the park and the health of the residents living there. As a result, the DHB has allocated additional funding to the Child and Family Service to enhance the services provided within the park. This funding was targeted to four key initiatives. These are:

1. Increase the scope and hours of the public health nursing service to the park (from 0.20fte to 0.40fte).
2. Subsidise and/or provide free primary care services to the residents of the park
3. Support and fund the hub co-ordinator to promote local health services, support residents to enrol and access services and enable the delivery of healthy living programmes for residents.
4. Provide ‘welcome packs’ as a means of engaging with new residents.
The Mobile Health Clinic funded by the Well Foundation has been used to support the public health nursing service and visits the park on a weekly basis.

10.7 House crowding and Rheumatic Fever Incidence

Rheumatic Fever is one of the 10 Better Public Service targets and ADHB is contracted to support the reduction of Rheumatic Fever by two thirds by 2017. The AWHI Hub was established through a direct contract between the Ministry of Health and an NGO alliance to develop a housing plan that addresses crowding for children and families at risk of rheumatic fever. The AWHI Hub is located in the community and works alongside eligible families to assess housing need and develop a housing plan to reduce structural or functional overcrowding. The assistance available for these families includes:

- HNZC will improve five capital interventions - carpet, ventilation, heating, curtains and insulation, as well as some minor repairs.
- MSD will undertake a full and complete financial entitlement assessment (FACE) and assist families that require alternative accommodation.

The DHB works alongside the AWHI Hub to embed referral pathways for at risk children and refer them to the AWHI Hub. A recent review of all the eligible bronchiectasis patients at Starship has shown that 92% have had work completed on their homes (or in the process of having work completed) as a result of this work. There remains a concern with the length of time taken to complete interventions included in each of the workplans, with over 300 AWHI families across Auckland needing insulation, over 350 needing curtains, over 150 needing beds and bedding, over 200 needing ventilation and over 450 waiting for social housing. A significant delay in the supply of materials and labour to complete the identified interventions continues to contribute to the delay in these interventions being completed. These interventions are reliant on multiple agencies supporting and contributing to complete identified interventions. These agencies include MSD, Auckland Council, Treasury, MBIE, HNZC and others. Those families who have received full and complete interventions have identified a very positive outcome.

In recognition of the need to form better pathways, a review of AWHI by the Ministry of Health in 2014, has resulted in referral pathway changes being made between AWHI, MSD and HNZC, and also between AWHI and the DHB. This has improved outcomes for families through reduced timeframes for interventions and a co-design process is currently underway to develop workable and sustainable supply.

11. Conclusion

Housing affordability, supply and security are major issues within the Auckland region. Having a suitable and secure dwelling in which to house oneself and one’s family/whanau is an important determinant of health. Serious and on-going health issues are one of the many adverse consequences arising from insecure and poor quality housing. There is an acknowledged housing shortage in Auckland and despite current efforts this is likely to persist for many years yet. Whilst low income families are most severely impacted, first home buyers are struggling to make their way into the housing market.

There are concerns about the on-going social and economic impacts of the Auckland housing situation.
Both central and local government have a range of plans and actions underway to increase supply, improve affordability and reform the social housing sector.

The health sector needs to continue to monitor the housing situation and also the rates of illnesses commonly associated with unsatisfactory housing. The health sector also has a responsibility for identifying families who are suffering adverse health effects secondary to housing related issues, to link them wherever possible to available social and housing initiatives and to advocate for improvements.
Appendix One: Maps of Household Crowding

West Auckland CAU and Local Boards
Appendix Two: Special Housing Areas in Auckland

Special Housing Areas (Tranches 1 - 7)
4.1 New Zealand Health Strategy - Refresh

Recommendation

That the Community and Public Health Advisory Committee:

1. Receive the report.

2. Note the deadline for submissions on the draft New Zealand Health Strategy is 5pm Friday, 4 December 2015.

3. Provide feedback on any issues they would like included in the DHB submission.

Prepared by: Wendy Bennett (Manager, Planning and Health Intelligence ADHB/WDHB), Karen Bartholomew (Acting Clinical Director Health Gain ADHB/WDHB)
Endorsed by: Simon Bowen (Director Health Outcomes ADHB/WDHB), Dr Debbie Holdsworth (Director Funding ADHB/WDHB), Andrew Old (Chief of Strategy, Participation and Improvement ADHB)

Glossary

DHB - District Health Board
MoH - Ministry of Health
MRG - Ministerial Review Group

1. Introduction

The Minister of Health asked the Ministry of Health (MoH) to lead a refresh of the New Zealand Health Strategy 2000. The refreshed Strategy proposes to build on the current progress of the New Zealand health and disability system and improve its adaptability and responsiveness to meet future needs. The draft Strategy has recently been released for feedback.

2. New Zealand Health Strategy

The New Zealand Health Strategy has not been updated since 2000. The Ministry has developed the draft update of the Health Strategy with input from clinicians, leaders and organisations in the health, disability and social sectors. This included a series of meetings and workshops held over May and June 2015. In addition to this engagement, inputs to the draft update include other government programmes and initiatives, for instance, Better Public Services targets; independent reviews on sector funding and sector capability and capacity; and the Productivity Commission’s recent report on social services.

The draft updated Strategy aims to provide a clear view of the future of the health system over the next 10 years, to ensure all New Zealanders ‘live well, stay well, get well’. A Roadmap of Actions proposes a direction of travel for the next five years (see Appendix 2). The draft updated Strategy covers challenges and opportunities for the health system, and its future direction, including principles and behaviour that will enable it.
1. people-powered  
2. closer to home  
3. value and high performance  
4. one team  
5. smart system.

The seven original guiding principles remain, with a new principle added: thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing. Including this principle signals the need for new ways of working to improve our health system (see Appendix 1).

Priorities include prevention and wellbeing, more integrated services, support for innovation, better collaboration, new ways of working to reach our most vulnerable, giving every child a healthy start, enabling people to control their own health with patient technology, and ensuring information and services are more accessible.

Notable examples of good practice highlighted in the Strategy include the e-tool SPARX, the health and design lab at Auckland DHB and the Healthy Auckland Together coalition to address obesity which was initiated by the three Auckland DHBs and led by the Auckland Regional Public Health Service.

3. High level commentary

The Strategy refresh is a significant opportunity to provide leadership and direction to the New Zealand health system. Overall the strategy is simple, concise, and easy to read. It acknowledges that there have been challenges in delivering on the principles articulated in the 2000 Health Strategy, and that broad examination of patient experience, systems and services, and funding are important in order to recommit to those high level principles while stretching them further to add collaborative interagency working.

The strategy justifiably emphasises a number of strengths of New Zealand’s health system. These include:

- a publicly funded, universal health system with a committed and highly trained workforce
- a strong primary care focus
- a no fault ACC compensation system
- local decision makers in DHBs well positioned to respond to community needs
- Maori and Pacific providers connected to their communities

The draft Strategy signals some change. In a number of places there is reference to a targeted investment approach with social benefits, particularly in bringing care closer to home and assisting in making informed trade-offs in investment decisions (under the principle of value and high performance). For example Roadmap Action 11 proposes to ‘develop and use a health investment approach with DHBs … to target high-need populations to improve overall outcomes’. There is an
increased focus noted on collaborating across government, with examples of the Social Sector trials and Children’s Teams and indications of expansions of these approaches. There is also a commitment to the development of a national electronic health record and sharing of health information to support targeted intervention, integration and monitoring of outcomes.

Despite the potential significance of a health investment approach in terms of change for the sector, most of what is in the strategy represents a continuation of current approaches. For example the implementation of the Roadmap guide (Appendix 3) does not contain large scale or new actions to match the approaches signalled in the Strategy itself; including in the areas of prevention, technology and people-centred care which are key principles of the document.

Although population based strategies are mentioned there is no activity indicated at this level. Our population is one of the most obese and we have very high rates of alcohol-related harm and domestic violence and well documented issues with inadequate housing. These are key areas that impact on health and the social sector where there is opportunity for policies, population health interventions and interagency collaboration.

A move to outcomes based reporting and commissioning is signalled as new activity in the Strategy however this is already aligned with current Waitemata and Auckland DHB Outcomes Frameworks and focus. A movement from treatment to prevention and support is mentioned several times in the Strategy. A focus on health outcomes would support moves to a preventative approach, however the Strategy and its implementation roadmap do not provide any concrete preventative approaches such as a national Bowel Screening Cancer Programme or specific opportunities in primary care to reduce hospital demand. There is a very significant burden associated with mental ill health but the Strategy does not include addressing this area, or specifically about how we will prevent and improve treatment for the largest causes of death and ill health (cardiovascular disease and cancer).

The principle of care closer to home is strengthened in the refreshed Strategy. While the ongoing need for treatment is briefly noted, the section does not mention that there are some instances where improved efficiency can be gained from regionalisation or centralisation of some high cost or specialised services. There is likely to be a trade-off between providing more services locally and making other investments such as prevention, improving equity or providing access to drugs and interventions that prolong life such as advanced pharmaceutical therapies (eg for Hepatitis C and melanoma).

The Action Plans need further development – they lack clarity on what will actually be delivered and how success will be measured. It is unclear what will specifically be required of DHBs and how real interagency collaboration might be actioned or measured. For instance Action 3 in relation to closer to home proposes to ‘ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way.’ Proposals to clarify roles, responsibilities and accountabilities are the subject of further reviews by the Ministry of Health.

4. Consultation

Consultation is now open on the draft strategy. Auckland and Waitemata DHBs will be developing a submission on the draft Strategy.

Feedback is being welcomed from any person or organisation interested and there are a number of ways to submit formal feedback. The Ministry of Health website details the various options for feedback:

Those interested can complete an online survey or email feedback to nzhs_strategy@moh.govt.nz. Feedback may also be posted to:

New Zealand Health Strategy Update Consultation
New Zealand Health Strategy Team
Ministry of Health
PO Box 5013
Wellington 6145

Consultation closes 5 pm Friday, 4 December 2015. The Ministry aims to consider all feedback and reflect common themes in the final, updated New Zealand Health Strategy - expected to be released in the first half of 2016.

5. Conclusion

In conclusion it is positive that the Ministry has undertaken to refresh the Strategy and it is a significant opportunity to provide leadership and direction to the New Zealand health system. There are some changes signalled in the Strategy and the associated Sector Capability and Capacity Review and Funding Review such as the commitment to a health investment approach. However there are some opportunities to strengthen the Strategy and provide more detail about how it will address some of the key health challenges and provide more ambitious use of technology as a health enabler.

Along with the web-based discussion forum, online and other feedback options, the Ministry of Health has organised more than 80 workshops, meetings, hui and fono around the country to gather feedback on the draft New Zealand Health Strategy. They are seeking a wide range of views from anyone who has an interest in the future direction of the health sector and members are encouraged to provide their views through the DHB submission on the Strategy or personally through one or more of the other avenues available.
Appendix 1

Refreshed guiding principles for the system

1. The best health and wellbeing possible for all New Zealanders throughout their lives
2. An improvement in health status of those currently disadvantaged
3. Collaborative health promotion and disease and injury prevention by all sectors
4. Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
5. Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
6. A high-performance system in which people have confidence
7. Active partnership with people and communities at all levels
8. Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing
## Appendix 2
### Summary of actions

<table>
<thead>
<tr>
<th>People-powered</th>
<th>1. Improve coordination and expand delivery of information to support self-management in health through digital solutions.</th>
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<td>2. Promote people-led service design including for high-need priority populations.</td>
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<tr>
<td>Closer to home</td>
<td>3. Ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way.</td>
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<td></td>
<td>4. Enable all people working in the health system to add the greatest value by providing the right care at the earliest time, fully utilising their skills and training.</td>
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<td>5. Increase the effort on prevention, early intervention, rehabilitation and wellbeing for long-term conditions and for obesity.</td>
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<td></td>
<td>6. Collaborate across government agencies, using social investment approaches, to improve the health outcomes and the equity of health and social outcomes for children, families and whānau, particularly those at risk.</td>
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<tr>
<td>Value and high performance</td>
<td>7. Implement service user experience measures.</td>
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<td>8. Implement a health outcome-focused framework to better reflect links between people, their needs, and outcomes of services.</td>
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<td>9. Work with the system to develop a performance management approach with reporting that enhances public transparency.</td>
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<td>10. Align funding across the system to get the best value from health investment, starting with better access to those most in need, improved delivery of major capital expenditure, and more effective commissioning by contracting for outcomes.</td>
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<td></td>
<td>11. Develop and use a health investment approach with DHBs and consider using this to target high-need priority populations to improve overall outcomes while developing and spreading better practices.</td>
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<tr>
<td>One team</td>
<td>12. Continuously improve system quality and safety.</td>
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<td>13. Improve governance and decision-making processes across the system, through a focus on capability, innovation and best practice, in order to improve overall outcomes.</td>
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<td>14. Clarify roles and responsibilities and accountabilities across the system as part of the implementation of the Strategy.</td>
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<td>15. Establish a simplified and integrated health advisory structure.</td>
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<td>16. Implement a system leadership and talent management programme and workforce development initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility.</td>
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<td>17. Create a ‘one team’ approach for health through an annual whole of system forum, sharing best practice and contributing to a culture of trust and partnership.</td>
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<tr>
<td>Smart system</td>
<td>18. Increase New Zealand’s national data quality and analytical capability to improve transparency across the health system.</td>
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<td>19. Establish a national electronic health record that is accessed via certified systems including patient portals, health provider portals, and mobile applications.</td>
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<td></td>
<td>20. Develop capability for effective identification, development, prioritisation, regulation, and uptake of knowledge and technologies.</td>
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Appendix 3
4.2 Community Engagement and Participation Update for Auckland and Waitemata DHBs

Recommendation

That the report be received.

Prepared by: Tony O’Connor (Director Participation and Experience ADHB), Carol Hayward (Community Engagement Manager WDHB), Sue Copas (Community Participation Manager ADHB), Wiki Shepherd-Sinclair (Health Link North) and Tracy McIntyre (Waitakere Health Link)

Endorsed by: Simon Bowen (Director Health Outcomes ADHB/WDHB), Andrew Old (Chief of Strategy, Participation and Improvement ADHB) and Wendy Bennett (Manager Planning and Health Intelligence ADHB/WDHB)

Glossary

DHB - District Health Board
NGO - non-government organisation

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.

2. Work on Strategies/Work Programmes and Policies

An engagement strategy will be presented to the Waitemata DHB Board in December. This considers why it is important to involve patients, their families or whānau and the wider community in developing plans, improving services and monitoring how well we are performing. The strategy will build on existing programmes of work and demonstrate how engagement supports the DHB’s promise, purpose, priorities and values.

Auckland DHB has established a Steering Group to define an integrated, DHB-wide work programme and drive improvements in patient, whānau and community participation in service planning and improvement and the delivery and experience of care. The initial framework for the work programme is evidence-based and includes the following areas of focus:

- Leadership, values and culture
- Engaging patients and whānau at the point of care
- Working with communities
- Measurement, evaluation and feedback
- Healing environments (including but not limited to facilities)
- Supportive communications and technology

Each focus area will be coordinated with the others and an owner responsible for the definition and delivery of it. Currently, there is action in each focus area (eg, Tamaki Wellbeing programme). However, some new activity is needed to ensure that participation is as accessible and effective as it
should be (eg, the outpatients ‘poor’ and ‘fair’ experience of care ratings need to be properly understood so we can address the underlying issues).

To maximise meaningful community participation in this initiative and to help ensure we address inequities, the membership of the Steering Group includes Te Kahu Pokere, TANI (The Asian Network Incorporated), Be Accessible (a leading accessibility social change agency) and a Pacific community leader nominated by the Auckland and Waitemata DHB General Manager Pacific. The Steering Group also includes senior clinical and management staff and is involving the Board to ensure the work programme will deliver on the Board’s priorities.

The joint Auckland and Waitemata DHB Public Consultation and Engagement Policy is in the process of being updated. The current policy was due for review and the opportunity is being taken to ensure that the policy fits with the new ADHB and WDHB engagement and participation strategic approaches.

3. Progress, Achievements and Activity

3.1 Health Services Plan

A stakeholder workshop was held to gain input into the development of the Waitemata DHB Health Services Plan. 61 stakeholders attended the event which included representation from PHOs, a range of NGOs, other agencies such as the Ministry of Social Development, Ministry of Education, ACC and the police plus consumer representation both through health links and through DISAC and CPHAC representatives.

Common themes from the table discussions were:

- need better working together, sharing of information and connectivity between agencies and providers
- desire for more health coaches and navigators from the community
- more community based services and more of a focus on prevention of illness and healthy lifestyles
- need a stronger focus on Māori, Pacific, Asian communities and people with a disability
- more specialist advice available for GPs – use of technology to enable and support this.

Views from stakeholders were incorporated into the plan which has now been presented to the board.

3.2 Reo Ora Health Voice – online community

Workshops have been taking place with community representatives to gain a range of perspectives on how we can redesign the existing website to make it attractive, accessible, appealing and easy to use for our many culturally and linguistically diverse communities.

Key aims for the panel are that it becomes:

- a voice that is representative (as far as possible) – one that reflects our population’s breadth and depth
- a voice that is valued and able to influence services
- timely – allowing time where needed, and also engaging authentically and respectfully with timely feedback loops to panel members
- complementary to face to face and other forms of engagement
• sustainable – with senior leadership buy-in, organisational champions and adequate resourcing; and
• technologically engaging.

Community and stakeholder involvement will continue over the coming months as an implementation and recruitment plan is developed.

3.3 Community Consultation on the New Zealand Health Strategy
Auckland DHB received a request from the Ministry of Health to help consult the Auckland DHB community about the draft health strategy. An invitation was sent to Reo-Ora community panel members (excluding staff). The community workshop was held 5 November. Panel members were also sent a hyperlink to provide feedback online.

3.4 Supporting the Women’s Collaboration work
Ongoing advice and support has been provided through the women’s collaboration steering group as the maternity services plan has been progressed. A stakeholder workshop has been scheduled to take place on 25 November to launch this plan.

A consultation and engagement plan has been put in place to support the plan’s implementation through working groups for each of the strategic themes, and a formal public consultation on primary birthing unit options that will take place in 2016. Engagement will involve the use of the Reo Ora Health Voice online engagement website and working in partnership with key service and community providers such as Te Rūnanga o Ngāti Whātau and TANI.

3.5 Supporting the development of a transgender care pathway
Options for a transgender care pathway have been co-designed through an advisory group with transgender representatives and clinicians who work in the areas of primary care, child and youth health, sexual health, mental health, surgery and endocrinology.

A draft pathway and service specification was presented to the transgender community through a series of community workshops in July across the Auckland Metropolitan region for feedback and to gain an understanding of the community’s perspectives and experiences to date. This was supplemented by an online survey and the facilitation of a number of patient stories.

This is now being developed further into a proposal for consideration by the DHB Boards later this year.

3.6 Co-designing patient journeys
A project is underway to review the journey for patients through the Waitemata DHB Upper GI Cancer service. The project involves mapping the current journey (both from a process and emotional/behavioural perspective) and co-designing the optimal journey. A visual journey map has been prepared and will be used to create an interactive digital map to allow patients to better understand their potential health journey and access the right information at the right time.

3.7 NEHR (Northern Electronic Health Record)
A consumer working group has been established to support the Northern Electronic Health Record programme. Patient Engagement Leads have been identified from both DHBs and consumers will also be appointed. The workstream has a planning and monitoring function and is expected to ensure that consumers are suitably engaged across all workstreams.
3.8 Health Link highlights

New three-year contracts are now in place between Waitemata DHB and the two health links: Waitakere Health Link and Health Link North. To help support contract changes, training was provided by the DHB to both health links in Results Based Accountability and Engagement Essentials from the International Association of Public Participation (IAP2).

3.9 Consumer representative forum

A Waitemata consumer representative forum took place on 5 November with over 40 attendees from a mixture of consumer representatives, DHB staff, health literacy volunteers and consumer advisors (paid staff). The purpose of the forum was to:

- Identify what support is required by consumer representatives (including training, mentoring, networking opportunities).
- Enable networking between consumer representatives so they can learn from each other and share their experiences.
- Understand any concerns or issues that consumer representatives have that require additional follow up.
- Celebrate success stories of what is working well and where consumer representatives have added value to be used in news items, promotion and marketing activities.
- Consider how to encourage more people to be consumer representatives and how to attract different demographics and service users.

Based on feedback from the day’s discussions, a new framework of support for consumer representatives will be developed. Comments from consumer representatives on the day included:

- If consumer reps are volunteering their time, it is likely that they are very passionate about change. It is in accordance with this, that I believe Consumer Reps and the WDHB senior management as well as the board should have a strong relationship where Consumer Reps are appreciated for their time and input.
- Reach out to more young people, I think more young people would like to be involved but wouldn’t know how.
- Need more training of Consumer Reps eg: structure, policy, process
- Working in a consumer role is a unique opportunity to improve people’s experiences
- Want time to be valued – easier access to parking and knowing whether we will get a voucher or parking ticket beforehand helps to encourage us.

3.10 Open days at Waitakere and North Shore hospitals

An NGO open day took place on 3 November at Waitakere Hospital to coincide with Patient Safety Week. Over 35 NGOs had stalls at the open day and for the first time some GPs attended. An evaluation is currently under way but stall holders commented that they had found the day valuable and were pleased with the level of interest. One of the GPs commented: “Had some great conversations and learnt a lot about some quite useful NGOs.”

Discussions are underway for holding a similar event at the North Shore Hospital.

3.11 Volunteer Shop at Waitakere Hospital

Waitakere Health Link have played an active role in supporting the volunteers and advocated strongly for a new shop site when they were moved out of their former location, including identifying the community’s support. The new shop is now open.
3.12 Focus group on accessing health services for baby

Waitakere Health Link facilitated a focus group with young first time Pacific and Māori mums so that the DHB could engage with them about breastfeeding, support services for baby at home and other free services that were available to them. The feedback from the mothers will have an impact on how the DHB will shape services, for example, discussions are underway with Plunket around establishing a Pacific mothers group to provide support for the mothers who might not feel that antenatal classes are a suitable option for them.

3.13 AGMs

Waitakere Health Link’s AGM took place on 15 September with nearly 70 people attending. It included a presentation on nutrition services in primary care. A new board member from the Ranui community has been appointed.

Health Link North’s AGM took place on 25 September. The guest speaker was Trevor Simpson, the Deputy Executive Director Senior Health Promotion Strategist of the Health Promotion Forum of New Zealand. He spoke on “Preparing for the future - an effective and competent Māori workforce”. Three new board members have been appointed to fill one vacant spot and to replace members who had stood down.

3.14 Contact centre feedback

As part of the work to update the existing contact centre, Waitakere Health Link solicited feedback through their health literacy group and board members on concerns experienced in relation to the contact centres and in an ideal world, what would users like to see in terms of new technology. Points raised included:

- Couldn’t leave a message had to keep ringing back, then gave up
- The menu doesn’t provide the correct options so people just press any number just to talk to someone
- Second language is a barrier to accessing via the phone
- Ability to book, confirm and review appointments online
- Need 0800 numbers for people to ring on mobile phones as more and more people do not have landlines and don’t want to be charged for the call
- Need confirmation via the medium booked through eg, confirmed by email, the reply needs to be via email
- Conflicting appointments – a second contradictory letter being received in the post before the first letter. Receiving letters of appointments the day of the appointment or with very little advance notice.

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 provide updates on work in progress.
5.1 Primary Care Update Quarter 1, 2015/16

Recommendation

That the report be received.

Prepared by: Tim Wood (Deputy Director Funding and Development Manager - Primary Care, WDHB/ADHB) and Dr Stuart Jenkins (Clinical Director – Primary Care, WDHB/WDHB)

Endorsed by: Dr Debbie Holdsworth (Director Funding, WDHB/ADHB)

Glossary

ALT - Alliance Leadership Team
ATD - Access To Diagnostics
CARE - Co-ordinated care, Assessment, Rehabilitation and Education
CARs - CARE Action Resources
DAR - Diabetes Annual Review
DSLA - Diabetes Service Level Alliance
DHB - District Health Board
FTE - Full Time Equivalent
GNS - Gerontology Nurse Specialists
IPIF - Integrated Performance Incentive Network
MACGF - Metro Auckland Clinical Governance Forum
MoH - Ministry of Health
NHT - National Health Target
NZCMHN - New Zealand College of Mental Health Nurses
NGO - Non-governmental organisation
PHO - Primary Health Organisation
PMS - Patient Management System
SMO - Senior Medical Officer
VDR - Virtual Diabetes Register
WPHO - Waitemata Primary Health Organisation

Summary

This report provides an update on specific primary care activities across the Auckland and Waitemata District Health Boards (DHBs) which have shown variance during the first quarter (Q1) of the 2015/16 financial year. The report is presented under the following headings:

- Primary Care Highlight (Q1), 2015/16 Annual Plan
- National Health Targets (NHT)
- Integrated Performance Incentive Framework (IPIF) – data not released until 25/11/15
- Exception reporting and highlights against the 2015/16 Annual Plan deliverables.
1. Primary Care Highlight (Q1), 2015/16 Annual Plan

1.1 The CARE (Co-ordinated Care, Assessment, Rehabilitation and Education) Project

The CARE (Co-ordinated care, Assessment, Rehabilitation and Education) Project is a Waitemata DHB pilot undertaken in partnership with ProCare and Waitemata Primary Health Organisation (WPHO). The project receives oversight from the CARE Project Steering Group and this includes consumer, DHB secondary care, PHO and clinical representatives chaired by the project sponsor, Tim Wood. The project aims to improve the health of people aged 75 and over and Maori and Pacific people aged 65 and over, who are at high risk of unplanned hospitalisation or other adverse outcomes, by providing a whole-system approach, integrating primary care and hospital services.

An outcome evaluation will determine whether the CARE Project leads to a reduction in acute hospitalisations and bed days, and delayed aged residential care placement. It will also investigate whether the new service delivery model impacts on secondary outcomes such as other health service utilisation, quality of life, and overall costs. The evaluation will also capture implementation issues and inform any future rollout.

The CARE service delivery model includes a range of proactive primary care-based interventions as outlined in the Figure 1 below.

Figure 1: CARE Project interventions

A key feature of the service delivery model is supporting and upskilling practice nurses and general practitioners in the care of older patients at risk of hospitalisation. General practices receive ongoing mentoring and support from three Gerontology Nurse Specialists (GNSs), equating to one Full Time Equivalent (FTE), who have been seconded to the project from the WDHB community team. General practices also have access to the project clinical leader, Dr Diana North (a general practitioner) and Dr John Scott (geriatrician, WDHB).
In summary, participating general practices will:

- Carry out a comprehensive assessment of patients’ needs for the at risk cohort
- Compile a care plan with the patient (and family/whanau), and coordinate services and referrals in a more proactive manner
- Proactively follow-up any patients discharged from hospital
- Regularly review and monitor patient needs from the patient’s perspective.

The development and implementation of the CARE Project service delivery model represents a significant change for the delivery of primary care. A highly collaborative approach which includes GNS support, regular collaborative workshops, focus on quality processes and evaluation is being adopted to this change management process as it is critical that general practices are fully engaged and support the new model.

In terms of development and progress to date, the CARE Project Business Case was approved at the November 2014 Board meeting. Further development occurred in early 2015 and various practices were approached to confirm their interest to participate between April and July 2015.

Currently five general practices (Kaipara Medical Centre, Orewa Medical Centre, Silverdale Medical Centre, Family Doctors Whangaparaoa, Whangaparaoa Medical Centre), are in the early phases of implementing the project. Other general practices in the Rodney/North Shore area likely to be included next year as part of a phased approach. Several practices declined to participate in phase one due to a range of reasons, but largely due to funding concerns or capacity and logistical reasons (e.g. insufficient space, nurse or general practitioner availability).

A phased implementation approach is now planned as the current cohort includes 669 patients across the five practices and there is a need to add practices/patients to achieve a cohort of 1,250 patients for the full pilot evaluation.

There has been some delay to the commencement of the project due to difficulties setting up and training practices to use the Shared Care platform, delays in providing the patient lists (technical issues in compiling the lists), and in developing an electronic format for care planning that is embedded in the Practice Management System (PMS). These processes and tools are now fully developed and documented to enable more efficient set-up for further practices in Phase two.

In summary the set-up phase between July and September 2015 has included:

- Establishment of a process to risk stratify patients (i.e. a method to identify the top 25% or so high-risk patients of hospitalisation), distribution of patient lists, and guidance to practices on patient selection (e.g. exclusion of patients in Aged Residential Care facilities)
- Provision of a patient information form and invite letter/process
- Set-up of the comprehensive assessment (including the Self Management questionnaire, Partners in Health, and an assessment summary report) and practice set-up on the Health Alliance Shared Care platform
- General Practice Team engagement including provision of training workshops, regular visits and communication that facilitates a collaborative approach to the project development and implementation
- Provision of GNS team support to work through mock assessments, resolve project process/tool set-up issues, provide training, and establish ongoing mentoring and support
- Final development (clinical input from GNS, secondary care, Dr John Scott and primary care representatives), and distribution of the CARE Action Resources (CARs) along with a directory of community resources to further assist a self management approach and care planning

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 25/11/15
- Development and set-up of an electronic care planning tool based on the CARs to streamline care planning and secondary care referrals
- Set-up of evaluation processes that enables electronic monitoring of the project and minimises PHO and practice manual data gathering.

Since October 2015 the project team has worked with the practices to enable them to work through a mock assessment and complete the set-up process prior to full patient recall. In November 2015 practices commenced patient recall and assessments.

Feedback from general practice teams at the 12th November 2015 collaborative workshop along with a series of follow-up interviews with declining practices (currently in process), will be used to plan phase two of the project with a possible start of February/March 2016. So far, participating practices have provided positive feedback on the project resources and tools and are highly engaged in the project.

Supplementary funding from the WELL Foundation has been provided to deliver an initial series of six patient Self Management Education groups. These groups are scheduled to run for six weeks between February and October 2016 and are based on the Stanford Chronic Disease Self Management programme. In addition, the WELL Foundation has secured sponsorship from Barfoot & Thompson that covers the majority of the costs associated with the GNS involvement in the project.

In summary, the project has been slightly delayed from the updated timeline established early in 2015 and now requires a phased approach, but excellent traction and progress is being made and practice engagement is high and overall positive towards the project. Phase two will be planned building on the early collaborative success of phase one, with the intention of increasing the cohort to 1,250 patients. This will enable a full evaluation of the project outcomes and the implementation process will provide an evidence base to support the model of care/intervention and any future roll out. The pilot will run until September 2017.

2. National Health Targets

The Primary Care Scorecard (Figure 2), is a standardised tool that is used by both Auckland and Waitemata DHBs to internally review and track performance against a range of measures including the National Health Target (NHT).

The Scorecard shows for each measure the actual performance of both DHBs during Q1 2015/16, against the NHT.
### Figure 2: Auckland & Waitemata DHB Primary Care Scorecard (Q1)

#### Auckland and Waitemata DHB Monthly Performance Scorecard

**Primary Care Outcome Scorecard**

#### Auckland DHB

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieved/ On track</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substantially Achieved/below target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Achieved/off track</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### How to read

1. **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. **Actuals and targets** in grey bold text are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented.

#### Key notes

- Small data range may result in small variations perceived to be large.
- Performance was compared to previous month.
- Performance was maintained.

#### A question?

**How to read**

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#### A question?

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#### Key notes

- Small data range may result in small variations perceived to be large.
- Performance was compared to previous month.
- Performance was maintained.
2. 1 Better Help for Smokers to Quit

**National Health Target:** 90% of enrolled patients who smoke and are seen by a health practitioner in primary care are offered advice and help to quit by July 2016.

The ‘Better Help for Smokers to Quit’ result is reported both as a NHT and at PHO level within the Integrated Performance Improvement Framework (IPIF) (see Section 3). Please note that Q1 data for Better Help for Smokers to Quit is not available until November 25th 2015.

Two technical changes were applied to the NHT for Better Help for Smokers to Quit from 1 July 2015. Both of these changes were introduced to improve recording and reporting of the target. The changes were:

- **Removing the ‘seen by a health practitioner’ wording from the target definition.** This change takes away the need for an adjuster in calculating the denominator of the target’s indicator. Removing the adjuster improves the accuracy of the target as the NHT result is now based on actual numbers rather than estimates. Importantly though, this change allows PHOs to better support all enrolled patients who smoke, regardless of whether they are seen by their health practitioner. This means that PHOs could reach enrolled smokers via a range of activities such as health promotion and public health activities.
- **Changing the numerator to cover 15 months, rather than 12 months.** This change gives the practice/PHO 12 months to offer smokers help to quit, and then a three month follow-up period to contact those smokers who did not go to see their health practitioner.

The final results for Q1 2015-16 are not yet available; however the preliminary results indicate that the drop for Auckland and Waitemata DHBs is approximately 10 percent and within the range expected by the MoH. All the PHOs are adjusting their approaches and plans to meet the new revised NHT for 2015-16. The DHBs will be reviewing the PHOs Smokefree Plans for 2015/16 as well as to review activities and events towards achieving the new target. Furthermore, a teleconference has been arranged with the MoH and PHOs on 16th November to discuss strategies that PHOs could do or use to achieve the revised targets.

2.2 More Heart and Diabetes Checks

**National Health Target:** 90% of the eligible adult population will have had their Cardiovascular Disease risk assessed in the last five years by July 2014.

Both Auckland and Waitemata DHBs have met the More Heart and Diabetes Checks NHT in Q1 2015/16. The preliminary results from the MoH shows that Auckland DHB achieved 92.2% whilst Waitemata DHB achieved 90.5% (see Figure 3).
2.3 Improving Population Health - Diabetes Annual Reviews

**National Health Target:** A minimum of 75% of people who have had a Diabetes Annual Review (DAR) will have an HbA1c of <= 64mmol/mol.

In Q1 2015/16, for Auckland DHB 89% of those who are on the Virtual Diabetes Register (VDR) have had a Diabetes Annual Review (DAR) whilst it was 68% for Waitemata DHB. However, the VDR contains 2013 data and its accuracy could be questionable. An updated VDR is due to be released by the MOH but we do not have a timeline on this at the moment.

Of those who have had a DAR in Q1 2015/16, approximately 65% and 72% showed good diabetes management for Auckland and Waitemata DHB respectively. As shown in the Figure 4, for Auckland DHB there has been a drop in the percentage of good management overall as well as across ethnicities, especially for the Pacific population. We are in the process of clarifying the accuracy of this data with the PHOs and an update on this will be provided in the next report. For Waitemata DHB (see Figure 5), the percentage of good management has been stable overall and across ethnicities except Maori who showed an improvement in good management.

Increasing the number of people with good diabetes management is a priority for the Diabetes Service Level Alliance (DSLA). It is reflected in the DSLA Work Programme under the ‘Optimisation of Clinical Management’ Workstream that will aim to implement a range of complementary strategies targeted at improving prescribing. For example, supporting the implementation of a dynamic pathway, and other electronic decision support tools, measuring and reporting on clinical indicators, actively targeting individuals with poor control, and increasing GP access to specialist advice. It will also aim to improve patient’s access to specialist input.

The DSLA Work Programme has three other Workstreams namely: (1) Systems Redesign, (2) Diabetes Self-Management and Education and Care Planning and (3) Workforce Development. It has been submitted to the Alliance Leadership Team (ALT) on 12th November 2015 for endorsement. Overall it
is aimed at addressing the key issues identified by the Stocktake and Gap Analysis undertaken earlier this year.

Each workstream has a range of initiatives/activities with their own objectives and deliverables. Once the Work Programme is endorsed, the DSLA will make further recommendations to the ALT to finalise the prioritisation of the workstreams and the resources required to complete this work.

Figure 4 The Good Diabetes Management National Health Target – ADHB Trend Data
3. Integrated Performance Incentive Framework (IPIF)

Note that the data for all IPIF targets was not released by the Ministry of Health before the CPHAC reporting deadline. IPIF data will be available on 25th November 2015.

4. Progress against the 2015/16 Annual Plan Deliverables

4.1 Waitemata DHB Palliative Care model agreed and implementation initiated by 1 April 2015

The Palliative Care model of care was approved and finalised in October 2013. A Clinical Governance Group has been in operation since March 2014, and is currently overseeing the work of a subgroup.

The first element of the model of care to be addressed was the design and implementation of the Senior Medical Officer (SMO) hub. The model has been designed and endorsed by all hospice Boards and DHB Boards. An implementation group developed job adverts, compared contracts and completed job sizing. The next step would be to release job adverts to recruit into the hub. Ongoing discussions are taking place with the hospice CEOs and Chairs to progress this initiative.

The Clinical Working Group have completed the localisation of the palliative care pathway for HealthPathways for the Waitemata District. This work has now gone to a regional group with representatives from all three Auckland Metro Districts to build on and develop a pathway for use across the Auckland Metro region.

4.2 Auckland DHB Palliative Care

The concept and the key elements of a Lead provider model were endorsed by the Auckland Palliative Care Governance Group. One of the key features of a Lead provider model is a single
clinical leadership and governance across both hospital and community services. Scoping of an implementation plan is underway.

4.3 The Auckland Waitemata Rural Alliance

The Auckland Waitemata Rural Alliance has been set up to provide advice and direct improvement in care and services across rural areas in Auckland DHB and Waitemata DHB. The Rural Alliance has a particular focus on patient centred care, service delivery, integration and sustainability issues with representation from rural general practices covering the areas of Wellsford, Warkworth, West Rodney, Waiheke Island and Great Barrier Island, servicing a combined enrolled population of approximately 58,600 patients.

The Rural Alliance conducted its inaugural meeting on 13th May 2015 and since then has:

- Developed and signed off the Rural Alliance Terms of Reference
- Appointed the Rural Alliance Chair (Dr John Elliott) and Deputy Chair (Dr Kate Baddock)
- Agreed that the goals of the Rural Alliance work plan are to: avoid hospitalisations, keep people in the community, provide clinical commitment and target high needs, Māori, Pacific and Q5 populations
- Agreed a draft three-year work plan with activities to assist primary care services in rural areas to be comprehensive, sustainable, and provide continuity of care by the right person, at the right time, in the right place. A significant component of this work plan will focus on reducing a patient’s need to travel by increasing access to diagnostics and interventions in the rural areas. A further focus of the Rural Alliance will be overseeing and providing direction in an advisory capacity for the review of health services on Waiheke Island
- Approved that a Rural General Practice Services Stocktake be undertaken to provide a baseline and ensure that the Rural Alliance work plan is able to successfully achieve its goals
- Agreed to provide support and clinical champion representation for the Government’s Emergency Response – Rural Mental Health Initiative.

4.4 Primary Mental Health

**Stepped Care Model**

Work is continuing in the integration of primary and secondary mental health services to facilitate the delivery of the Stepped Care model across Auckland and Waitemata DHBs’ Mental Health services.

Within the Tamaki Mental Health project and Well-Being project the Non-governmental organisation (NGO) integration with GP practices pilot is underway. During the first week of the pilot, eleven referrals were made by GPs to the NGO providers, with the initial feedback being very positive. The pilot is for a six month period and will result in a model of care that will be implemented more widely across the Tamaki locality.

Within the New Lynn Totara House project a number of initiatives are underway. Cognitive Behavioural Therapy groups have been established and are co-facilitated by Procare and Waitemata DHB primary care liaison nursing staff. Procare has initiated co-training in self-management for primary care and DHB staff. Work continues on the planned evaluation of this project. The data collection methodology has been developed, however the scope of the evaluation is still to be finalised.

A five-year Primary Mental Health Action Plan (2016-2021) is being developed for Waitemata DHB, which will be presented to the Board for endorsement in February 2016. It will encompass DHB Funder and Planning, Health Gain and Provider activities, and service development. The Action Plan
will describe how across the lifespan and whole service system, Waitemata DHB can achieve better mental health outcomes for the population; as well as improve access and experience of care.

**Primary Mental Health Initiatives**
The delivery of ADHB Primary Mental Health Initiatives (PMHI) continues to be significantly higher than the contracted volumes (see Table 1). This continues the trend seen in 2014/15.

### Table 1 Auckland DHB volumes (Q1, 2015/16)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland PHO</th>
<th>Procare</th>
<th>AH+</th>
<th>NHC</th>
<th>Youth Alliance</th>
</tr>
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<tbody>
<tr>
<td>NZ European</td>
<td>Q1</td>
<td>Q1</td>
<td>Q1</td>
<td>Q1</td>
<td>Q1</td>
</tr>
<tr>
<td>Māori</td>
<td>190</td>
<td>1,106</td>
<td>112</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>40</td>
<td>357</td>
<td>60</td>
<td>16</td>
<td>47</td>
</tr>
<tr>
<td>Asian</td>
<td>24</td>
<td>291</td>
<td>118</td>
<td>6</td>
<td>58</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
<td>465</td>
<td>210</td>
<td>41</td>
<td>59</td>
</tr>
<tr>
<td>Unknown</td>
<td>55</td>
<td>93</td>
<td>96</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>352</td>
<td>2,312</td>
<td>596</td>
<td>155</td>
<td>270</td>
</tr>
<tr>
<td>Contracted Volumes</td>
<td>84</td>
<td>352</td>
<td>115</td>
<td>79</td>
<td>104</td>
</tr>
</tbody>
</table>

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

The delivery of Waitemata DHB PMHI, as with Auckland DHB, continues to be significantly higher than the contracted volumes (see Table 2). This also continues the trend seen in 2014/15.

### Table 2: Waitemata DHB volumes (Q1, 2015/16)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Waitemata PHO</th>
<th>Procare</th>
<th>HealthWest</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>Q1</td>
<td>Q1</td>
<td>Q1</td>
</tr>
<tr>
<td>Māori</td>
<td>260</td>
<td>1,022</td>
<td>181</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>38</td>
<td>413</td>
<td>136</td>
</tr>
<tr>
<td>Asian</td>
<td>15</td>
<td>116</td>
<td>57</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>125</td>
<td>14</td>
</tr>
<tr>
<td>Unknown</td>
<td>10</td>
<td>62</td>
<td>21</td>
</tr>
<tr>
<td>Totals</td>
<td>340</td>
<td>1,738</td>
<td>409</td>
</tr>
<tr>
<td>Contracted Volumes</td>
<td>348</td>
<td>547</td>
<td>357</td>
</tr>
</tbody>
</table>

Discussions have been held with Healthwest regarding the reported Q1 over delivery. Healthwest has advised that this is a seasonal trend (which is confirmed by previous years reporting data), and service delivery is reducing to that required by the Agreements.
Utilisation of services is currently under review. The DHB and the providers are working together to better understand utilisation against the current Agreements.

**Metro Auckland Collaborative for training primary care nurses in mental health and addictions**

Metro Auckland DHBs and PHOs have formed a Collaborative to provide a regional mental health and addictions credentialing programme for primary health care nurses based on Te Ao Māramatanga New Zealand College of Mental Health Nurses (NZCMHN), *Primary Care Nursing Mental Health and Addiction Credentialing Framework*.

The evaluation of the credentialing programme is currently underway. The interim evaluation report, due in late September, has been delayed until late October. This delay was in part due to a delay in obtaining some stakeholder feedback.

### 4.5 Continue to Support the Regional Primary Options for Acute Care Services

The annual target of Primary Options for Acute Care Services (POAC) referrals is 6,042 for Auckland DHB, 6,519 for Waitemata DHB and 12,320 for Counties Manukau DHB. 85% of POAC interventions will avoid the patient needing to go to hospital.

The 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 closer 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 DHBs’ performance in Q1 2015/16 is as follows:

- The total number of Auckland Metro POAC referrals in Q1 (July – Sept 2015) was 6,178 (1% below the target - see Table 3 below). Counties Manukau DHB is 22% below target and Auckland DHB is 11% below target, while Waitemata DHB is 50% above target volumes for the quarter.
- Overall, the total referrals received increased by 7% compared with the same period in the previous year of 5,762 (Auckland DHB >17%; Counties Manukau DHB >5%; Waitemata DHB >5%).
- The average cost per referral remains lower across the whole region compared with the same time last year. This in part can be attributed to changes in clinical policies and revised provider agreements. In addition, the percentage of lower cost St John pathway patients being referred has kept the average costs down.
- In Counties Manukau DHB, 85% of patients were safely managed in the community and avoided hospital presentation with 88% in Auckland DHB and 90% in Waitemata DHB.
The proposal to review POAC and Access To Diagnostics (ATD) initiatives within the Metro Auckland area has been endorsed by the Metro Auckland Clinical Governance Forum (MACGF). The review is a key deliverable of both the Auckland and Waitemata DHBs’ 2015/16 Annual Plans.

<table>
<thead>
<tr>
<th>Table 3: Total number of Auckland Metro POAC referrals (Q1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Waitemata DHB</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>Actual number of POAC referrals (target number of referrals)</td>
</tr>
<tr>
<td>Average cost per referral (excl. GST), budget $200.00</td>
</tr>
</tbody>
</table>

Referrals by ethnicity

<table>
<thead>
<tr>
<th>European</th>
<th>74%</th>
<th>56%</th>
<th>51%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>7%</td>
<td>8%</td>
<td>16%</td>
</tr>
<tr>
<td>Pacific</td>
<td>6%</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td>Asian</td>
<td>8%</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>5%</td>
<td>8%</td>
<td>4%</td>
</tr>
</tbody>
</table>
5.2 Planning, Funding and Outcomes Update

Recommendation

That the report is received.

Prepared by: Wendy Bennett (Manager - Planning and Health Intelligence), Tim Wood (Acting Funding and Development Manager – Mental Health & Addictions), Ruth Bijl (Funding and Development Manager – Women, Children and Youth), Kate Sladden (Funding and Development Manager - Health of Older People), Aroha Haggie (Manager - Maori Health Gain), Jane McEntee (General Manager - Auckland Regional Public Health Service)

Endorsed by: Dr Debbie Holdsworth (Director Funding), Simon Bowen (Director Health Outcomes)

Glossary

ARPHS - Auckland Regional Public Health Service
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
HBSS - Home Based Support Services
HCSS - Home and Community Support Services
MoH - Ministry of Health
MoU - Memorandum of Understanding
NASC - Needs Assessment and Coordination
NHB - National Health Board
RFP - Request for Proposals
RhF - Rheumatic Fever

Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata District Health Boards’ (DHB) planning and funding activities and areas of priority, since the last meeting on 24 October 2015. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting’s agenda.

1. Planning

1.1 Annual Plans

Both the Auckland DHB and Waitemata DHB Annual Plans for 2015/16 have been published to their respective websites.

Draft 2016/17 DHB Planning guidance has been released by the National Health Board for consultation – this is currently being reviewed. Feedback is due to the Ministry of Health (MoH) by 17 November. A new health target will be implemented from quarter one 2016/17: by December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.
Two planning workshops will occur in Wellington mid-November – one regional, the other for DHBs to discuss the 2016/17 planning package.

The final 2016/17 Planning Package will be released early December, along with the Minister’s Letter of Expectations.

1.2 NZ Health Strategy – refresh
The revised NZ Health Strategy has been released for consultation. An Auckland forum was held on 7 November. Consultation is open until 4 December – see separate paper on this agenda.

1.3 Annual Reports
The Auckland and Waitemata DHB 2014/15 annual reports have both received audit clearance and final versions have been supplied to the NHB. Auckland DHB’s Annual Report has been given NHB clearance, so will proceed to printing. Printing and publishing of both reports will occur by the end of November.

1.4 Health Needs Assessment
Development of disease-specific summaries continues - cardiovascular disease, health of older people and cancer summaries have been completed and are under review.

1.5 Asian International benchmarking report
A demographic profile has been completed and a set of indicators for comparison being developed.

2. Health of Older People

2.1 Home and Community Support Services (HCSS)
The Director General’s Report on Home and Community Support Services is still under consideration and yet to be released. However, in a recent memo from the Lead CE for Health of Older People, DHBs were notified that the report will have explicit recommendations that contracts will support the goal of an 80% regularised HCSS workforce and that base minimum expectations will form part of future contracting. The memo recommended that DHBs roll over their existing HCSS contracts for 12 months to allow for in-between Travel actions to be finalised and the implications of requirements from the Director General’s report on future contracting to be fully understood. This is likely to impact on time frames for Waitemata and Auckland DHBs going out to tender for these services.

2.2 Aged Related Residential Care (ARRC)

interRAI (standardised assessment tool)
Previous reports have reported on the proportion of ARRC facilities with registered nurses trained to undertake interRAI long term care facility (LTCF) assessments. For the 15/16 year a new clause is included in the ARRC Agreement that requires all facilities to use interRAI as their primary assessment tool. This is a significant change for ARRC in managing assessments. The performance measure required quarterly by the Ministry of Health is:

- percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI LTCF assessment completed within 230 days of the previous assessment.
Data has been received for the first quarter with 49% of Auckland DHB and 42% of Waitemata DHB residents having a subsequent assessment within 230 days. There is no target for this measure at this stage.

Audits
Twenty six audits of ARRC facilities were undertaken during the first quarter of 2015/16 with an average of four corrective actions per facility in Auckland and three corrective actions per facility in Waitemata.

The gold standard attainment against an audit criterion is ‘continuous improvement’ (CI). During this quarter eight Auckland facilities and seven Waitemata facilities achieved CI. Continuous Improvement is achieved when a criterion is fully attained and continuous improvements against the Health and Disability Sector Standards are demonstrated indicating quality improvement processes in place against service provision and consumer safety or satisfaction.

3. Maori Health Gain

3.1 Māori Health Plans
The Māori Health Gain Team has commenced preparations for the 2016/17 Māori Health Plans for Auckland and Waitemata DHBs. Initial guidance has been received from the MoH which will assist the development of activities in the Plans. As with the previous planning cycle, the Māori Health Gain Team will work closely with the relevant Portfolio Managers and teams to ensure activities in the Māori Health Plans and Annual Plans align to support demonstrable gains for Māori.

Engagement with Memoranda of Understanding partners and Māori providers has started, and engagement with PHOs will also occur.

3.2 Smoking cessation
The Māori Health Gain Team is leading the development and implementation of the Living Smokefree initiative. Living Smokefree is an incentives-based smoking cessation in pregnancy pilot programme for pregnant women who smoke. Pregnant women who join the programme receive professional support and gift vouchers as they progress through the programme up to a value of $310. These vouchers can be redeemed at various suppliers across the Auckland DHB and Waitemata DHB regions and beyond. One provision is that the vouchers cannot be redeemed for cash, or to purchase alcohol and/or tobacco related products. Living Smokefree was launched on 5th October 2015. Initial data for analysis will be available early next year.

3.3 Cardiac rehabilitation
The Maori Health Gain Team is leading the development of a framework for phase two cardiac rehabilitation in the community. The framework has been drafted and is being reviewed by the Northern Regional Alliance Rehabilitation Network. The development of models of service delivery for Cardiac rehabilitation phase two are currently being aligned with the framework.
4. Children, Youth and Women (CPHAC 25/11/15)

4.1 Immunisation

The Immunisation Team continuing to make good progress with achieving the immunisation coverage target. Auckland DHB is maintaining the 95% coverage rate target and WDHB has increased coverage by one percentage point to 94%.

Coverage rates by ethnicity are:

- Maori 89% ADHB, 92% WDHB
- Pacific 95% ADHB, 97% WDHB
- Asian 98% ADHB, 98% WDHB.

Guidance from the MoH in relation to the Annual Plan 16/17 has identified 95% coverage at 5 years of age is also expected. Rates of immunisation for 5 years olds has made gains of 4% ADHB and 5% WDHB over the last two years (30 June 2013 – 30 June 2015) to 83% ADHB and 81% WDHB but achieving the 95% coverage target for this cohort by June 2017 will be a stretch. However, with high coverage rates for the B4 School Check programme we are now better positioned to achieve this.

4.2 Rheumatic Fever

DHBs were required to submit refreshed Rheumatic Fever (RhF) plans to the Ministry in October, as signalled to CPHAC in July 2015. The MoH has informed us that no DHB had their plan endorsed and that it requires further detail on expected activities to be provided by February 2016. Of particular interest to the MoH is the primary school based programme. Their own evaluation does not support the primary school swabbing and treatment programme alone as a means to achieve the RhF target. The DHBs are not proposing to achieve the target through a primary school programme alone, nor are the DHBs proposing that the primary school programme solely focuses on the RhF target. The two DHBs are continuing to refine the proposed evaluation, but as endorsed by CPHAC, still need time to establish whether the throat swabbing school programme does make a difference in reducing the incidence of RhF. The DHBs are also considering the broader model of care provided by the Public Health Nursing (PHN) workforce and will bring a paper to CPHAC regarding the model of care in the new year.

4.3 Child Health

Of the six draft Annual Plan Cross Government priorities, five relate to Children, Youth and Women. These are: Increased Immunisation, RhF, Children’s Action Plan (CAP), Prime Minister’s Youth Mental Health Project and Social Sector Trials (WDHB only). In addition, childhood obesity has been identified as a strategic priority. A component of this is a new health target for referrals from the B4 School Check programme for obese children. The Child Health Team are working on a draft local response to the new childhood obesity priority. We have also met regionally to discuss priorities for regional child health action and will continue to build on work that has been underway to standardise measurement of children across DHBs. It is likely that we will try to work regionally on a referral pathway for referrals from the B4 School Check programme. Consideration of breastfeeding is part of the work currently being undertaken. It is anticipated that support to encourage breastfeeding will be a component of the response to reduce childhood obesity, though it has not been signalled nationally as a priority. It is also likely that there will be areas of additional investment required. This work will inform the 2016/17 Annual Plans as well as papers to the Audit and Finance Committees as appropriate.
4.4 Youth Health

HEADSS coverage to the end of term 3 of the school year in now available with term 3 results also available by ethnicity. Coverage in ADHB schools for Year 9 students is 74%, with 1049 young people screened and in WDHB, 62%, with 794 young people screened. The ADHB visiting psychology service appears to be very effective in increasing the reach of primary mental health, particularly with Pacific Island young people. The Youth Health Clinical Governance Group and YSALT are considering how to increase access to primary mental health for other young people as GP led services and referrals continue to be low. Improving the interface with the Kari Centre (for those who do not meet their referral threshold), increasing access for young pregnant women (by referral from their LMC) and extending referrals in through Guidance Counsellors in schools that are not part of the DHB funded enhanced school based health services programme have been identified initially. A triage mechanism will need to be developed to support this. A pilot will be undertaken in 2016 to better connect young people in Alternative Education to services.

4.5 Women’s Health

The Pregnancy and Parenting Information and Education app, website and curriculum are being developed through the University of Auckland, through a consortium of Whakawhetu, TAHA (Well Pacific Mother and Infant Service), IMAC (Immunisation Advisory Centre) and the Centre for Asian and new migrant Research. They expect to have completed this work by March 2016 and will provide training in the new resources to child birth educators. An RFP for providers of the education to women has been undertaken and the outcome is still being finalised. Once this decision has been taken, we will begin negotiations with the preferred provider/s regarding delivering services under the new service specification.

A feasibility study of HPV self-sampling for cervical screening has been developed in collaboration with our MoU partners and primary care in West Auckland. This is testing an innovative approach to reaching women currently not screened or significantly overdue. The Waitemata DHB arm of the study has successfully received grant funding from Awhina, and the outcome of the Auckland DHB arm grant funding is awaited. The study has been developed with advice from the investigators of a similar study in Melbourne. The objective of this study is to examine the feasibility and acceptability of self-sampling for Māori women to help address the current inequities that exist in screening coverage and to determine pathway requirements for follow-up with the colposcopy service. The study has been developed to inform a larger study under consideration by the Health Research Council (HRC) for self-sampling for priority group women examining mailed and clinic based approaches with usual care. The outcome of the HRC funding application will be known in early 2016.

5. Auckland Regional Public Health Service

5.1 Submissions

ARPHS has completed and submitted two submissions during October 2015.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Brief note</th>
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<tbody>
<tr>
<td>18 October</td>
<td><strong>Content Regulation in a Converged World</strong></td>
<td>Highlighting the need for appropriate regulatory settings minimising harm from online advertising to children that are viewing content in a non-conventional time-shifted manner.</td>
</tr>
<tr>
<td>19 October</td>
<td><strong>Response to the NZ Diet Study</strong></td>
<td>Providing feedback on the five-yearly survey undertaken by Ministry of Primary Industries.</td>
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Building (Pools) Amendment Bill Submission

In early November ARPHS, with the endorsement of the three Auckland DHB CEOs, has submitted a response to the Building (Pools) Amendment Bill that is currently before the Local Government and Environment Select Committee. The Bill, in its current form, repeals the Fencing of Swimming Pools Act 1987 which has been a highly effective piece of legislation reducing childhood drowning in domestic swimming pools by over 70% since its introduction. We estimate over 200 childhood deaths from drowning and several thousands of near drowning injuries have been prevented. The changes are driven by cost saving measures by bringing two pieces of legislation together. Our concern is that the proposed Bill reduces well-tested safety measures and can lead to unintended adverse consequences for children and their families.

Our final recommendations that the Local Government and Environment Select Committee were to either:

- set this Bill aside and request it be redrafted, following a full assessment of the issues raised; or
- make extensive amendments to the Bill to ensure that child safety is not compromised, and ensures that at least the level of protection in the existing legislation is retained.

A copy of our full submission is available on the ARPHS website on this link: http://www.arphs.govt.nz/about/submissions

The Select Committee received submissions on 5 November and is required to report back to Parliament on 16 March 2016. ARPHS representatives will be presenting the key messages from the submission at the Select Committee Oral Hearing on Thursday 19 November.

5.2 Collaboration Framework Auckland Regional Public Health Service (ARPHS), Toi Te Ora Public Health Service (TTO) and Health Promotion Agency (HPA)

ARPHS Workplace Health Promotion team, TTO Workwell team and HPA, Senior Advisor Workplace have progressed their relationship and collaboration opportunities. This has resulted in TTO Workwell team aligning their approach to ARPHS Workplace Health strategic plan and the development of a collaboration project. Work is underway to nationally align wellbeing tools, resources and language to ensure consistency across New Zealand when supporting businesses. These tools will also be made available to Healthy Families New Zealand.

5.3 Healthy Auckland Together (HAT) Update

Implementation is underway on the Healthy Auckland Together Plan 2015-2020 with the next meeting of the inter-agency partners scheduled for 24 November. Stakeholder engagement activities are raising the profile of HAT and its work and ensuring support for the work at appropriate levels. The draft NZ Health Strategy released last week features HAT (page 23 of the NZ Health Strategy) as an example of ‘One Team’ (a strategic theme).

HAT partners are collaborating on profile raising activities and submissions, most recently submitting to the World Health Organisation – Final Draft Report of the Commission on Ending Childhood Obesity.

The website has been launched and can be located on - www.healthyaucklandtogether.org.nz. The new website highlights how better policy and infrastructure design could reduce obesity in Auckland, with proposed changes across five settings – school and early childhood education, workplaces, communities, urban spaces and food environments.