Community and Public Health Advisory Committees Meeting

Wednesday, 10th June 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
10th June 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
Pat Booth - WDHB Board member
Chris Chambers - ADHB Board member
Sandra Coney - WDHB Board member
Warren Flaunty - Committee Deputy Chair (WDHB Board member)
Lee Mathias - ADHB Deputy Chair
Robyn Northey - ADHB Board member
Christine Rankin - WDHB Board member
Allison Roe - WDHB Board member
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: Lester Levy, Christine Rankin and Ailsa Claire
Leave of Absence: Pat Booth

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
2.05pm  2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 29/05/15.......................................................................................................................... 7
Matters Arising from Previous Meeting ......................................................................................................................... 17

3 DECISION ITEMS

4 INFORMATION ITEMS
2.10pm  4.1 Community Engagement Update .................................................................................................................. 19
2.25pm  4.2 Nga Painga Hauora – Maori Health Outcomes Framework ........................................................................ 24

5 STANDARD REPORTS
2.40pm  5.1 Primary Care Update ........................................................................................................................................ 63
3.15pm  5.2 Planning, Funding and Outcomes Update ..................................................................................................... 83

3.30pm  6 GENERAL BUSINESS

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 10/05/15
## Member Attendance Schedule 2015

<table>
<thead>
<tr>
<th>NAME</th>
<th>FEB</th>
<th>MAR</th>
<th>APRIL</th>
<th>JUNE</th>
<th>JULY</th>
<th>SEPT</th>
<th>OCT</th>
<th>NOV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gwen Tepania-Palmer (ADHB / WDHB combined CPHAC Committees Chair)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warren Flaunty (ADHB / WDHB combined CPHAC Committees Deputy Chair)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Lester Levy (ADHB and WDHB Chair)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max Abbott</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jo Agnew</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter Aitken</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Judith Bassett</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pat Booth</td>
<td>✓</td>
<td>^</td>
<td>^</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chris Chambers</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandra Coney</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lee Mathias (ADHB Deputy Chair)</td>
<td>✓</td>
<td>×</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robyn Northey</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christine Rankin</td>
<td>✓</td>
<td>×</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allison Roe</td>
<td>✓</td>
<td>×</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-opted members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elsie Ho</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rev. Featunai Liuana</td>
<td>×</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Tim Jelleyman</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* ▲ absent
* * attended part of the meeting only
* ^ leave of absence
* # absent on Board business
* + ex-officio member
**REGISTER OF INTERESTS**

<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
</tr>
</thead>
</table>
| 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)  
Director - Orion Health Ltd (includes Director – Orion Corporate Trustee Ltd)  
Member – State Services Commission’s Performance Improvement Framework Review Panel                                                                                                                   | 04/02/15     |
| 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     |
| Pat Booth        | Consulting Editor – Fairfax Suburban Papers in Auckland                                                                                                                                                                                | 24/06/09     |
| Chris Chambers   | Employee - Auckland District Health Board (wife employed by Starship Trauma Service)  
Clinical Senior Lecturer - Anaesthesia Auckland Clinical School  
Associate - Epsom Anaesthetic Group  
Member - ASMS  
Shareholder - Ormiston Surgical                                                                                                                                                                                                                   | 20/04/11     |
| Sandra Coney     | Elected Member - Chair: Waitakere Ranges Local Board, Auckland Council                                                                                                                                                                 | 12/12/13     |
| Warren Flaunty   | Member - Henderson – Massey and Rodney Local Boards, Auckland Council  
Trustee (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 – healthAlliance FPSC  
Managing Director - Lee Mathias Ltd  
Trustee - Lee Mathias Family Trust  
Trustee - Awamoana Family Trust  
Director - Pictor Ltd  
Director - John Seabrook Holdings Ltd  
Chair - Health Promotion Agency  
Director - IAC IP Ltd  
Advisory Chair - Company of Women Ltd                                                                                                                                                                                                              | 15/10/14     |
| Robyn Northey    | Project management, service review, planning etc - Self-employed Contractor  
Board member - Hope Foundation Northern Region  
Trustee - A+ Charitable Trust                                                                                                                                                                                                                     | 18/07/12     |
### Register of Interests continued...

<table>
<thead>
<tr>
<th>Member</th>
<th>Position/Role</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Christine Rankin</strong></td>
<td>Member - Upper Harbour Local Board, Auckland Council, Director - The Transformational Leadership Company, CEO - Conservative Party</td>
<td>17/05/13</td>
</tr>
<tr>
<td><strong>Allison Roe</strong></td>
<td>Member - Devonport-Takapuna Local Board, Auckland Council, Chairperson - Matakana Coast Trail Trust</td>
<td>02/07/14</td>
</tr>
<tr>
<td><strong>Gwen Tepania-Palmer</strong></td>
<td>Chairperson - Ngatihine Health Trust, Bay of Islands, Life Member - National Council Maori Nurses, Alumni - Massey University MBA, Director - Manaia Health PHO, Whangarei, Board Member - Auckland District Health Board, Committee Member - Lottery Northland Community Committee</td>
<td>10/04/13</td>
</tr>
<tr>
<td><strong>Co-opted Members</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Elsie Ho</strong></td>
<td>Associate Professor - School of Population Health, University of Auckland, Member - Waitemata DHB Asian Mental Health and Addiction Governance Group, Member - Problem Gambling Foundation of New Zealand Advisory Board, Trustee – New Zealand Chinese Youth Trust</td>
<td>03/09/14</td>
</tr>
<tr>
<td><strong>Rev Featunai Liuaana</strong></td>
<td>Chairperson – Congregational Christian Church Samoa Sandringham Trust Board, Trustee – Congregational Christian Church Samoa Trust, Chairperson – Mothers and Daughters Health – HVAZ and Alliance Health Plus, Committee Member – Working Group for Pacific Health Action Plan (ADHB and WDHB), Deputy Chairperson – Working Group Pacific Family Violence (ADHB and WDHB), Member – MIT Pasifika Students Forum, Secretary - Negotiation Committee – EFKSNZ Trust, Secretary – EFKSNZ Trust</td>
<td>29/04/15</td>
</tr>
<tr>
<td><strong>Dr Tim Jelleyman</strong></td>
<td>Clinical Chair - Child Health Network, Northern Regional Health Plan, Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland, Member-Board of Kaipara Medical Centre, Community Paediatrician, Waitakere Hospital, Member – ASMS</td>
<td>14/04/15</td>
</tr>
</tbody>
</table>
2.1  Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 29th April 2015

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 29th April 2015 (including the public excluded minutes) be approved.

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

Community and Public Health Advisory Committees

Wednesday 29 April 2015

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

PART I – Items considered in Public Meeting

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair)
Jo Adnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren Flaunti (Committee Deputy Chair) (WDHB Board member) (present until 3.27p.m.)
Lee Mathias (ADHB Deputy Chair)
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) (present until 3.00p.m)

ALSO PRESENT:

Ailsa Claire (ADHB, Chief Executive) (present until 3.00p.m.)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Tim Wood (ADHB and WDHB, Deputy Director Funding)
Andrew Old (ADHB, Chief of Strategy/Participation and Improvement)
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
Wiki Shepherd-Sinclair, Health Link North
Lorelle George, Comprehensive Care/Waitemata PHO
Gaylene Sharman, HealthWest

APOLOGIES:

Apologies were received and accepted from Max Abbott, Pat Booth (leave of absence), Dale Bramley and Debbie Holdsworth, together with apologies for early departure from Warren Flaunti, Tim Jelleyman and Ailsa Claire.
KARAKIA: The Committee Chair led the meeting in the Maori and English versions of the karakia.

WELCOME: The Committee Chair welcomed all those present, with a particular welcome for health partners: the representatives from the Auckland Womens Health Council, the Health Links and the PHOs.

DISCLOSURE OF INTERESTS
There were no additions or amendments to the Interests Register advised at the meeting. Tim Jelleyman has advised separately of changes to his interests which will be shown in the register in the next CPHAC agenda, as will the interests provided by Rev. Featunai Liuaana.

There were no declarations of interests relating to the open 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 18th March 2015 (agenda pages 7-17)

Resolution (Moved Jo Agnew/Seconded Peter Aitken)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 18th March 2015 be approved.

Carried

Matters Arising (agenda pages 18-19)

No issues were raised.

3 DECISION ITEMS
3.1 Draft Tobacco Control Plan 2015-18 (agenda pages 20-62)

Leanne Catchpole (Programme Manager – Primary Care Team), Dr Patricia Bolton (Public Health Physician) and Tracy Walters (Business Analyst – Maori Health Gain Team) were present for this item.

Leanne Catchpole introduced the report. Matters that she highlighted or updated included:

- Both DHBs are performing very well in terms of the national health targets for providing advice to quit smoking and have mastered that. The next challenge is the Government’s target for reduction in the percentage of smokers by 2025. If current trends continue the two DHBs are on track to achieve that for the “other” population, but not for Maori and Pacific.
• A wide range of discussions have informed the development of this Plan. Many very good ideas had been put forward; some had been included in the Plan while others are able to be utilised as part of "business as usual".
• Two major areas of focus in the Plan are supporting more people in their attempts to stop smoking and addressing the priority population groups identified: Maori, Pacific, young people, pregnant women and mental health and addiction clients.
• A new development is that at the end of March the Ministry of Health announced that they wish to go through a significant realignment of tobacco control contracts including all of the stop smoking services and also the funding provided to the DHBs for purchasing these services. The Ministry is going through a re-design process which will lead into a procurement process from August to December. The new services will commence between January and June in 2016. This will mean that many of draft actions in the Plan will need to be altered to reflect whatever changes the Ministry makes.

Matters covered in discussion and response to questions included:
• Patricia Bolton confirmed that there needs to be more focus on issues specific to youth smoking rates. There needs to be consultation with youth and a co-design approach developed. Tim Jelleyman noted that differences by locality in youth smoking rates also need consideration.
• In answer to a question as to what has been the most successful anti-smoking service, Leanne Catchpole advised that judging that needs to be in relation to the particular population served. An example of a highly successful service was the one which prepares people waiting for elective surgery at Waitemata DHB. This team had a very experienced stop smoking practitioner. Lee Mathias also advised that perhaps the most successful programme had been the “Stop before you start” programme aimed at 14 to 17 year olds, which had achieved a substantial reduction in smoking rates within a one year period.
• Simon Bowen noted that changes at national level including the Smokefree Environments legislation and particularly increases in taxation levels for cigarettes had made a real difference.
• The re-design of services by the Ministry will not involve any reduction in the overall funding allocated. The Ministry will be getting input from the DHBs and the wider health sector as part of this process.
• Patricia Bolton advised that with encouraging pregnant women to stop smoking, the international evidence was that the most effective strategy is to use incentives. Most often vouchers are used. A New Zealand study involving pregnant Maori women pointed to providing products as being more successful than using vouchers.
• It was confirmed that the plan includes young people as a priority group; this had been missed out in error in the covering paper on the agenda.
• Sandra Coney expressed concern that the plan is too much focused on individuals and not enough on changing environments, where many of the successes have been. A particular approach that would be promising would be to focus on the sports clubs and other groups that operate on reserves which are smokefree; often their leases require them to promote a smokefree approach. There is an opportunity to work with clubs to encourage their members not to smoke. She also suggested that sports clubs and licencing trusts that provide specific areas for people to smoke should be challenged on that. A further opportunity lay with working with Auckland Council to encourage them to implement new rules for areas such as outside bars and cafes and on beaches. The fact that there are four Board members on the two DHBs who are local board members also provided an opportunity. The Local Board Chairs
Forum might be a useful place to raise such issues. Sandra Coney also noted the active and important role that the Cancer Society had played, including presenting material supporting a smokefree approach to each local board on more than one occasion.

- There was agreement that changes to the environment should be a priority area for the Plan. This is happening at the national level and ARPHS is making a real effort at the regional level. Smoking needs to be made something that is not a norm. The Plan had been focused on the areas where the DHBs can have the most influence; often this is at the individual level and with community groups.
- Lee Mathias advised of a pilot between the Health Promotion Agency and Wellington Rugby League involving removing alcohol, smoking and gambling from all their clubrooms. The main difficulty was that these had been significant sources of income for the clubs and the issue was how to replace that lost income.
- In conclusion Simon Bowen noted that the Plan does talk about sports clubs, community settings etc., but generally it is focused on the approach to individuals. It would be good to strengthen the message about the environment and he would follow that up.

**Resolution** (Moved Chris Chambers/Seconded Lee Mathias)

That the Community and Public Health Advisory Committee:

a) Note the Ministry of Health requirement that the Auckland and Waitemata DHBs produce a Tobacco Control Plan for 2015-18, based on national guidelines.

b) Approve the draft Tobacco Control Plan attached as Appendix 1 to this paper, which the Funder submitted to the Ministry of Health on 31 March 2015 for feedback.

c) Subject to any suggested amendments from the Community and Public Health Advisory Committee (including strengthening the message about the importance of smokefree environments), agree that the draft Tobacco Control Plan be finalised on the basis of Ministry of Health feedback, and re-submitted to the Ministry of Health on or before 31 May 2015.

Carried

4. INFORMATION ITEMS

4.1 Overview – Food Environments Paper to Healthy Auckland Together (agenda pages 63-82)

Dr Julia Peters (Clinical Director – ARPHS) and Jane McEntee (General Manager – ARPHS) were present for this item.

Simon Bowen outlined the background to this paper.

Julia Peters introduced the paper. Matters that she highlighted included:

- Issues of obesity and lack of exercise are getting worse, with one third of children now overweight or obese. There are inequalities reflected in the distribution of this problem. It is a serious problem, socially debilitating and the cost will be very high if something is not done about it.
- Most of the relevant players in the region are collaborating on this issue.
• With the food environment it is possible to increase the availability and affordability of healthy food and to decrease the availability of unhealthy options.

• The broad areas for interventions are outlined on pages 64 and 65 of the agenda under the three headings of working within Healthy Auckland Together workplaces; actions that require working with other organisations and sectors; and actions that support or advocate for wider environmental change. ARPHS can advocate for approaches such as pricing strategies and food labelling, but these are decisions for the Government to make.

• Currently they are working on an action plan for the next financial year and are submitting on policy at any opportunity.

Matters covered in discussion and response to questions included:

• ARPHS has in the past submitted in opposition to certain fast food premises being established, but had been unsuccessful with those submissions. They would take a look at the particular proposal in Te Atatu North which had been raised at the meeting as being of concern.

• Auckland DHB is contracted to provide communications assistance to ARPHS but it was suggested that more could be done in terms of engaging the media and using public relations when ARPHS makes submissions on public health issues. A recommendation to both Boards was approved at the conclusion of this item.

• Lee Mathias advised the meeting on the Blue Zone pyramid, which provides a framework for considering the various elements of what being healthy looks like.

• Rev. Featunai Liuana referred to HVAZ (Healthy Village Action Zones, an Auckland DHB approach). He noted that in papers such as this the tendency is to target sports clubs and overlook the key role that churches play in Pacific communities. For example on this issue, the church that he is a Minister at runs six or seven community gardens which provide healthy food for families. There also seems to be a lack of communication between HVAZ and other structures promoting community health such as Healthy Auckland Together. Good approaches could be transferred to and from HVAZ and other organisations. In response Julia Peters said that this was a really good point. These are early days in the project and there was no intention of having an alliance that was exclusive. She would follow up on the issue. Simon Bowen commented that they can make sure that interaction with HVAZ and Waitemata DHB’s Enua Ola programme flows through into the Action Plan being developed.

• In answer to a question, Julia Peters advised that the emphasis by ARPHS on submitting to the Unitary Plan, the Auckland Land Transport Plan and land use decisions is because the decisions being made now will be determining the future shape of Auckland. Illustrating that point, Sandra Coney pointed out that in the Unitary Plan currently 90% of the land proposed for development in the Franklin area is on prime or unique soils.

• Sandra Coney noted that Auckland Council does not have a healthy food policy and unhealthy foods are often provided at Council sponsored events.

• In answer to questions, Julia Peters advised that ARPHS has a budget which covers activity related to improving food environments this financial year and will also have one next financial year. Not everything that could be done will be able to done. They will be looking at the biggest return for investment, what can be done with the resources available and what might be able to be done additionally if they are able to secure additional resources for that in the future. The problem that now exists had taken about 40 years to create and this is early days in tackling it. They would definitely look into interaction with HVAZ and Enua Ola.

Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting 10/05/15
Sandra Coney suggested that ARPHS might wish to utilise the Local Board Chairs Forum as a means of making contact with all the Local Boards. She confirmed that she would be willing to facilitate a session for ARPHS with the Forum on this.

Media/Public Relations Support for ARPHS

Resolution (Moved Lee Mathias/Seconded Allison Roe)

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

That the Board be cognisant of the media/public relations package required to assist the Auckland Regional Public Health Service in the submissions that they make and provide additional assistance where appropriate.

Carried

4.2 Child, Youth and Women’s Health Scorecard (agenda pages 83-96)

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

Ruth Bijl introduced the report, highlighting the excellent result for Maori children fully immunised at two years for ADHB (98%); the positive trend for breast feeding; and the HPV Immunisation end of year results for ADHB at 76%, the highest rate in New Zealand. She acknowledged the work of the providers of these services.

Matters covered in discussion and response to questions included:

- Ruth Bijl advised that information on breast feeding at six months comes from Well Child reports from Plunket and other providers. The target of 59% for six months is set by the Ministry and is part of the Well Child Tamariki Ora contract. In discussion of this low target, Lee Mathias suggested considering recommending to the Boards that they pursue a higher target with the Ministry of Health. Following discussion it was agreed that more work first needs to be done on what that target should be. This is to be carried out and reported back to the next CPHAC meeting.
- Ruth Bijl confirmed that use of prophylactic antibiotics (bicillin) to provide secondary prevention against rheumatic fever (page 87 of the agenda) is only for those at increased risk because of previous exposure. Alison Leversha noted that those who have had rheumatic fever and then suffer another episode of it are more likely to incur heart damage. The antibiotic is administered as a prophylactic for a period of ten years. In answer to further questions she advised that the antibiotic is administered to approximately 1,000 young people across the three Auckland region DHBs. A further group is administered it through primary care. Studies looking at outcomes had not been indicative of adverse reactions. The Board Chair also advised that the antibiotic used is a very narrow spectrum antibiotic.
- With regard to rheumatic fever, mention was made of the work being done to focus on housing and primary protection. Alison Leversha also advised that another area
identified as important is talking to young women about fertility and pregnancy and the additional risks that rheumatic fever pose to mother and baby.

- In answer to a question about evaluation of the success of the school based programme, Ruth Bijl advised that the Ministry of Health has signalled that it may look at funding the programme for a longer period. The two DHBs are responsible for part of the evaluation; there is some evidence that some parts of the programme are making a difference, with some changes in initial hospitalisation rates. Until there is definitive information, it would be worthwhile to continue the programme. Tim Wood advised that when advice is received from the Ministry on whether or not it will continue funding, this will be brought back to CPHAC. The funding decision is still to be made.

- In response to further questions concerning the use of prophylactic antibiotics (bicillin) for rheumatic fever, Allison Leversha advised that children and adults receiving that were seen at least every 21 days for ongoing monitoring and the cost per child was $6,000 over the ten year period.

- Alison Leversha also advised that nationally there is a separate research project looking at altering the oral flora in the population at risk of rheumatic fever. The Auckland region had not been able to participate in this trial because it would have contaminated the results of the school based programme.

The Committee Chair thanked the team who had prepared and presented the report.

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

5. STANDARD REPORTS

5.1 Planning, Funding and Outcomes Update (agenda pages 97-102)

Simon Bowen (Director Health Outcomes), Tim Wood (Deputy Director Funding), Aroha Haggie (Manager-Maori Health Gain), Craig Heta (Maori Health Portfolio Manager) and Karen Bartholomew (Public Health Physician) were present for this report.

Matters that were highlighted or updated included:

- Simon Bowen advised that the Minister of Health had now signed off the Auckland DHB Annual Plan for 2014/15. He thanked the Board Chair for his efforts in getting this signed.

- Tim Wood noted the Maori Health Outcomes work with Sir Mason Durie (pages 97-98 of the agenda). Aroha Haggie advised that the framework being developed focused not just on Maori health providers, but the whole system. They had gone through a series of consultations and hoped to end up with a framework to align all service contracts to see if they contribute to Maori Health outcomes. The outcome will contribute to the next series of Maori Health Provider contracts.

- Karen Bartholomew commented on the implementation of the Ethnicity Data Audit Tool (page 98 of the agenda). She updated the report by advising that implementation for 84% of all general practices had now been achieved. They are
very confident of meeting the Ministry target of 95% by the end of the project in June 2015.

- With the Ambulatory Sensitive Hospital Survey (page 98 of the agenda), Karen Bartholomew commented that they had surveyed 230 Maori patients and are getting positive feedback; their experiences are being noted and are contributing to improvements for the future.
- With regard to the Asian, Migrant and Refugee Health Gain section of the report, Tim Wood advised that one issue is a data gap in identifying refugees, where they settle and which GPs they go to. There are a number of refugees who say they don’t want to be identified as refugees. Also when they arrive in the country often refugees are not in the mind set for a discussion about health services. It can be a problem to give them the full opportunity to make use of those services.
- The update on progress with the Pacific Health Action Plan (pages 99-100 of the agenda).

Warren Flaunty asked whether ARPHS made submissions on sealing of unsealed roads, which can cause breathing and asthma problems. Simon Bowen advised that he would follow up and see whether ARPHS had made submissions of this type. Warren Flaunty will be advised.

The Committee Chair thanked those involved for the report.

Resolution (Moved Lee Mathias/Seconded Jo Agnew)

That the Community and Public Health Advisory Committee receive the report.

Carried

6. General Business

There was no general business.

The Committee Chair thanked the public representatives for their attendance at the meeting.

7. Resolution to Exclude the Public (agenda page 103)

Resolution (Moved Judith Bassett/Seconded Lee Mathias)

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

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

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review of 2015/16 Annual Plan and Statement of Intent for Auckland and</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information</td>
<td>Obligation of Confidence The disclosure of information would not be in the public interest because of the greater need to</td>
</tr>
</tbody>
</table>
General subject of items to be considered | Reason for passing this resolution in relation to each item | Ground(s) under Clause 32 for passing this resolution
--- | --- | ---
Waitemata DHBs | information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)] | protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]

3.27p.m – Warren Flaunty retired from the meeting.

3.27p.m -3.45p.m – Public excluded session.

3.45p.m – the meeting resumed in open session.

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

The meeting concluded at 3.45p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS’ COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 29 APRIL 2015

_________________________________________________________ CHAIR
## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 2nd June 2015

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPHAC 04/02/15</td>
<td>4.1</td>
<td><strong>Rheumatic Fever Programme</strong> Evaluation/Public Nurse Role in Schools – that the regional evaluation results for the rheumatic fever programme be reported back to the Community and Public Health Advisory Committee when available and that the public/community health nurse role in schools and the appropriate model of care related to that then be reviewed by the Committee.</td>
<td>Ruth Bijl</td>
<td>CPHAC 22/07/15</td>
<td>Will provide an interim evaluation report with options for further evaluation at the July meeting.</td>
</tr>
<tr>
<td>CPHAC 18/03/15</td>
<td>3.1</td>
<td><strong>Alliance Diabetes and Cardiovascular Disease Clinical Indicators and Measures:</strong> Issue with triple therapy of aspirin of 100mg being funded but not 75mg to be looked at.</td>
<td>Catherine McNamara</td>
<td>CPHAC 10/06/15</td>
<td>Please refer below (next page).</td>
</tr>
<tr>
<td>CPHAC 18/03/15</td>
<td>5.1</td>
<td><strong>Primary Care Update:</strong> – more information on the issue of under-utilisation of POAC to be brought to CPHAC. Time frame for doing this to be advised.</td>
<td>Debbie Holdsworth</td>
<td>CPHAC 22/07/15</td>
<td>Analysis has been initiated. Update to be provided in July.</td>
</tr>
<tr>
<td>CPHAC 29/04/15</td>
<td>4.2</td>
<td><strong>Child, Youth and Women’s Scorecard:</strong> – work to be done on what it is considered the target for breast feeding at 6 months should be and report back to CPHAC for possible recommendation to the Ministry of Health.</td>
<td>Ruth Bijl</td>
<td>CPHAC 22/07/15</td>
<td></td>
</tr>
<tr>
<td>CPHAC 29/04/15</td>
<td>5.1</td>
<td><strong>Planning, Funding and Outcomes Update:</strong> – to check whether ARPHS has made any submissions supporting sealing of unsealed roads for health reasons – Warren Flaunty to be advised.</td>
<td>Simon Bowen</td>
<td>CPHAC 22/07/15</td>
<td>Referred to ARPHS. They are checking their records and also seeing what has been done elsewhere. Advice will be provided to the next CPHAC meeting.</td>
</tr>
<tr>
<td>CPHAC 29/04/15</td>
<td>1.1 (Pub Excluded)</td>
<td><strong>Maori Health Plans/Pacific Health Action Plan:</strong> - when the Maori Health Plans have been finalised a presentation to be arrange for CPHAC on them and also covering the Pacific Health Action Plans.</td>
<td>Simon Bowen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Response re Issue Raised Concerning Aspirin (from Catherine McNamara, Consultant Physician and Diabetologist, WDHB)

Gastric Bleeding risk on 100mg enteric coated aspirin versus 75mg?

This is in response to the query raised at the March CPHAC meeting regarding PHARMAC’s decision to fund 100mg versus 75mg:

“Warren Flaunty raised a concern from his experience as a pharmacist. Triple therapy involves aspirin of 100mg which has the possibility of causing gastric bleeds. Lower dose aspirin is available but unfortunately is not funded and therefore not prescribed. A lot of people had experienced gastric bleeds and are paying for 75mg aspirin themselves. The Committee asked that Catherine McNamara look at that issue.”

I have consulted the literature and discussed the issue with cardiology and pharmacy colleagues. 75 and 100mg aspirin are both classed as low dose. Both doses come in enteric-coated (EC) formulation. Chronic aspirin use can be associated with GI bleeding (this seems to be dose related and certainly occurs more frequently at doses of 150 or 300mg). I’m not aware of any data which shows significantly higher propensity for gastric bleeds on 75mg (EC) dose compared with 100mg (EC) dose, though in susceptible individuals e.g. those with prior gastric ulcer disease, this could be the case.

Consulting the international literature, there are differences of opinion regarding the most appropriate dose of aspirin, and even the most appropriate formulation. PHARMAC do their best to suit the needs of the majority of the population, but there will always be some patients that will be better suited to a lower dose e.g. 75mg or less, because of their bleeding risk.

I found this article on the subject interesting:

http://www.australianprescriber.com/magazine/19/3/79/81/
4.1 Community Engagement Update

Recommendation

That the report be received.

Prepared by: Andrew Old (Director Strategic Unit ADHB), Wendy Bennett (Funding and Development Manager – Health Intelligence and Planning ADHB/WDHB), 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)

Glossary

DHB - District Health Board
MHWG - Maungakiekie Health and Wellbeing Group
NGO - Non-Government Organisation
ROHV - Reo Ora Health Voice

1. Summary

This report is an update on the wide range of consumer and community engagement activity being undertaken by Auckland and Waitemata District Health Boards (DHBs), and includes current information from Health Link North and Waitakere Health Link. Changes in roles and responsibilities for community engagement are also noted.

2. Changes in roles and responsibilities

2.1 Auckland District Health Board - Director, Participation and Experience
Dr Tony O'Connor (Ph.D.) has been appointed to the position of Director, Participation and Experience within the Auckland DHB Strategy, Participation and Improvement group.

The role brings together community participation and patient experience work across Auckland DHB focusing on how the DHB can work effectively together with patients and communities to achieve more integrated people-centred healthcare.

2.2 Health Link North - Manager
Wiki Shepherd-Sinclair has been appointed as the new Manager for Health Link North. Wiki formerly worked at Waitemata DHB as a health promoting schools advisor and more recently as a health promoter at Auckland Regional Public Health Services.

2.3 Health Link Contracts
Discussions are underway to renew contracts with Health Link North and Health Link Waitakere.
3. **Waitemata District Health Board - Engagement Strategy**

Work is underway at Waitemata DHB on the development of an engagement strategy. The current focus is on bringing together community participation and patient experience work. In particular, Waitemata DHB is looking at the importance of involving patients, their family and whānau and the wider community in developing plans, improving services and monitoring how well the DHB is performing.

The strategy will build on existing programmes of work and demonstrate how engagement supports Waitemata DHB’s promise, purpose, priorities and values.

While the initial strategy focuses on Waitemata DHB, due to the existing well-established patient experience work, it is intended that Waitemata DHB will work closely with the new Auckland DHB Director, Participation and Experience.

4. **Consumer and Community Engagement Activity**

4.1 **Reo Ora Health Voice – online community**

The Reo Ora Health Voice (ROHV) online panel was developed by Auckland DHB in 2011 as part of a Consumer and Community Engagement Framework. Recruitment to the panel is generally passive and there are now just over 800 people registered with participants mainly taking part in surveys. However, panel members have also been invited to participate in other forums such as recent ‘In your shoes’ workshops as part of Auckland DHB Values Week.

Work is currently underway to co-design ROHV so that it becomes a more vibrant and interactive community covering both DHB areas in a way that will be welcoming and responsive to different cultural and demographic communities.

Census 2013 data shows that internet access in the Auckland and Waitemata DHB catchments justifies the development of ROHV. Other research shows the increase in older people using online forums and smart phones.

Key aims for the panel are that it becomes:

- a voice that is representative (as far as possible) of our populations’ breadth and depth
- a voice that is valued and able to influence services
- timely
- complementary to face to face and other forms of engagement
- sustainable
- technologically engaging.

Further work will be taking place over the coming months to progress the ROHV online panel.

4.2 **Tamaki Mental Health and Wellbeing Initiative**

The Tamaki Mental Health and Wellbeing vision (co-designed with communities in this locality) is to create, “an experience of health and wellbeing focused on the wellness of the whole person in their family, whanau and community, over the whole of their life, supported by integrated services that are relevant to Tamaki.”
The Initiative is moving into an intensive co-design and prototyping phase where proposed solutions will be developed and tested in response to the vision from the Tamaki community.

A Social Labs framework\(^1\) has been adopted. This brings together a diverse group of stakeholders (people from communities in Tamaki, DHBs, Primary Health Organisations, non-Government organisations (NGO) and government agencies) to design, test and review innovative co-designed solutions to the challenge set.

Dr. Sue Copas, ADHB's Community Participation Manager, is working with stakeholders to co-design a participatory action learning evaluation framework. This innovative approach gives all those involved the opportunity to share control and responsibility for:

- deciding what is to be evaluated
- selecting the methods and data sources (qualitative and quantitative)
- carrying out evaluation activities in the midst of practice
- analysing information and collating results

4.3 Connecting, collaborating and co-designing with communities

The Maungakiekie Health and Wellbeing Group (MHWG) wanted to make healthcare information easily accessible in their area. To do this they were collecting and collating relevant health service provider information to share widely with their community via a google site they had created. Auckland DHB introduced the MHWG to Healthpoint’s web service. MHWG were very taken with the service but identified public transport information as a gap. Many members of their community rely on public transport and they felt that having the Auckland Transport Journey planner link alongside the location maps for services would be a useful addition.

Auckland DHB worked in collaboration with Healthpoint, who also agreed this would be a great addition to their service. Healthpoint is now looking to provide public transport links alongside the health services information they provide. Auckland DHB connected Healthpoint, Auckland Transport and the community group and together co-designed a fridge magnet:

2. [https://vimeo.com/932](https://vimeo.com/932)
This resource is written from the community’s perspective (that is, from the point of view of the people who use the services, not the people who provide the services) and will provide joined-up health and transport information to the Maungakiekie area.

Auckland DHB has sponsored and produced the fridge magnet and the community group have undertaken to deliver 3,000 units to residences in their area.

4.4 Youth engagement project
Health Link North has recently concluded a youth engagement project, funded by an ASB Community Trust grant, which focused on identifying access and barriers to health care in the Rodney region. Kirsten Turnbull was employed by Health Link North, on a short term contract, as the Community Engagement Officer – Youth to manage the youth engagement project.

Kirsten held discussions with youth, youth workers, service providers and community networks which found there were definite barriers for youth engaging with health services. In particular the Wellsford/Warkworth area was felt to have limited representation in the youth health advisory group and there are also significant barriers to youth in this area due to the rural locality.

A report by Kirsten identified that mental and sexual health care were the two largest areas youth find difficult to access and there is a perceived lack of resource in these areas, particularly for youth in Rodney. In response to the recommendations in the report, a youth health expo took place in Wellsford on 1 May, in partnership between Waitemata DHB, Health Link North, Auckland Council, Te Ha Oranga and Te Runanga o Ngāti Whātua.

The purpose of the expo was to raise awareness of health services available for youth in the Upper Rodney region and to directly address some of the concerns of youth.

The expo involved interactive stalls from a range of services and NGOs as well as a panel discussion session that encouraged youth to ask questions on any health-related topic. A report is currently being prepared on the outcome of the day and what should happen next. It is expected that further youth health expos will take place in other parts of Rodney.

4.5 Open days at Waitakere and North Shore hospitals
NGO open days were held in March in conjunction with the DHB’s first Patient Experience week and Well at Work week. Discussions will be taking place with Health Links to determine the future of these events and whether a different approach is needed to connect NGOs with staff and the community.

NGOs also provided feedback that there needs to be better transitioning from leaving hospital to community services.

4.6 Health forums
A medications forum took place in Waitakere on 3 March on The Changing Landscape of Health Treatments. This featured the consumer perspective, the role of Pharmac and provided an opportunity to consider improvements in the discharge process.

72 people attended this forum and feedback was that this was a good mix of information concerning medications from hospital, upon discharge and pharmacy. The presentation provided by the community pharmacist that explained what pharmacies can provide was particularly appreciated.
4.7 Health literacy

Health Links continue to facilitate consumer review of DHB material. Recent material has included a DVD on immunising babies, the Waitemata DHB website and a range of documents such as breathlessness management, health psych information sheet, hysterectomy booklet and radiology correspondence letters.

A new group in Helensville, with a Māori focus, is now operational and is currently supporting the Rodney West Localities work by reviewing information that has been developed on community services in partnership with Health Point. In partnership with Te Rūnanga o Ngāti Whātua, Health Link North staff met with whānau and staff from Te Ha Oranga on 20 May 2015 and provided feedback on the usability of accessing services on the Healthpoint website.

A Families and Parents Brochure for the Rodney/Hibiscus Coast has been developed. The brochure is similar to the very successful ‘Babies Out West’ brochure produced by Waitakere Health Link.
4.2 Ngā Painga Hauora - Maori Health Outcomes Framework

Recommendation:

That the report be received.

Prepared by: Aroha Haggie (Manager, Maori Health Gain)
Endorsed by: Dr Debbie Holdsworth (Director Funding)
Reviewed by: Dr Karen Bartholomew (Public Health Physician)

Glossary

CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
MOU - Memorandum of Understanding

Summary

This paper informs the Community Public Health Advisory Committee (CPHAC) of the process undertaken to develop Ngā Painga Hauora (Maori Health Outcomes Framework). The purpose of Ngā Painga Hauora is to measure the health sector’s contribution to Maori health gain with the immediate focus being the contribution Maori providers’ interventions make. Ngā Painga Hauora is attached to this paper as Appendix One.

1. Development Process

The Maori Health Gain team engaged Sir Mason Durie to develop Ngā Painga Hauora.

Sir Mason reviewed relevant strategies and frameworks and consulted with key internal and external stakeholders. He facilitated three workshops with (MOU) partners Te Rūnanga o Ngāti Whātua and Te Whānau O Waipareira and other Māori providers. The workshops were designed to allow input into the development and refinement of Ngā Painga Hauora. At the completion of the workshops, Te Rūnanga o Ngāti Whātua and Te Whānau O Waipareira and other Maori providers were supportive of the process and the framework developed.

2. Key Elements

Ngā Painaga Hauora has five key elements:

- High level outcome aims
  Mauri Ora, Whānau Ora, Wai Ora (Ministry of Health)

- Long term outcomes and outcome classes
  population health, patient experience, financial sustainability;
  prevention, early detection, intensive interventions, rehabilitation (Auckland DHB and Waitemata DHB)

For a diagram see page 32 of Appendix One.
• **Intermediary outcome goals**  
enagement, alleviation/prevention of a health condition, risk reduction, promotion of wellness

• **Indicator sets**  
aligned to one or more of the intermediary outcome goals

• **Intervention pathways for Māori Health Providers**  
community outreach, clinical interventions, cultural enhancement, capability building, collective impact

**3. Application**

The initial focus of Ngā Painga Hauora is the contribution Māori providers make to Maori health gain. To this end, Ngā Painga Hauora has been used to support the development of Māori provider integrated contracts. Integrated contracts are a mechanism to enable more flexible service delivery, which results in improved health outcomes for clients and whānau.

Ngā Painga Hauora will be used to measure to the current contribution Māori providers are making and will also be used to support the development of new models of care and service delivery to improve Māori health gain. This immediate focus is the first step in an ongoing process, which aims to achieve a more strategic approach to monitoring responsiveness to improving Māori health outcomes.
NGA PAINGA HAUORA

MĀORI HEALTH GAINS:

OUTCOME INDICATORS FOR MĀORI HEALTH PROVIDERS

Mason Durie

8 May 2015
WAITEMATA DHB & AUCKLAND DHB

NGĀ PAINGA HAUORA
MĀORI HEALTH GAINS:

OUTCOME INDICATORS FOR MĀORI HEALTH PROVIDERS

Contents

Executive Summary 3
1. Introduction 5
2. The Process 6
3. The Population 7
4. Building the Framework 8
5. Relevant Strategies and Frameworks 10
6. Māori Health Gains 15
7. Māori Health Providers 18
8. Outcomes 22
9. Indicators 28
10. Ngā Painhga Hauora Framework 30
11. Discussion 33
12. Recommendations 34

Appendix 35
EXECUTIVE SUMMARY

Ngā Painga Hauora contains two recurring themes. The first is related to the measurement of health gains for Māori while the second identifies the links between Māori Health Providers and their contributions to Māori health.

It is no longer sufficient to measure contributions to Māori health by the number of people who have been assisted or by the efforts of health providers, no matter how extensive those efforts might be. Instead the focus needs to be on individuals or whānau who have been receiving assistance and the extent to which their health has benefitted from that assistance. A user-centred outcomes approach is important not only because it highlights the main point of any health intervention – which is to improve health – but also because it enables Providers to know whether or not the work they are doing leads to positive results and as a corollary whether or not they should change direction.

A number of interventions can deliver health gains for Māori. They include programmes or policies that increase levels of wellness and foster 'healthy living' as well as programmes that are aimed at preventing specific diseases or injuries. Prevention comprises efforts to stop a disorder from ever occurring (such as immunisation for measles), preventing complications from a disorder (by for example early intervention) and preventing limitations caused by a permanent disability (hearing aids, mobility scooters). In addition, health gains can follow the reduction of known risks to health (including tobacco and sub-standard housing) and an increase of measures to protect against against poor health (e.g. sport and exercise, whānau capability).

Ngā Painga Hauora is a framework for measuring health gains for Māori, especially gains that can be attributed to Māori Health Providers. The framework is based on intervention logic, other existing outcome frameworks, measures known to lead to Mori health gains, the working context for Māori Health Providers, DHB expectations of Providers, regional Māori population
trends, and the national Māori Health Strategy (He Korowai Oranga, revised 2014).

Ngā Painaga Hauora has five key elements:

1. **High level outcome aims**: Mauri Ora, Whanau Ora, Wai Ora (Ministry of Health)
2. **Long term outcomes**: population health, patient experience, financial sustainability and outcome classes: prevention, early detection, intensive interventions, rehabilitation (ADHB & WDHB)
3. **Intermediary Outcome Goals**: engagement, alleviation/prevention of a health condition, risk reduction, promotion of wellness (Nga Painga Hauora)
4. **Indicator sets** aligned to one or more of the intermediary outcome goals
5. **Intervention pathways** for Māori Health Providers: community outreach, clinical interventions, cultural enhancement, capability building, collective impact Nga Painga Hauora).

The outcomes arising from the intervention pathways can be mapped against the four intermediary outcome goals. For each goal, a set of measurable indicators shows the results. Indicators that can be quantified or at the very least described, are chosen because of their dual relevance – to the intervention – and to a desired outcome. In turn, the intermediary outcome goals can be aligned with DHB long term outcomes and outcome classes as well as with the national Māori Health Strategy.

A large number of indicators can be employed to measure different aspects of Provider interventions. Some are readily accepted as health indices, others reflect the determinants of health, and others still recognise Provider contributions to building foundations that are necessary for good health.

Importantly the selection of indicators should involve both funders and providers.
1 Introduction

The Waitemata District Health Board (WDHB) and the Auckland District Health Board (ADHB) requested the construction of a framework for assessing health gains for Māori. The purpose of the framework was to enable the Boards to contribute to the development of a sustainable and strategic approach to Māori health that included measurements of the benefits of health interventions. While the framework would have potential implications for all services concerned with Māori health, the immediate focus was on interventions by Māori Health Providers.

An outcomes focussed framework relevant to Māori Health Providers coincided with plans to integrate contracts with the Providers. Rather than maintaining a series of separate contracts for specific aspects of health a single over-arching contract was envisaged. But in line with increasing interests in demonstrating provider effectiveness across the whole sector, the transition to an integrated contract provided an opportunity to shape the new contracts around outcome goals.

The framework was to contribute to a reduction in health inequities and to ‘the development of the Māori Provider contracting and procurement process, improving the quality of measuring Māori health gains and opportunities to establish and then review inputs, outputs and outcomes.’

Three overarching aims of Pae Ora, the recently updated He Korowai Oranga Māori Health Strategy (Ministry of Health 2014) were to provide a basis for the framework:

- Mauri Ora – healthy individuals
- Whānau Ora – healthy collectives
- Wai Ora – healthy environments

In addition to the overall aims, indicators for each of the broad areas were to be developed in consultation with the contracted Providers.
2  The Process

The development of the framework was informed by Māori Health Providers, senior Board staff, the Māori Health Gains team from the WDHB and ADHB and by reference to comparable frameworks.

A combined orientation session was held on 18 February 2015 at Waitemata DHB. Twenty participants were drawn from Māori Provider partnerships (Ngati Whatua ki Orakei, Waipareira), senior WDHB and ADHB staff (Funding, Outcomes, Māori Health), and the Māori Health Gains team (Planning and Funding). A broad discussion on outcomes, service expectations, Māori health provider organisations, and Māori Health plans provided a rounded background for considering the framework and led to three further consultations with Māori Health Providers.

The first Māori Provider Hui on 17 March canvassed the parameters of activities currently undertaken by Providers and the competing demands from Māori communities on the one hand and DHB requirements on the other. The generic nature of Provider activities was emphasised with a blurring between health specific activities and activities more aligned to social interventions. A high priority placed on tikanga Māori was also emphasised. The role of Providers in facilitating access to health services was seen as a large component of day to day work, but it was not fully acknowledged as a distinct aspect of the health portfolio.

At the second Provider Hui (1 April) the scope of practice for Māori Health Providers was further discussed and a model of practice was considered. Different priorities were noted especially around the ongoing management of long term conditions, the incorporation of general medical practices, the relationships with Iwi and other Māori organisations, and arrangements for governance. Participation in a Whānau Ora collective had added another dimension for one Provider.
further narrowing the division between clinical interventions and interventions where health was part of a comprehensive intervention.

The third Provider Hui (1 May) discussed the appropriateness of outcome indicators to the work of Providers and considered a set of possible indicators. Providers were generally supportive of the introduction of indicators into contracts. However, there was also a strong opinion that contracts should not be finalised until there was agreement between funders and providers about the choice of indicators.

3 The Population

The combined Māori population served by the ADHB and WDHB is 97,600, approximately 9 percent of the total regional population. Most Māori reside in Maungakiekie-Tamaki, Mt Albert/Eden/Mt Roskill, Waitakere, and North Shore. The population age profiles show similar patterns to Māori in other parts of the country, 49 percent are under the age of 25 years (compared to 32 percent for non-Māori) and 5 percent are over the age of 65 years (compared to 13 percent for non-Māori). Life expectancy for Māori is 77.8 years (compared to 84.4 years for non-Māori). In both Board areas Māori are disproportionately represented in high deprivation areas: 46 percent for ADHB (non-Māori 34 percent) and 37 percent for WDHB (non-Māori 23 percent).

Over the next 20 years the Māori population in both Board districts will increase though not at the same rates. In the ADHB catchment there will be a 12 percent increase (compared to a national Māori increase of 19.5 percent) while in WDHB the Māori population increase will be 25 percent (higher than the national Māori increase). Increases in the non-Māori populations will also show different trajectories: a 26 percent increase in ADHB and a 31 percent increase in WDHB, both increases being higher than the projected national increase of 14.7 percent.

Both Boards have achieved significant health gains for Māori over the past decade including increased life expectancy, smoking cessation,
enrolments in PHOs (78 percent enrolment in 2014), and immunisation rates over 95 percent for Māori two year olds. But health inequities remain across both Board districts, Māori being two or three times more likely to suffer from ischaemic heart disease, lung cancer, non-intentional injuries, diabetes, chronic obstructive pulmonary disease, breast cancer and cerebro-vascular disorders. These are associated with increased frequency of risk factors such as smoking, obesity, lack of physical exercise, high blood glucose and high cholesterol.

4 Building the Framework

4.1 Considerations

In line with the Board requirements, a framework to guide the measurement of outcomes relevant to Board funded Māori Health Providers has been developed. The framework recognises the roles of the WDHB and ADHB (including the Māori Health Gains Team) and also takes into account:

- the Ministry of Health Māori Health Strategy
- the population served by the Providers
- health inequalities and inequities across the two Board catchments
- DHB processes, strategies and plans
- measures known to lead to gains in health for Māori
- the distinctive contributions of Māori Health Providers
- the expectations of communities and service users
- the significance of cultural dimensions to best outcomes
- distinctions between goals related to wellness and sickness
- the need for outcomes and indicators as a basis for measuring health gains over time

4.2 Outcomes

The Framework is built around high level and intermediary outcomes goals – end points that indicate gains in health. High level outcomes reflect progress over time while intermediary
outcomes are endpoints that can be more readily achieved in the short term. The achievement of outcomes is measured by employing specific indicators that are quantifiable, relevant, indicative of a gain in health, and attributable to an intervention.

4.3 Indicators

Three key variables associated with Māori health indicators are:

- Progression over time
- Proxy indicators
- Attribution

Progression over Time: Reaching high level outcome goals for health can take time. But even though the high level outcomes may not be realistic in the immediate future, meaningful results should still be achievable in the short term. Outcome indicators need to be able to mark achievements along a continuum that could extend over a decade or more. The continuum accommodates indicators that are related to a particular level of development and which lead on higher levels. For example:

- Level 1 indicators linked to the resolution of a crisis
- Level 2 indicators that are relevant to a recovery phase
- Level 3 indicators that measure positive development and the avoidance of further crises
- Level 4 indicators appropriate for the high level goals are achieved

Proxy Indicators: The use of proxy measures can compensate for a lack of measurable outcome indicators. Childhood immunisation for example has been used as a measure of responsible parenting and participation in mau rakau might be a step towards overcoming depression and social isolation. In that instance mau rakau would be a proxy measure for a gain in mental health. Referral to a medical provider has also been used as a proxy indicator for accessing primary health care regardless whether a beneficial consultation occurs or not.
**Attribution**  While assumptions about the impact of an intervention may appear obvious, the relationship between an intervention and an outcome is not always clear. Attribution implies cause and effect. But an intervention might:

- bear no relationship to an outcome
- be directly responsible for an outcome
- have an indirect effect on an outcome.

Variables other than a prescribed course of action can be responsible for an outcome. Generally, when an intervention and an outcome are close together in time, it is more likely that the result can be attributed to the intervention.

A further aspect of attribution is the distinction between *distal indicators* – indicators that measure high level outcomes - and *proximal indicators* that measure intermediary outcome goals.

## 5 Relevant Strategies and Frameworks

The recent emergence of a series of outcome frameworks recognises the importance of determining the benefits to those for whom a service is intended – the service users. While input measures and output measures have been the conventional indicators of provider effectiveness, essentially they have been commentaries about providers rather than about benefits to service users. In contrast, the focus on outcomes affords priority to the impact on service users and by implication, on provider effectiveness.

A number of frameworks have been developed for considering the benefits of policies and programmes to Māori. They include health policies, health services, whānau wellbeing, cultural gains, and mental health interventions.
5.1 Ministry of Health

The revised Ministry of Health Māori Health Strategy – *He Korowai Oranga* (2014) – introduced an overarching aspiration, Pae Ora, with three interconnected aims: Mauri Ora (healthy individuals), Whānau Ora (healthy families), Wai Ora (healthy environments). The Strategy is not an explicit outcome framework, but the three key elements all represent high level aims that envisage gains across three perspectives – individuals, whānau, environment.

*He Korowai Oranga* (2014) has implications for health status as well as the determinants of health. As a high level aim, Mauri Ora expects that individuals will have good health and that the health system will deliver services across a continuum from prevention to treatment. The second high level aim, Whānau Ora, recognises the contribution the health sector can make to the health and wellbeing of whānau and to the Whanau Ora policy. The third high level aim, Wai Ora, encompasses natural and built environments, is closely linked to public health and has implications for addressing the determinants of health, including water purity, poverty, and urban safety.

5.2 District Health Boards

Both ADHB and WDHB have developed outcome frameworks. The overall outcome aims are to increase life expectancy and quality of life and to reduce ethnic inequalities. A single overall measure for quality of life has yet to be developed but a number of proxy indicators have been suggested as indicative of overall health gain. Three long term outcomes have been identified: population health, patient experience, and financial sustainability and to address the outcomes, four output classes with measures of success are prioritised:

- Prevention
- Early detection and management
- Intensive assessment and treatment
- Rehabilitation and support.
Examples of success measures include positive changes in smoking cessation, immunisation, health screening, and reductions in accidents, hospital acquired infections, ED waiting times, and acute in-patient bed days.

The Boards have also developed Māori Health Plans. The purpose of the Plans is to map DHB and PHO direction for accelerating Māori health gains and reducing inequities for Māori. Actions that are consistent with the National Health Priority Areas form the substance of the Plans. The ten key areas for action are:

- Data quality
- Access to care
- Child health
- Cardio-vascular disease
- Cancer
- Smoking
- Immunisation
- Rheumatic fever
- Oral health
- Mental health

5.3 Whānau Ora

Whānau Ora was introduced as a whole-of-Government policy in 2010. In addition to recommending greater collaboration between family services, Whānau Ora also emphasised the need for measures that would reflect positive whānau development. The Whānau Ora outcome framework identifies six key outcome goals for whānau:

- self-managing
- living healthy lifestyles
- participating fully in society
- confidently participating in te ao Māori
- economically secure and successfully involved in wealth creation
- cohesive, resilient and nurturing.

The outcome goals are wellness goals that transcend sectors and bridge the individual-collective divide. While a health dimension is included in
the goals the focus is clearly on collective wellbeing rather than treatment or specific disease prevention.

5.4  Te Pou Matakana

Arising from the Whānau Ora policy, the overall goal of Te Pou Matakana (Whanau Ora Commissioning Agency for the North Island) is that: ‘whānau in the North Island will enjoy good health, experience economic wellbeing, be knowledgeable and well informed, be culturally secure, resilient, self managing and able to participate fully in te Ao Māori and in wider society’.

Six indicator sets have been identified:

• whānau knowledge
• whānau health
• whānau participation in community
• whānau engagement with te Ao Māori
• whānau standards of living
• whānau relationships.

While the emphasis is on whānau and wellbeing across a range of sectors and circumstances, good health has been identified as a distinct indicator set. Examples of indicators in the ‘whānau health’ set include:

• Whānau have taken steps to address health problems
• Whānau have adopted healthy eating patterns
• Whānau actively avoid health risks
• Whanau have health insurance
• Whānau are health literate
• Whānau are enrolled in a primary care organisation
• Whānau are involved in health promotional activities (e.g. sport)
• Whānau take advantage of preventative health measures (such as immunisation, health screening, cardiac assessment).
5.6  Te Runanga o Ngati Whatua

Te Runanga o Ngati Whatua has developed a health strategy, *Rautaki Hauora 2013-2018*. The Strategy recognises the obligations of the Iwi towards its people and is closely aligned to Whānau Ora. The Runanga aspirations are to achieve whānau ora outcomes by building the capacity and capability of whānau to realise their full potential in key outcome areas. In addition emphasis is placed on the organisational values and culture, strong partnerships with key organisations and communities, high quality services and outcomes.

*Rautaki Hauora* contains 15 key whainga (objectives) that cover ‘whānau facing activities’ and ‘system facing activities’ and recognise the obligations of the Iwi towards its people. Strength-based services, working partnerships, a competent workforce, value for money, measurable outcomes, and expectations of whānau are among the goals.

5.6  Auckland City Independent Māori Statutory Board

A *Māori Plan for Tāmaki Makaurau* was launched in 2012 by the Auckland City Independent Māori Statutory Board. At the core of the Māori Plan is the cultural, social, economic and environmental wellbeing of Mana Whenua and Mātaawaka.

Key directions for the Plan are:

- Developing vibrant communities
- Enhancing leadership and participation
- Improving quality of life
- Promoting a distinctive Māori identity
- Enduring sustainable futures

The Plan contains 111 ‘state of wellness’ indicators that can be used to measure progress or improvement in each domain. Indicators include access to health services, access to clean parks and resources, and resilient whānau.
5.7  *Hua Oranga*

An outcome framework to measure gains from mental health interventions was developed by Associate Professor Te Kani Kingi in 2002. It was later used for other types of interventions with Māori in health, education, and counselling. *Hua Oranga* is based on an assumption that a good outcome is one where an intervention can demonstrate gains in wairua, hinengaro, tinana, whānau.

Wairua refers to spiritual health (e.g. strengthened cultural identity), hinengaro to mental health (e.g. a positive mood), tinana to physical health (e.g. increased levels of fitness), and whanau to social health (e.g. positive family relationships). The framework is built on a holistic platform that equates a good outcome with gains that are reflected in spiritual, psychological, physical and family dimensions. A good outcome is one where there have been positive changes in all four dimensions.

The *Hua Oranga* framework also allows for parallel assessments to be made by patient, clinician, and a whānau member so that a combined and integrated approach is encouraged. For each of the four goals, a suite of questions scored on a five point scale has been developed.

6  *Māori Health Gains*

Three broad aims for Māori health gains are:

- gains in the level of wellness
- gains resulting from the prevention or alleviation of disease and injury
- gains resulting from an amelioration of living circumstances.

6.1  *Gains in Wellness*

Measuring gains in wellness emphasises a strength based approach more aligned to positive Māori development and the Whānau Ora model than to measuring treatment and care for sickness. Rather than an assessment of
poor health, wellness gains are concerned with progress towards ‘wellness’ and self management. Strengthening cultural identity is an important ingredient of wellness.

At the same time improving levels of wellness is a vital aspect of treatment and recovery. The chances of recurrence of a cardio-vascular disorder, for example can be significantly lowered through efforts to adopt healthy lifestyles and achieve greater levels of wellness. Similarly, medical treatments for obesity related diabetes mellitus can be enhanced by healthy eating and increased levels of wellness. In that respect, treatment and care on the one hand and the promotion of wellness on the other, are mutually compatible and reinforcing.

6.2 Gains through the prevention or alleviation of disease and injury

- **Primary prevention**
  Māori health gains can be measured from the perspective of primary prevention - a reduction in the incidence and prevalence of illness or injury e.g.
  o A reduction in preventable diseases such as type two diabetes, dental decay in children, tetanus, skin cancers, rheumatic fever
  o A reduction in injuries such as workplace accidents, road accidents, inter-personal violence.

- **Secondary prevention**
  Preventing a health disorder is not always possible but the prevention of complications arising from the disorder can frequently be achieved through early intervention and effective management e.g.
  o The avoidance of renal failure associated with diabetes
  o The avoidance of strokes caused by hypertension
  o The avoidance of suicide resulting from depression
  o The avoidance of prolonged recovery due to delayed or ineffective case management.
• **Tertiary prevention**
  While long term illness or permanent disabilities cannot necessarily be eliminated, their disabling consequences can be alleviated e.g.
  
  o Greater social participation through increased mobility
  o Removal of physical, mental and social barriers.

### 6.3 Gains through an amelioration of living circumstances

- **Reduction in risk factors** known to lead to disease or injury.
  
  A wide range of environmental, economic, social, and interpersonal risks are associated with the increased prevalence of health problems. Health gains can be achieved by reducing those risks e.g.
  
  o Tobacco controls
  o Reduction of water and air pollution
  o Improved standards of housing
  o Regulation of alcohol and fast food outlets.

- **Increase in protective factors** known to guard against disease or injury.
  
  Resistance to ill health due to disease or injury can be increased by building protective elements to maintain good health e.g.
  
  o Insulated homes
  o Immunisation
  o Participation in sport and exercise

<table>
<thead>
<tr>
<th>The Promotion of Wellness</th>
<th>The Prevention of disease or injury</th>
<th>The amelioration of Living Circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual measures</td>
<td>Whānau measures</td>
<td>primary</td>
</tr>
<tr>
<td>e.g. BMI</td>
<td>e.g. Whanau Ora Goals</td>
<td>secondary</td>
</tr>
<tr>
<td>Eating patterns</td>
<td>Cultural identity</td>
<td>tertiary</td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
<td>Reduction of risks</td>
</tr>
<tr>
<td>e.g. BMI</td>
<td>e.g. Absence of disease</td>
<td>Increase in Protection</td>
</tr>
<tr>
<td>Eating patterns</td>
<td>e.g. Avoidance of flow-on effects of disease</td>
<td>e.g. Smoking Nutrition</td>
</tr>
<tr>
<td>Exercise</td>
<td>e.g. Removal of social barriers</td>
<td>e.g. Housing Sport</td>
</tr>
<tr>
<td>e.g. BMI</td>
<td>e.g. Absence of disease</td>
<td>e.g. Smoking Nutrition</td>
</tr>
<tr>
<td>Eating patterns</td>
<td>e.g. Avoidance of flow-on effects of disease</td>
<td>e.g. Housing Sport</td>
</tr>
<tr>
<td>Exercise</td>
<td>e.g. Removal of social barriers</td>
<td>e.g. Immunity</td>
</tr>
<tr>
<td>e.g. BMI</td>
<td>e.g. Absence of disease</td>
<td>e.g. Smoking Nutrition</td>
</tr>
<tr>
<td>Eating patterns</td>
<td>e.g. Avoidance of flow-on effects of disease</td>
<td>e.g. Housing Sport</td>
</tr>
<tr>
<td>Exercise</td>
<td>e.g. Removal of social barriers</td>
<td>e.g. Immunity</td>
</tr>
</tbody>
</table>
7 Māori Health Providers

7.1 Providers for ADHB and WDHB

While the proposed framework has elements that are applicable across whole-of-Board activities, it has been designed specifically for Māori health providers and the distinctive nature of their practices.

Currently the two Boards have contracts with six Māori Health Provider organisations:

- Ngāti Whatua o Orakei (Tamaki Maungakiekie) (includes GP practice)
- Te Hononga (Tamaki Maungakiekie)
- Piritahi (Waiheke Island) (includes GP practice)
- Te Puna (North Shore) (includes GP practice)
- Waipareira (West Auckland)
- Te Runanga (Northern)

7.2 Māori Health Provider Context

Māori health providers work in a distinctive space with a distinctive set of expectations and accountabilities. The distinctiveness lies in the socio-economic circumstances and culture of their service users as well as in the characteristics of the communities within which they live. The accountabilities refer to the expectations of funders on the one hand and the expectations of wider Māori communities on the other.

Importantly the framework acknowledges the realities experienced by Māori Health Providers. Typically, the Providers have multiple obligations reflected not only in the strategies and missions of national and local agencies including the Ministry of Health and District Health Boards, but also in the expectations of Iwi, PHOs, a Commissioning agency, communities, and whānau. The expectations of each group overlap but are not identical and while DHB funders are required to ensure gains in health for the Māori population served by their Boards, the work of Providers cannot always be measured solely by conventional Board measures. Iwi for example may expect Māori Health Providers to be
readily available at Hui while whānau might expect Providers to address health problems within a multi-problem context that could include inadequate housing, malnutrition, and non-attendance at school.

7.3 Provider Parameters
The challenge in constructing an appropriate outcomes framework has been to identify indicators that are relevant to the broad parameters within which Providers operate and at the same time to satisfy the Funder that the contributions made by Providers lead to health gains which are consistent with Board funding priorities. In that respect while the immediate impact of an intervention may not deliver an obvious health gain, it may nonetheless be justified as a step towards a health gain. The progressive approach raises other concerns especially when the initial ‘step’ appears to be more aligned to another sector such as education or employment.

Māori health providers operate across the continuum of wellness, accident and disease prevention, treatment, the management of long term conditions, general health and mental health. They reach out to communities, interact with other providers within the health sector and with services in other sectors such as education, social welfare, housing and justice. To some extent the divisions between health promotion, prevention, and treatment, are blurred so that an intervention to address a particular health problem might lead to a range of other actions not directly related to the health problem but necessary to prevent the problem from worsening. Not infrequently the urgency of a health problem can be overshadowed by other plights that justify greater priority. The role of the health worker then becomes one of liaison and advocacy with various community resources.

7.4 Scope of Practice – Intervention Pathways
The scope of practice for Māori Health Providers can be considered as a combination of five overlapping intervention pathways:

- Community outreach
- Clinical interventions
• Interventions associated with Cultural Enhancement
• Interventions aimed at Capability Building
• Collective impact.

7.5 Community Outreach
As part of the communities they serve, Māori Health Providers generally adopt a proactive approach to service delivery. Their obligations extend to the Māori community generally, including those who are not regular service users. Contacts with vulnerable individuals and difficult-to-reach whānau, sourced by word of mouth, by the Courts, or other community organisations, enable interventions where otherwise no assistance would be forthcoming. Those interventions often include laying the foundations for clinical interventions and include:

• advice (on health matters as well as community resources)
• referral to other agencies (including A & D, PHOs, Housing agencies)
• engagement with Māori Health services
• assessment to identify health needs
• a range of clinical, cultural and supportive programmes

7.6 Clinical Interventions
Typically Māori Health Providers undertake clinical activities linked to:

• assessment (e.g. screening for breast cancer, well child checks, hearing tests, cardio-vascular risk assessments, and workplace safety checks)
• disease management (e.g. management of long term conditions)
• prevention of health disorders (e.g. immunisation, well child care, positive parenting, weight reduction, health literacy)
• monitoring (e.g. ‘at risk’ whānau, cholesterol levels, blood pressure)

7.7 Interventions Associated with Cultural Enhancement
The operating cultural context for Māori Health Providers is derived from tikanga Māori and is shaped by tangata whenua values and Māori community aspirations.
• Te Reo Māori (e.g. bilingual signage, options for Māori language interviews, brochures and information sheets in te reo Māori)
• Tikanga Māori (e.g. use of Māori values & perspectives to shape practice, use of kapa haka, mau rakau to endorse healthy living, connecting to marae, hapu, Iwi)
• Whānau Kawa (e.g. kawa for eating, or exercise)

7.8 **Interventions aimed at Capability Building**
While initial contact may have been sparked by a health crisis, Māori Health Providers place emphasis on building the capability of service users by improving health and wellbeing so that future crises and health-related disorders can be reduced and self management can become a reality. Building capability includes:
• Ongoing monitoring of health and health needs (especially for people with long term conditions)
• Rehabilitation (to increase mobility, confidence, social inclusion)
• Health literacy (for individuals and whānau)
• Positive parenting (to provide knowledge and skills necessary for bringing up children)
• Participation in exercise, sport
• Healthy eating

7.9 **Interventions Based on Collective Impact**
As organisations located in communities, Māori Health Providers collaborate with a range of other agencies, some linked to health services, others to education, or housing, or justice. Community-wide cooperation recognises the multi-faceted nature of health problems and the impact of a concerted approach where agencies contribute to a common agenda in an integrated way that avoids fragmentation or contradiction. Not infrequently, the Māori health providers assume an anchoring role that includes taking responsibility for problems that fall between sectoral obligations or competence. Typically Providers collaborate widely:
• Collaboration within the health sector (e.g. primary care providers, pharmaceutical groups, geriatric services, hospital services)
• Collaboration with other sectors (e.g. Housing, CYFS, Justice, Income & Employment)
• Collaboration with Whānau Ora (e.g. Whanau Ora providers, Te Pou Matakana)
• Collaboration with Māori (e.g. Iwi, Community organisations, MWWL, Kura Kaupapa, marae).

Table 2  Scope of Practice: Māori Health Providers Intervention Pathways

<table>
<thead>
<tr>
<th>Community Outreach</th>
<th>Clinical Interventions</th>
<th>Cultural Enhancement</th>
<th>Building Capability</th>
<th>Collective Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Advice</td>
<td>1 Assessment</td>
<td>1 Te Reo</td>
<td>1 Monitoring</td>
<td>1 Health sector</td>
</tr>
<tr>
<td>2 Referral</td>
<td>2 Disease management</td>
<td>2 Tikanga Māori</td>
<td>2 Rehabilitation</td>
<td>2 All sectors</td>
</tr>
<tr>
<td>3 Engagement</td>
<td>3 Prevention</td>
<td>3 Whānau Kawa</td>
<td>3 health literacy</td>
<td>3 Whanau Ora</td>
</tr>
<tr>
<td>4 Assessment</td>
<td>4 Monitoring</td>
<td></td>
<td>4 Positive Parenting</td>
<td>4 Māori, Iwi</td>
</tr>
<tr>
<td>5 Services</td>
<td></td>
<td></td>
<td>5 exercise, sport</td>
<td>communities</td>
</tr>
</tbody>
</table>

8 Towards Pae Ora: Intermediary Outcome Goals

8.1 A Progressive Approach

Gains arising from Māori Health Provider interventions encompass a range of health, cultural, economic, environmental and social gains. For the most part there are overlapping benefits. Economic gains are often associated with social gains, cultural gains are frequently reflected in parallel health gains, and environmental gains have both social and economic consequences with opportunities for health gains.

The five Māori Health Provider intervention pathways have the potential to achieve high-level outcomes but in the short term will be more likely focussed on intermediary outcome goals and proximal rather than distal indicators. As ‘stepping stones,’ intermediary outcome goals are aligned to high-level outcomes but are relevant to more immediate activities.
Four Outcome Goals have been identified as the intermediary outcomes most relevant to Māori Health Provider outputs:

- Engagement
- Alleviation of health conditions
- Reduction of factors that are risks to good health
- Promotion of wellness

Each Outcome Goal can be seen as a step towards the higher level Pae Ora outcomes: mauri ora, whānau ora, wai ora.

8.2 **Intermediary Outcome Goal 1 Engagement**

Engagement with individuals and whānau is a critical first step towards health gains for Māori. Unless the engagement process is positive and reflects cultural and social norms that are meaningful to prospective service users, the chances of active participation will be diminished. Given the circumstances of populations within Māori Health Provider catchments, and earlier unfortunate encounters with services, accessing a service will frequently be handicapped by mistrust and hesitancy in becoming involved in helping relationships.

To that end, Providers will need to be able to establish relationships that are non-threatening, non patronising, and geared to meeting immediate concerns identified by whānau. Because some of those concerns could be more pressing than a particular health problem, engagement with a health provider will be more fruitful if the provider prioritises the pressing matters. A successful outcome from the engagement process will provide a more sustainable platform for addressing health needs and building capability.

Intermediary Outcome Goal 1 has particular relevance to Mauri Ora and Whānau Ora
8.3 Intermediary Outcome Goal 2 Alleviation of a Health Condition

A core business of Māori Health Providers is to improve standards of health by identifying health problems and then ensuring they are effectively managed. Clinical interventions by Providers are generally aimed at resolving health incidents as quickly as possible and minimising the effects of illness through:

- early intervention with resolution and the prevention of complications,
- monitoring long term conditions to maintain optimal functioning and to avoid deterioration.

Both objectives require a collaborative approach with other practitioners, with whānau, and with community agencies.

A good outcome is one where health incidents are well managed so that the impacts are minimised and a return to healthy functioning is hastened. Intermediary outcome goal 2 aligns most closely with Mauri Ora though has relevance for Whānau Ora and the ways in which whānau can respond positively to health conditions.

8.4 Intermediary Outcome Goal 3 Reduction of Risk Factors

Sufficient is known about illnesses and injuries to enable the identification of environmental and socio-economic risks. Some risks such as water quality are linked to the natural environment. Others are linked to built environments including workplaces, housing, roads, food outlets, alcohol and drug availability, and transport options. Socio-economic environments also pose risks such as inter-personal violence, isolation, unemployment, cultural alienation, whānau dysfunction, internet hazards, and bullying. In addition it is now well known that poverty is disproportionately experienced by many whānau and is a major determinant of poor health, educational failure, and offending.

Māori Health Providers spend considerable time attending to health risks and dealing with them directly or with assistance from other agencies.
A good outcome would lead to a reduction in preventable illnesses and injuries and the generation of knowledge and practices to maintain higher standards of health across the wider population. Intermediary Outcome Goal 3 is aligned to Mauri Ora, Whānau Ora and Wai Ora.

8.5 **Intermediary Outcome Goal 4 Promotion of Wellness**

Apart from clinical activities that address the needs of people with health problems, Māori Health Providers are also active in the promotion of wellness. Wellness promotion is not necessarily prompted by an illness or injury; the aim may be to foster healthy living in order to remain healthy and increase both physical and mental stamina.

More typically, however, it is directed at people who are at risk for developing an illness or injury or who are recovering from a health problem. By encouraging healthy eating, physical exercise, cultural knowledge and skills, and workplace safety, the aim is not only to foster adaptive and positive approaches to life and healthy living but also to prevent further health incidents that might otherwise occur.

The promotion of wellness also includes advocating protective factors known to prevent illnesses (e.g. immunisation), a reduction of accidents (e.g. seat belts), or improved inter-personal relationships (e.g. positive parenting).

A good outcome is one where there has been a significant lifestyle change that results in increased vitality, normal physiological functioning, mental health, social inclusion, sufficient knowledge to maintain a high standard of health, and the avoidance of preventable illnesses.

Intermediary Outcome Goal 4 aligns with Mauri Ora, Whānau Ora, and Wai Ora.
Table 3  Intermediary Outcome Goals and the Pae Ora Aims

<table>
<thead>
<tr>
<th>Pae Ora Aims</th>
<th>Mauri Ora</th>
<th>Whanau Ora</th>
<th>Wai Ora</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alleviation of a Health Condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction of Risk Factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotion of Wellness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**8.6 Relationship of Provider Interventions to Intermediary Outcome Goals**
Although there is considerable overlap, it is possible to associate specific Provider interventions with each of the Intermediary Outcome goals.

**8.6.1 Community Outreach** for example, is directly related to the Engagement outcome goal. By being ‘in the community’ and known to the community, Providers will be more approachable, especially for whānau who are relatively estranged from services and resources. In addition, Community Outreach enables Providers to be more aware of environmental health risks and opportunities for health gains. As community leaders they are able to contribute to reducing risks and promoting wellness.

**8.6.2 Clinical Interventions** contribute directly to Outcome Goal 2, alleviating health conditions. As providers of front line services and support to people with long-term conditions, Providers are able to facilitate early clinical interventions and ensure that prescribed treatment plans are maintained over a period of time.
Clinical knowledge and expertise are also important attributes for advising on risk reduction and wellness promotion.

8.6.3 *Cultural Enhancement* is a distinctive aspect of the work of Māori Health Providers. It can greatly facilitate the engagement process, especially for service users whose values are underpinned by tikanga Māori. But the use of te reo Māori and tikanga Māori can also provide service users with greater insights into a health condition or the ways in which the condition can be alleviated. Similarly, there is mounting evidence that Māori cultural activities such as *Iron Māori* and waka ama, can be effective agents for promoting Māori wellness.

8.6.4 *Capability Building* is reflected in the efforts of Māori Health Providers help overcome disabilities and promote wellness, despite ongoing health problems. The contribution to the alleviation of health conditions can be increased through risk reduction, health literacy, exercise and sport, and other activities that will increase wellness. Monitoring a person with high cholesterol for example provides opportunities to increase self management through healthy eating, exercise, and knowledge to avoid associated risks.

8.6.5 *Collective Impact* recognises the effectiveness of intra-sectoral and inter-sectoral collaboration. As partners in community development, Māori Health Providers work with other agencies to reduce community risks and promote wellness. Improving child health for example requires a combined approach that includes education, housing, income generation, parental guidance, and cultural congruence. The contribution of Māori Health Providers is to bring a health perspective as well as cultural understandings and wider community knowledge.
9 Indicators for Intermediary Outcome Goals

9.1 Measuring Health Gains for Māori

A wide range of indicators are necessary to assess outcomes relevant to Māori Health Provider effectiveness. Some of the suggested indicators require further consideration to determine which units of measurement can best provide clear evidence of health gains. In addition some indicators overlap more than one outcome goal e.g. immunisation could be used as an indicator for actions that reduce risks to health (avoiding an infectious disease) or for actions that promote wellness (increasing health awareness and responsibility).

Decisions also need to be made as to whether the purpose of indicators is solely to assess Provider effectiveness or also to measure health gains for a defined population. A reduction of road accidents for example is not directly related to Provider inputs but because of their closeness to communities, Providers might be expected to contribute to policies and programmes that could lead to safer roads. Alternately, if a particular community health risk were identified, Boards might request Providers to take a more direct interest in addressing the risk.

Four sets of indicators are recommended.

- indicators relevant to Engagement
- indicators relevant to the Alleviation of a health condition
- indicators relevant to Risk reduction
- Indicators relevant to the Promotion of Wellness

9.2 Examples of Indicators that are relevant to Engagement

- New enrolments
- Whānau enrolments
- Home visits
- Missed appointments
- Goals achieved at 6 months
- Goals achieved at 1 year
Whānau enrolment in PHOs
Client satisfaction surveys

9.3 Examples of Indicators that are relevant to the Alleviation of a Health Condition

- positive changes in BMI levels
- timely medical referrals
- reduced blood levels of cholesterol and glucose,
- health screening
- hospital admissions for CORD
- attendance at specialist clinics
- stabilisation of long term health conditions
- participation in anger management courses (to reduce domestic violence)
- entry into ‘recovery’ programmes

9.4 Examples of Indicators that are relevant to the Reduction of Risks

- Reductions of Life style risks
- adoption of healthy eating plans
- weight loss
- participation in smoking cessation programmes
- smoke free buildings
- moderate alcohol intake
- cessation of illegal drug taking
- use of aids to reduce social exclusion
- levels of Māori homelessness and ‘living rough’
- Reduction of Environmental risks
- household over-crowding
- insulated homes
- motor vehicle accidents
- Economic risks
- poverty indicators
- gainful employment
o adequate household incomes
o household budgets

9.5 Examples of Indicators that are relevant to the Promotion of Wellness

- Cultural Identity
  o Te Reo Māori brochures, information pamphlets
  o Te Reo Māori option for Provider interventions
  o a whānau kawa for guiding family living
    (Kawa to include: Healthy eating, smoke free homes, use of social media, whānau relationships, exercise, te reo Māori, access to marae, caring for sick, young and old)

- Health Promotion
  o completion of a personalised health plan
  o immunisation uptake
  o breast feeding child at 6 weeks and 6 months
  o health literacy
  o participation in sport or exercise
  o Whānau uptake of health insurance

- Community Access
  o Enrolment in schools or education programmes
  o Marae participation
  o Legal services
  o Māori Land Court services

10 The Framework

The proposed Framework contains:

- Three high level outcome goals
  o Mauri Ora
  o Whānau Ora
  o Wai Ora

- Three DHB Longterm Outcomes
  o Population Health
  o Patient Experience
• Financial Sustainability

**Four Intermediary Outcome Goals**

- Engagement
- Alleviation of a health condition
- Reduction of health risks
- Promotion of wellness

**Four sets of indicators**

- Indicators to measure engagement
- Indicators to measure alleviation of a health condition
- Indicators to measure the reduction of health risks
- Indicators to measure the promotion of wellness

**Five Key Māori Health Provider Interventions**

- Community Outreach
- Clinical interventions
- Cultural enhancement
- Capability building
- Collective impact
Schematic Representation of *Ngā Painga Hauora* Framework

**Pae Ora Aims**  
(Māori Health Strategy)

- **Mauri Ora**
- **Whanau Ora**
- **Wai Ora**

**DHB Outcomes**

**Aims**:
- increase life expectancy
- improve quality of life
- reduce ethnic inequalities.

**Long term outcomes**:
- population health
- patient experience
- financial sustainability

**Outcome classes**:
- prevention
- early detection
- intensive interventions
- rehabilitation

**Intermediary Health Outcome Goals**

- Engagement
- Alleviation of a health condition
- Reduction of Risks
- Promotion of Wellness

**Indicators**

- Indicators that measure Engagement
- Indicators that measure Alleviation of a Health Condition
- Indicators that measure Reduction of Risks
- Indicators that measure Promotion of Wellness

**Māori Health Provider Interventions**

- Community Outreach
- Clinical Interventions
- Cultural Enhancement
- Capability Building
- Collective Impact
11 DISCUSSION

Ngā Painga Hauora provides a framework for measuring the contribution of Māori Health Providers to gains in Māori Health. While all DHB funded services could be expected to contribute to gains in Māori Health, not all services will do so in the same way. Secondary care services for example will provide treatment and care that can bring benefits to Māori but the indicators that reflect those benefits will differ from those used in primary care providers. Similarly, the indicators that are relevant to Māori Health Providers will not be the same as those for General Practitioners or Pharmacists. Because outcomes flow from particular services, intervention-specific indicators best measure results.

At the same time, all services should be able to demonstrate a contribution to the high level outcomes and to the wider national aims for Māori Health. In that respect Ngā Painga Hauora focuses on a relatively small but distinctive component of the total services that can benefit Māori health. The distinctiveness of Māori Health Provider contributions lies in the scope of practice, the characteristics of the communities served, and the vulnerability of the whānau helped. Much of the work undertaken by the Providers represents efforts to initiate actions that will lead to greater opportunities for health gains. However, those efforts often fall outside the orthodox parameters of 'health gains' since they are more closely aligned with socio-economic gains or gains in cultural identity. As a consequence many of the conventional health indicators do not adequately capture the contributions made by Māori Health Providers to initiate change and facilitate engagement.

The examples of indicators in the Appendix attempt to redress that situation by including indicators related to risk reduction and the promotion of wellbeing. Because they are 'stepping stone' indicators they signpost a move towards a health outcome but do not necessarily reflect a measurable gain in health. Neither are those indicators at a stage where they can be quantified in the same way as the more conventional health indicators. Nonetheless 'stepping stone' indicators point to current living circumstances for many
whānau and their estrangement from community and formal health services. In effect ‘stepping stone’ indicators are part of a health development continuum that extends from a pre-engagement stage to primary, secondary and tertiary health care.

A shift to outcome based health funding and servicing represents an important milestone in New Zealand’s health system and Ngā Painga Hauora is submitted as a contribution to that process.

12 RECOMMENDATIONS

It is recommended that:

12.1 Ngā Painga Hauora Māori Health Gains be received as a framework for assessing health gains for Māori.

12.2 The implementation of the framework be jointly managed by the Māori Health Gains team and Māori Health Providers.

12.3 The choice of indicators to reflect specific interventions be a matter for discussion between Boards and Māori Health Providers.

12.4 The recognition of the full range of work undertaken by Māori Health Providers be reflected by appropriate indicators.

12.5 The approach underlying Ngā Painga Hauora be considered when other Board funded services are assessing their contributions to Māori health gains.
**APPENDIX 1 EXAMPLES OF INDICATORS**

<table>
<thead>
<tr>
<th>Outcome Goal</th>
<th>Indicator</th>
<th>Description</th>
<th>Unit of Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>New enrolments</td>
<td>Completed new registrations</td>
<td># Individuals enrolled</td>
</tr>
<tr>
<td></td>
<td>Whānau enrolments</td>
<td>Completed new Whānau registrations</td>
<td># Household groups enrolled</td>
</tr>
<tr>
<td></td>
<td>Home visits</td>
<td>Visits to new enrolments</td>
<td># of visits – new enrolment</td>
</tr>
<tr>
<td></td>
<td>Missed appointments</td>
<td>Did not keep scheduled appointments</td>
<td># who have missed appointments</td>
</tr>
<tr>
<td></td>
<td>Goals achieved @ 6 months</td>
<td>Has followed through with advice/plan</td>
<td>Achieved/not achieved</td>
</tr>
<tr>
<td></td>
<td>Goals achieved at 12 months</td>
<td>Has continued to follow advice/plan</td>
<td>Achieved/not achieved</td>
</tr>
<tr>
<td></td>
<td>Whānau enrolment PHO</td>
<td>Household members enrolled in a PHO</td>
<td>Enrolled/not enrolled</td>
</tr>
<tr>
<td></td>
<td>Satisfaction surveys</td>
<td>Whānau complete satisfaction surveys after 3 months</td>
<td>Favourable/not favourable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alleviation of Health Condition</th>
<th>BMIs</th>
<th>Baseline measure of body mass</th>
<th># completed BMI assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Timely medical referrals</td>
<td>Medical condition warranting referral</td>
<td># of referrals</td>
</tr>
<tr>
<td></td>
<td>Blood glucose, cholesterol</td>
<td>Maintained at ideal levels</td>
<td># at ideal/above ideal levels</td>
</tr>
<tr>
<td></td>
<td>Health screening</td>
<td>Oral, breast, cervical, prostate, heart disease, diabetes, strep throat</td>
<td>Total screened per condition #abnormalities # referred</td>
</tr>
<tr>
<td></td>
<td>Well child checks</td>
<td>Identification of disorders</td>
<td># disorders detected # referred for remediation</td>
</tr>
<tr>
<td></td>
<td>Specialist treatment</td>
<td>Disorders requiring specialist treatment</td>
<td># referred to specialist</td>
</tr>
<tr>
<td></td>
<td>Stabilisation of long term health conditions</td>
<td>No deterioration in clinical state or blood levels</td>
<td># stabilised/not stabilised</td>
</tr>
<tr>
<td></td>
<td>Anger management</td>
<td>Anger management courses arranged</td>
<td># referred for anger mgt.</td>
</tr>
<tr>
<td></td>
<td>Recovery programmes</td>
<td>A &amp; D recovery process</td>
<td># referred to recovery</td>
</tr>
<tr>
<td>Reduction of Risks</td>
<td>Healthy eating plans</td>
<td>Adherence to healthy eating plan</td>
<td># in healthy eating programmes # in healthy eating after 6 months</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------</td>
<td>----------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Weight loss</td>
<td>Weight loss over agreed period of time</td>
<td># who have lost weight</td>
<td></td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>Inclusion in smoking cessation programmes</td>
<td># referred to smoking cessation # who ceased smoking # smoke free after 6 months</td>
<td></td>
</tr>
<tr>
<td>Smoke free buildings</td>
<td>Designation of smoke free buildings</td>
<td>Provider rooms smoke free</td>
<td></td>
</tr>
<tr>
<td>Moderate alcohol intake</td>
<td>Reduction of alcohol intake to safe levels</td>
<td># involved in alcohol reduction # alcohol free after 6 months</td>
<td></td>
</tr>
<tr>
<td>Cessation of illegal drug taking</td>
<td>Involvement in drug misuse education/treatment</td>
<td># involved in drug free programmes # drug free after 6 months</td>
<td></td>
</tr>
<tr>
<td>Social exclusion due to disability</td>
<td>Aids to increase mobility &amp; participation</td>
<td># fitted with aids for mobility, sensory loss</td>
<td></td>
</tr>
<tr>
<td>Homelessness and rough living</td>
<td>Alternate arrangements for living</td>
<td># rehoused in quality accommodation</td>
<td></td>
</tr>
<tr>
<td>Household overcrowding</td>
<td>Reduction in number living in same house</td>
<td># alternate housing arrangements</td>
<td></td>
</tr>
<tr>
<td>Insulated homes</td>
<td>Adequate insulation in family homes</td>
<td># housing insulations arranged</td>
<td></td>
</tr>
<tr>
<td>Motor vehicle accidents</td>
<td>Road and street safety programmes</td>
<td># referred to road safety courses</td>
<td></td>
</tr>
<tr>
<td>Drownings</td>
<td>Water safety programmes</td>
<td># referred to water safety courses</td>
<td></td>
</tr>
<tr>
<td>Poverty</td>
<td>Inter-sectoral solutions</td>
<td>Contribution to reducing poverty impacts</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td>Options for employment, including training</td>
<td># referred to employment agencies</td>
<td></td>
</tr>
<tr>
<td>Household incomes</td>
<td>Options for increasing incomes</td>
<td># referred to relevant agencies</td>
<td></td>
</tr>
<tr>
<td>Household budgets</td>
<td>Improved budgeting for health gains</td>
<td># referred to budgeting services</td>
<td></td>
</tr>
<tr>
<td>Promotion of Wellbeing</td>
<td>Te Reo Māori</td>
<td>Increased options for use of te reo Māori</td>
<td># service publications in te reo Māori # interviews in te reo</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Whānau kawa</td>
<td>Kawa to guide family living (eating, smoke free homes, use of social media, relationships, exercise, te reo Māori, caring for sick, young and old)</td>
<td># whānau adopting a ‘kawa for living’ # whānau upholding whānau kawa after 6 months</td>
<td></td>
</tr>
<tr>
<td>Health plans</td>
<td>Personalised and whānau health plans over 5 years</td>
<td># whānau with 5 year health plans # people with 5 year personal health plans</td>
<td></td>
</tr>
<tr>
<td>Immunisation</td>
<td>Immunisation for children, adults</td>
<td># children fully immunised by 8 months and 2 years # family members with 2 dose MMR immunisation # adults over 60 with flu vaccinations</td>
<td></td>
</tr>
<tr>
<td>Breast feeding</td>
<td>Breast feeding for new born and older children</td>
<td># breast feeding at 6 weeks # breast feeding at 6 months</td>
<td></td>
</tr>
<tr>
<td>Health literacy</td>
<td>Access to health information, knowledge</td>
<td># participating in health education programmes</td>
<td></td>
</tr>
<tr>
<td>Sport and exercise</td>
<td>Increasing Māori participation in sport and exercise</td>
<td># service users referred to sport and exercise programmes # continuing after 6 months</td>
<td></td>
</tr>
<tr>
<td>Health insurance</td>
<td>Increase options for health services</td>
<td># taking up health insurance</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Enrolment in schools, education programmes</td>
<td># educational placements</td>
<td></td>
</tr>
<tr>
<td>Marae participation</td>
<td>Reconnecting with marae, hapū</td>
<td># whānau reconnected to marae</td>
<td></td>
</tr>
<tr>
<td>Legal advice</td>
<td>Contact with legal system</td>
<td># referrals for legal services</td>
<td></td>
</tr>
<tr>
<td>Māori Land interests</td>
<td>Reconnecting whānau with turangawaewae</td>
<td># whānau referred to Māori Land Court</td>
<td></td>
</tr>
</tbody>
</table>
5.1 Primary Care Update Quarter 3, 2014/15

Recommendation

That the Community and Public Health Advisory Committee receive the report.

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

Glossary

ARMS - Auckland Regional Migrant Service
CAB - Citizens Advice Bureau
CCP - Contribution to Cost Pressures
CPSA - Community Pharmacy Services Agreement
CT - Computed Tomography [radiology imaging]
CVD - Cardiovascular Disease
DAR - Diabetes Annual Review
DCIP - Diabetes Care Improvement Package
DHB - District Health Board
DM - Diabetes Mellitus
DNA - Did Not Attend
EDAT - Ethnicity Data Audit Tool
EOI - Expression of Interest
FTE - Full Time Equivalent
GP - General Practitioner
IFHC - Integrated Family Health Centre
IPIF - Integrated Performance and Incentive Framework
ISG - Implementation Support Group
JPSC - Joint Project Steering Group
MACGF - Metro Auckland Clinical Governance Forum
MH - Mental Health
MoH - Ministry of Health
MRI - Magnetic Resonance Imaging [radiology imaging]
NGO - Non-Government Organisation
NHT - National Health Targets
PBFF - Population Based Funding Formula
PHO - Primary Health Organisation
PMS - Practice Management System
POAC - Primary Options for Acute Care
RFP - Request for Proposal
QIT - Quality Improvement Team
Q3 - Quarter 3
SLA - Service Level Alliance
SMOs - Senior Medical Officers
VDR - Virtual Diabetes Register
Summary

This report provides an update on primary care activities across the Auckland and Waitemata District Health Boards (DHBs) during the third quarter (Q3) of the 2014/15 financial year. The report is presented in the following sections:

- National Health Targets (NHT)
- Integrated Performance Incentive Framework (IPIF)
- Progress against the 2014/15 Annual Plan Deliverables.

1. National Health Targets

Primary Care Scorecard

The Primary Care Scorecard (see Figure 1) 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 NHT. Given the DHBs' focus on health targets, these are presented first in the scorecard. Where available, indicators are presented with performance by ethnicity.

How to Read the Scorecard

For each measure, the green bar reflects how well each DHB is doing against the target for the period presented. The bar will begin to show green when the target has been partially achieved. For most indicators, this is once 60% of the target has been met. If performance is meeting target or better than target the bar will display as a solid green line. For the Health Targets, the scale is more sensitive as any variance is deemed to be significant. The bar will only begin to show green once 80% of the target is achieved. Where the bar is blank, this reflects very poor performance against the target or where no data is available or no target has been set.
Auckland and Waitemata DHB Primary Health Care Scorecard

Note: The trend indicators (little arrows on the right end of the green bar) for diabetes management data are provisional. The DHBs are currently checking Q2 data to ensure drop in % for ADHB is not reflective of a quality issue.

The Scorecard above shows for each measure the actual performance of both DHBs during quarter three, 2014/15 against the target. This is described in detail as follows:

I. Better Help for Smokers to Quit – Primary Care Health Target (Q3, 2014/15)

   Target: 90% of enrolled patients who smoke and are seen by a health practitioner in primary care are offered advice and help to quit by July 2015.

   The ‘Better Help for Smokers to Quit’ result is reported by the Ministry of Health (MoH) as a National Health Target and is part of the Integrated Performance Incentive Framework (IPIF, see also Section 3). Both Auckland and Waitemata DHBs have maintained achievement of the primary care ‘better help for smokers to quit’ Health Target. All of the PHOs continue to have a focus on maintenance and achievement of the target and provide comprehensive support to general practices to ensure that people that smoke receive advice and help to quit.

   The final quarter three results released by the MoH rank Waitemata DHB as the second highest performing DHB and Auckland DHB as the third highest. The results are also shown in the Scorecard under Health Targets as well as by the bar chart below:

   - Auckland DHB 96%, ↓1.8% from the previous quarter; and
- Waitemata DHB 99% ↓1.1% from the previous quarter.

All PHOs are prioritising high needs populations in their programmes to support people to quit smoking. The most recent ethnicity data that is available is for quarter two, as shown in the table below.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB (Q2 2014/15)</td>
<td>102%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Waitemata DHB (Q2, 2014/15)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

PHOs have maintained achievement of the target for the previous four quarters. PHOs report monthly to the DHBs on their performance against this target. The PHO results for the month of April are showing a drop in performance with Auckland DHB estimated to be at 84% and Waitemata DHB at 85%. This drop is due to a lot of advice to quit smoking being provided in quarter four of 2013-14; these patients are now due to receive this advice again. The PHOs predicted this drop-off and have planned a proactive approach to reach these patients, such as providing General Practices with recall lists and making outreach texts and phone calls. By the end of quarter four we anticipate that the target will be above 90% again.

II. More Heart and Diabetes Checks Health Target (Q3, 2014/15)

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

The ‘More Heart and Diabetes Checks’ result is reported by the MoH as a National Health Target and is part of the IPIF. The quarter three denominators are 144,991 for Waitemata DHB and 153,904 for Auckland DHB. The denominator increase between quarter two 2014-15 and quarter three 2014-15 for Waitemata DHB was 721. The denominator increase between quarter two 2014-15 and quarter three 2014-15 for Auckland DHB was 874. The quarter three results released by the MoH are as follows (also shown in the Scorecard under Health Targets):

- Auckland DHB 92% (141,522 people CVD risk-assessed)
- Total coverage ↑0.1% from quarter two. This is currently ranked first in the country.
- Coverage for Māori ↑by 0.1% (from 88.4% to 88.5%) and for Pacific ↓by 0.2% (from 90.1% to 89.9%). Auckland DHB is first in the country for Māori coverage and third for Pacific coverage.

- Waitemata DHB 91% (131,188 people CVD risk-assessed)
- Total coverage ↑0.3% from quarter two. This is currently ranked sixth in the country.
- Coverage for Māori ↑0.9% (from 84.5% to 85.4%) and for Pacific ↑0.4% (from 88.1% to 88.5%). Waitemata DHB is ninth for Maori coverage and fourth for Pacific coverage.

The impact of the rolling cohort means that people are moving in and out of the age bands, and people assessed more than five years ago are adding to the number of required assessments.

The increase in cardiovascular disease (CVD) risk assessments has been achieved through:

- Weekly reporting and monitoring of PHO level performance
- Improved access to services
- Increased support to practices from PHO support teams
• Access to advanced IT tools to identify and assess patients who have not had a risk assessment.
• Access to CVD incentive payment on achieving the target.

The Primary Care Team continues to meet with the PHOs on a monthly basis (or more frequently as necessary), to discuss coverage and activities undertaken to maintain the 90% target. Recent meetings continue to focus on increasing coverage for Maori and Pacific people.

III. Improving Population Health - Diabetes Annual Reviews (DARs)

The good diabetes management targets for 2014/15 are: A minimum of 75% of people who have had a DAR will have an HbA1c of <= 64mmol/mol.

HbA1c is a measure of blood glucose, and provides information on how well blood glucose is controlled over a three-month period. Diabetes Annual Reviews (DARs) are measured against the MoH Virtual Diabetes Register (VDR). The VDR is an estimated population of people with diabetes calculated from health information, laboratory tests and pharmacy prescriptions.

The Diabetes Care Improvement Package (DCIP) provides people with diabetes and their primary healthcare providers with specific resources to assist in care. Each PHO has funding to provide services to their populations and they work with the DHB and practices to determine the most effective way to assist people in primary care. Each PHO service differs for this reason. Both DHBs' performance is shown in the Scorecard under 'Improving Population Health (diabetes)', and is described below:

Auckland DHB (Q3 2014/15)
Total DARs completed – 4,578; this represents 86% of diabetes prevalence (VDR) in ADHB:
• Maori - 377 (93% of prevalence)
• Pacific – 1,743 (135% of prevalence)
• Other - 2,458 (68% of prevalence).

Good management:
• 64% of all patients who had a DAR completed had HbA1c <= 64mmol/mol (indicating good diabetes management)
• 60% of Maori who had a DAR completed showed good management
• 50% of Pacific who had a DAR completed showed good management
• 74% of Other who had a DAR completed showed good management.

Waitemata DHB (Q3 2014/15)
Total DARs completed – 3,119; this represents 54% of diabetes prevalence (VDR) in WDHB:
• Maori - 294 (62% of prevalence)
• Pacific - 563 (66% of prevalence)
• Other - 2,261 (51% of prevalence).

Good management:
• 75% of patients who had a DAR completed had HbA1c <= 64mmol/mol (indicating good diabetes management)
• 61% of Maori who had a DAR completed showed good management
• 64% of Pacific who had a DAR completed showed good management
• 79% of Other who had a DAR completed showed good management.
IV. Service Delivery Targets – PHO Enrolment

PHO enrolment for Auckland DHB is 92% and 94% for Waitemata DHB, which has remained unchanged from the previous quarter (Q2, 2014/15). Pacific enrolment is over target for both DHBs – 113% in Auckland DHB and 102% in Waitemata DHB. Māori enrolment rates are 79% for Auckland DHB and 80% for Waitemata DHB; and Asian enrolment rates are 78% and 81% for Auckland DHB and Waitemata DHB respectively. The Alliance will have a role in increasing the focus on Maori enrolment.

The following two campaigns have been planned, and are in the process of concurrent roll-out to increase awareness of the role of the family doctor, and benefits of enrolling with a PHO and general practice:

1. The role of the family doctor as a first contact point for non-life threatening, non-serious medical care (e.g. cough and colds, minor illnesses and injuries). The campaign includes promotional resources in English, Chinese, Korean, Japanese and Vietnamese languages available in settings such as educational institutions (i.e. polytechnics, universities, Auckland Council platforms, Asian partners and targeted Asian communities), and
2. Your Local Doctor campaign which aims to outline the facts on how and why individuals and their families should enrol with a family doctor. This campaign (previously rolled out in 2012), includes new updates as a second phased approach in Chinese, Korean and English languages. Promotion of the resources will include ethnic media channels, Citizens Advice Bureau (CAB) sites, Asian partners and Asian communities.

Ongoing orientation workshops to new migrants on the New Zealand health system and health services are continuing to be held via the Auckland Regional Migrant Services (ARMS), and at CAB information-sharing sessions.

2. Integrated Performance Incentive Framework (PHO Performance as at Q3, 2014/15)

The Integrated Performance and Incentive Framework (IPIF), is a quality improvement programme that will support the health system to address equity, safety, quality, access and cost of services. The IPIF has been developed by clinicians, sector leaders and the MoH. It is recognised that IPIF is new and in a transition phase nationally and will continue to evolve as the programme is rolled out under a phased implementation approach.

The following five PHO performance indicators (focused on the three preventative primary National Health Targets) have been agreed, along with the proposed weightings:

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

Each quarterly payment is calculated on the basis of the PHO’s performance in each quarter during the year – and commenced on 1 July 2014. The DHB will pay the proportion of the quarterly pool for
the quarterly target as set out in the table above. Note that cervical screening activity will be reported in the Women Children and Youth scorecard for the next CPHAC meeting.

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

The Q1, Q2 and Q3 2014/15 IPIF target vs. actual for Auckland PHO are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 Target</th>
<th>Q2 IPIF Result</th>
<th>Q3 Target</th>
<th>Q3 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q4 Target - National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>87.8%</td>
<td>91.9%</td>
<td>88.6%</td>
<td>92%</td>
<td>89.3%</td>
<td>93%</td>
<td>Yes</td>
<td>90.0%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>68.2%</td>
<td>100.3%</td>
<td>75.5%</td>
<td>107%</td>
<td>82.7%</td>
<td>104%</td>
<td>Yes</td>
<td>90.0%</td>
</tr>
<tr>
<td>Increased Immunisation – 8 Month Olds</td>
<td>91.2%</td>
<td>93.8%</td>
<td>92.5%</td>
<td>95%</td>
<td>93.7%</td>
<td>96%</td>
<td>Yes</td>
<td>95.0%</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
<td>93.8%</td>
<td>96.8%</td>
<td>94.2%</td>
<td>91%</td>
<td>94.6%</td>
<td>97%</td>
<td>Yes</td>
<td>95.0%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>80.0%</td>
<td>81.1%</td>
<td>80.0%</td>
<td>81%</td>
<td>80.0%</td>
<td>82%</td>
<td>Yes</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

The Q1, Q2 and Q3 2014/15 target vs. actual for ProCare are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 Target</th>
<th>Q2 IPIF Result</th>
<th>Q3 Target</th>
<th>Q3 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q4 Target - National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>86.9%</td>
<td>91.8%</td>
<td>88.0%</td>
<td>92%</td>
<td>89.0%</td>
<td>92%</td>
<td>Yes</td>
<td>90.0%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>74.4%</td>
<td>102.4%</td>
<td>79.6%</td>
<td>99%</td>
<td>84.8%</td>
<td>101%</td>
<td>Yes</td>
<td>90.0%</td>
</tr>
<tr>
<td>Increased Immunisation – 8 Month Olds</td>
<td>93.4%</td>
<td>94.3%</td>
<td>94.0%</td>
<td>94%</td>
<td>94.5%</td>
<td>94%</td>
<td>No</td>
<td>95.0%</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
<td>94.9%</td>
<td>93.4%</td>
<td>94.9%</td>
<td>94%</td>
<td>95.0%</td>
<td>94%</td>
<td>No</td>
<td>95.0%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>79.0%</td>
<td>78.1%</td>
<td>79.3%</td>
<td>78%</td>
<td>79.7%</td>
<td>79%</td>
<td>No</td>
<td>80.0%</td>
</tr>
</tbody>
</table>
The Q1, Q2 and Q3 2014/15 target vs. actual for Waitemata PHO are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 Target</th>
<th>Q2 IPIF Result</th>
<th>Q3 Target</th>
<th>Q3 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q4 Target - National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>80.1%</td>
<td>88.4%</td>
<td>83.4%</td>
<td>89%</td>
<td>86.7%</td>
<td>90%</td>
<td>Yes</td>
<td>90.0%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>65.2%</td>
<td>96.8%</td>
<td>73.5%</td>
<td>99%</td>
<td>81.7%</td>
<td>94%</td>
<td>Yes</td>
<td>90.0%</td>
</tr>
<tr>
<td>Increased Immunisation – 8 Month Olds</td>
<td>93.2%</td>
<td>93.2%</td>
<td>93.8%</td>
<td>94%</td>
<td>94.4%</td>
<td>92%</td>
<td>No</td>
<td>95.0%</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
<td>93.6%</td>
<td>91.0%</td>
<td>94.1%</td>
<td>91%</td>
<td>94.5%</td>
<td>92%</td>
<td>No</td>
<td>95.0%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>80.0%</td>
<td>81.1%</td>
<td>80.0%</td>
<td>81%</td>
<td>80.0%</td>
<td>82%</td>
<td>Yes</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

The Q1, Q2 and Q3 2014/15 targets vs. actual for Alliance Health Plus (hosted by CMDHB) are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 Target</th>
<th>Q2 IPIF Result</th>
<th>Q3 Target</th>
<th>Q3 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q4 Target - National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>85.6%</td>
<td>89.6%</td>
<td>87.1%</td>
<td>90%</td>
<td>88.5%</td>
<td>90%</td>
<td>Yes</td>
<td>90.0%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>83.9%</td>
<td>91.0%</td>
<td>86.0%</td>
<td>89%</td>
<td>88.0%</td>
<td>92%</td>
<td>Yes</td>
<td>90.0%</td>
</tr>
<tr>
<td>Increased Immunisation – 8 Month Olds</td>
<td>92.5%</td>
<td>95.5%</td>
<td>93.3%</td>
<td>96%</td>
<td>94.2%</td>
<td>93%</td>
<td>No</td>
<td>95.0%</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
<td>95.0%</td>
<td>94.9%</td>
<td>95.0%</td>
<td>95%</td>
<td>95.0%</td>
<td>94.6%</td>
<td>No</td>
<td>95.0%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>73.9%</td>
<td>72.6%</td>
<td>75.9%</td>
<td>73%</td>
<td>78.0%</td>
<td>74%</td>
<td>No</td>
<td>80.0%</td>
</tr>
</tbody>
</table>
The Q1, Q2 and Q3 2014/15 target vs. actual for National Hauora Coalition (hosted by CMDHB) are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 Target</th>
<th>Q2 IPIF Result</th>
<th>Q3 Target</th>
<th>Q3 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q4 Target - National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>83.8%</td>
<td>90.3%</td>
<td>85.9%</td>
<td>90%</td>
<td>87.9%</td>
<td>89%</td>
<td>Yes</td>
<td>90.0%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>83.1%</td>
<td>91.2%</td>
<td>85.4%</td>
<td>89%</td>
<td>87.7%</td>
<td>76%</td>
<td>No</td>
<td>90.0%</td>
</tr>
<tr>
<td>Increased Immunisation – 8 Month</td>
<td>88.9%</td>
<td>95.0%</td>
<td>90.9%</td>
<td>96%</td>
<td>93.0%</td>
<td>94%</td>
<td>Yes</td>
<td>95.0%</td>
</tr>
<tr>
<td>Olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased Immunisation – 2 Year</td>
<td>91.5%</td>
<td>94.7%</td>
<td>92.6%</td>
<td>93%</td>
<td>93.8%</td>
<td>95%</td>
<td>Yes</td>
<td>95.0%</td>
</tr>
<tr>
<td>Olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>73.6%</td>
<td>72.1%</td>
<td>75.7%</td>
<td>72%</td>
<td>77.9%</td>
<td>73%</td>
<td>No</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

3. Progress against the 2014/15 Annual Plan Deliverables

I. Auckland Waitemata District Alliance

The Auckland Waitemata District Alliance has continued to meet monthly since July 2014. The Alliance Agreement was signed on 10 September 2014 and includes accountability, the sharing of information and resources so that we are collectively responsible for performance and best use of resources.

An important focus for the District Alliance has been the development and progression of the diabetes and cardiovascular disease work programme. Key activities that have progressed during quarter three include:

- Completion of a stocktake and gap analysis of services currently available to people with diabetes living in Auckland and Waitemata DHBs
- Formation of a Diabetes Service Level Alliance (SLA) to further develop and oversee the District Alliance diabetes work programme and to provide the Alliance with regular diabetes system performance and quality reports according to the agreed set of indicators. Terms of Reference for the Diabetes SLA have been developed and signed-off by the District Alliance.

The DHB engaged Francis Group International to start a process to look at what the District Alliance representative organisations believe ‘success’ looks like. This process will help to determine the scope of the Alliance and how we should govern for success going forward. The Francis Group International held interviews with 23 key stakeholders and experts with interview questions being focussed on the following:

- What does success for the Alliance look like?
- What integrated care means
• The roles that Alliance members play in making the Alliance successful
• What the priorities are going forward, and
• What lessons have been learnt so far

The Francis Group International presented their findings to the District Alliance at the May meeting. The findings were well received by Alliance members and it has provided a structure for moving the Alliance forward.

A process is underway to align the Terms of Reference for the various SLAs to the District Alliance. This will consider alignment of the principles, priorities and key performance indicators. This work will also involve setting expectations, the scope of the service level alliance, establishing the key performance indicators and reporting templates.

II. Auckland Waitemata Rural Service Level Alliance

The Rural SLA draft scope has been consulted on with stakeholders and subsequent feedback has been incorporated into the proposed SLA document. Nominations for the members of the Rural SLA have been received. The first Rural SLA meeting took place on 13 May, and focused on discussing a workplan, and agreeing and subsequent sign-off of the Terms of Reference.

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

On 9 March 2015, the DHBs released a proposal on the Community Pharmacy Services Agreement (CPSA) 2012 extension and sought feedback from pharmacies. The Metro Auckland DHBs organised an information evening to engage with the pharmacy sector. Approximately 100 pharmacy owners/managers attended this session across the three Metro Auckland DHBs with representatives from Pharmacy Guild NZ, Pharmacy Partners and Green Cross Health.

Individual or group feedback (excluding the sector agents’ feedback) was received from over 270 pharmacy owners and/or pharmacists. Both group and individual membership submissions represented approximately 960 contracted community pharmacy owners and pharmacists. Following the DHBs’ consideration of feedback received on the CPSA extension proposal, the 20-DHBs Collective agreed to present the variation to the CPSA 2012 to pharmacies for their acceptance on 13 April 2015.

This variation extends the term of the CPSA by an additional 12-month period and, in addition, provides for the CPSA to be further extended by an additional period of 12 months should this be required. The majority of the provisions are to be effective from 1 July 2015. Sitting alongside the CPSA Extension, but separate to, is the acknowledgement that community pharmacy should be at the Alliance Table - taking into account local processes and protocols within each region. Overall, the variation will equate to a 1.07% funding increase for the first 12 months of the contract extension and continuation of the annual funding envelope through this period (1 July 2015 – 30 June 2016). Each DHB has also been allocated a portion of a one-off $750,000 fund (based on the DHBs’ population-based funding formula [PBFF]). DHBs will hold their portion of the one-off fund and will work with community pharmacy contract holders in their regions to agree local community pharmacy initiatives focused on quality improvement and patient-centric services. We are discussing with Metro Auckland Pharmacy Advisory Group (MAPAG) investment options for the fund.

Should there be a need to extend the contract to the second year, the annual funding envelope will be removed from 1 July 2016. The mechanism included in the variation will provide up to a 1.00%
funding increase for Year Two (1 July 2016 – 30 June 2017), which is comprised of a Contribution to Cost Pressures (CCP) and a demographic volume growth adjuster.

IV. Waiheke Island Service Review

A stocktake of Waiheke Island health services and gap-analysis has been completed and an internal stakeholder consultation process is near completion. A plan for an external stakeholder consultation process is currently being drafted. Once a plan for external consultation is completed, approval to proceed with this process will be sought from ADHB Executive Leadership Team and the Auckland DHB Board. It is anticipated that robust consultation processes will inform the future planning of Waiheke Island health services.

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

The annual target of POAC referrals is 5,700 for Auckland DHB, 6,150 for Waitemata DHB and 11,623 for Counties Manukau DHB. 85% of POAC interventions will avoid the patient needing to go to hospital.

The Primary Options for Acute Care (POAC) service provides responsive coordinated acute care in the community, with an aim to reduce acute demand on hospital services and allowing patient care to be managed close to home. Funded by the three Auckland DHBs, POAC offers a safe and effective alternative to a hospital presentation or admission. Clinical pathways and policies support consistent practice and drive greater safety and quality of care.

The DHB performance in quarter three 2014/15 is as follows:

- The total number of Auckland Metro POAC referrals in quarter three (January - March 2015), were 16% below the target (see table below). Counties Manukau DHB is 57% below target and Auckland DHB is 22% below target, while Waitemata DHB is 28% above target volumes for the quarter.
- Overall, the total referrals received increased by 9% compared with the same period in the previous year (Auckland DHB >16%; Counties Manukau DHB >9%; 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, 86% of patients were safely managed in the community and avoided hospital presentation, with 87% in Auckland DHB and 88% in Waitemata DHB.
- Total referrals year-to-date (July 2014 – March 2015):
  - Auckland DHB: 3,540
  - Counties Manukau DHB: 6,280
  - Waitemata DHB: 6,487
January – March 2015 Results:

<table>
<thead>
<tr>
<th></th>
<th>Waitemata DHB</th>
<th>Auckland DHB</th>
<th>Counties Manukau DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual number of POAC referrals (target number of referrals)</td>
<td>2081 (1630)</td>
<td>1180 (1510)</td>
<td>1966 (3080)</td>
</tr>
<tr>
<td>Average cost per referral (excl. GST), budget $200.00</td>
<td>$156.69</td>
<td>$151.63</td>
<td>$174.72</td>
</tr>
</tbody>
</table>

Referrals by ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Waitemata DHB</th>
<th>Auckland DHB</th>
<th>Counties Manukau DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>72%</td>
<td>55%</td>
<td>48%</td>
</tr>
<tr>
<td>Maori</td>
<td>7%</td>
<td>9%</td>
<td>16%</td>
</tr>
<tr>
<td>Pacific</td>
<td>7%</td>
<td>14%</td>
<td>21%</td>
</tr>
<tr>
<td>Asian</td>
<td>8%</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>6%</td>
<td>8%</td>
<td>5%</td>
</tr>
</tbody>
</table>

The Auckland/Waitemata DHB Primary Care Team is working with the provider to undertake analysis of current utilisation and quality/audit processes, with a focus on access for the high needs population.

VI. Integrated Models of Care

a) Mental Health stepped-care pilots complete with approved roll-out plans by 30 June 2015

Procare Health Limited, Auckland and Waitemata DHBs, and the New Lynn Integrated Family Health Care Centre are working on a pilot to establish and refine a collaborative stepped-care model integrating primary and secondary care. Four key components are being integrated in order to deliver the clinical care required:

- GP assessment processes
- Coordination/guidance processes
- Primary/Secondary (stepped care) pathways
- Community / Non-Government Organisations (NGO) resources.

The Integrated Family Health Practice in New Lynn continues to host the project. Waitemata DHB Secondary Mental Health Services have established a role to enable specialist psychiatrist support for this model. The psychiatrist provides telephone support to the practice, and also conducts assessments on-site (over 65 clients have been seen to date with less than 7 Did Not Attend (DNAs)). A designated DHB community mental health primary care liaison nurse is also based part-time in the practice. This allows for timely intervention and support for primary care staff and clients both exiting and entering secondary care, and at the interface between the two.

The practice at New Lynn has also designated a practice nurse with a special interest in mental health, who meets regularly with the primary care liaison nurse to discuss system issues and specific clinical issues. A mental health network is in place at the practice together with DHB staff, practice staff, an Odyssey House drug and alcohol primary care youth clinician and Procare health psychologists. A psycho-social assessment model is ready for trial and clinical pathways for primary mental health have been developed, but are yet to be tested.

Coordination and guidance processes have been developed for referral to the primary care liaison nurse and the psychiatrist clinic on site. Determining improved referral pathways to secondary care...
have been delayed awaiting a decision on single point of entry/triage to West Auckland Adult Mental Health Services, and the implementation of e-referral through Care Connect.

A supported e-therapy programme has been developed and started, and self-management groups for mental health clients are in process. The primary care liaison nurse is facilitating referral of primary and secondary mental health clients to the new Stanford Chronic Disease Self-Management programme. Two of the WDHB primary care liaison staff will train in this model in June 2015.

b) The Waitemata DHB Cognitive Impairment Clinical Pathway

The DHB has received the University of Auckland’s Department of Geriatric Medicine Final Evaluation Report of the Waitemata DHB Cognitive Impairment Clinical Pathway Pilot that ran from 4 November 2013 to 31 July 2014.

The report is now being taken through the formal approval processes within both Auckland and Waitemata DHBs before being presented to both Boards. Work is underway exploring the options for implementing the pathway across all general practices in both DHBs.

c) 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 subgroup is comprised of senior medical officers (SMOs) in palliative medicine.

The SMO subgroup developed a paper describing a collaborative working model to improve utilisation of SMO resource within the district. The paper was submitted to the WDHB Board and the Hospice Governance Group in December 2014, and received full endorsement. In 2015 the subgroup have been working on a job-sizing exercise as their final task before handing over to a newly formed Implementation Group. The Implementation Group includes representation from areas such as Human Resources, hospice management and the DHB. This group have begun looking into the SMOs’ work contracts and working with hospice management to compare job descriptions and job-sizing information. It is anticipated to have the collaborative model in operation in the district by the end of 2015.

In addition to this the Clinical Working Group has re-grouped and had its first meeting under the new chairmanship of Professor Pat Alley. The group are looking into the clinical pathways element of the Model of Care. The group have linked in with the Northern Health Pathways Group using their web-based platform as a foundation on which to build on. The group will be leading the way for the Auckland region linking-in with Auckland DHB and Counties Manukau DHB in due course.

For Auckland DHB, scoping of a work programme to develop options for a lead provider is in progress. This is identified as a key component to the development of an integrated palliative care service.

VII. Regional After Hours Network (ADHB)

A procurement subgroup with PHO and DHB representation is undertaking the development of a procurement process to identify suitable service provider(s). Responses from potential providers were received by 1 May 2015 and procurement panel members have subsequently been evaluating responses. The panel convened on 21 May to discuss scoring and agree a shortlist for the Request for Proposal (RFP) process. This process is being overseen by independent probity advisors with a
focus on the process, documentation, and management of conflicts of interests. It is planned for new agreements to be in place this year.

The procurement process for the GP deputising service has started. A subgroup is meeting fortnightly to formalise the procurement process and service specification. It is anticipated that the service specification will go out for consultation to potential respondents before proceeding with a formal RFP process. It is planned for a new agreement to be in place this year.

**VIII. Localities Development**

a) Tamaki locality

The Tamaki Mental Health and Wellbeing paper was accepted by the District Alliance in April 2015. This paper included seven project proposals developed through a co-design process:

1. Whole person/whole of life care
2. NGO integration with Primary Care
3. Developing Primary and Secondary Care integration
4. Linkage service
5. Creating an integrated network of wellbeing hubs
6. Developing the community voice
7. Developing a Tamaki wellbeing framework.

The District Alliance approved the re-allocation of existing resources required to undertake these seven projects. Resources include a core team consisting of 4.3 Full Time Equivalent (FTE) (including a programme director, project managers, a clinical facilitator, GP clinical lead, youth leads, and a Wellness Hub lead). All positions are appointed to, except 1 FTE for project management. Three of the core team members have undergone training in ‘Social Labs’, which is a framework for change in complex social systems. In addition, members of the original working groups that developed the proposals last year will now act as contributors to the development of specific initiatives.

The team will work from three locations – two in Glen Innes (a mixture of office and workshop space), and a further larger space located in Panmure, which will be the main hub of activities.

Current Initiatives that continue to be developed include:

1) NGO integration with Primary Care and Navigation Service
   An Expression of Interest (EOI) process was launched for Mental Health NGOs to release some of their workforce to be involved in the ‘NGO Support Hours for Primary Care’ and the ‘Linkage service’ pilots. This EOI has closed and 10 responses were received. The successful organisation(s) will be chosen soon and different service options trialed in July.

2) Primary-Secondary Integration
   Following meetings with primary care and secondary care representatives this work will focus on two aspects to support better integration – relationships and technology enablers. A tour of primary mental health initiatives in Wellington, Midlands and Canterbury has been arranged for Dr Kristin Good (Clinical Director for Primary Mental Health ADHB). This will help to inform the options that are trialed in this workstream.

3) Youth Innovation Forum
The Tamaki team is working with the ADHB project manager regarding a Youth Innovation Forum for Wellbeing. This forum has come from the ADHB Service Direction for Youth Mental Health. The event will be hosted at the Glen Innes Music and Arts Centre. This is a high profile event and will have positive benefits to the on-going youth engagement with the wider Tamaki work. The youth leads in the core team will support the development of this innovation forum and will ensure that it benefits Tamaki youth.

4) Wellbeing Hubs
The Wellbeing Hub concept has a focus on co-ordinating existing activities and developing new activities that support wellbeing - into a programme of activities that will improve access to services for the community. A team is being formed consisting of the Tamaki Redevelopment Company, Maungakiekie-Tamaki Local Board, Auckland Council and MSD Community Investment to work with the community to develop this programme.

Stakeholder mapping and a Communications Plan have been completed. A website is also under development, which will operate as a portal for two-way information. For evaluation purposes, a participatory action-learning framework has been chosen. This innovative and developmental approach gives the opportunity for all stakeholders to share control and responsibility for the evaluation processes. This evaluation will seek to cultivate a learning culture in the programme of work and will also track progress against baseline measures.

In terms of governance, the District Alliance will act as overall sponsors of the work. The Tamaki Steering Group is responsible for the strategic oversight of the initiative and is also responsible for championing a learning culture in all facets of the initiative. In keeping with the emphasis on partnership at all levels, this steering group will be co-chaired by a community representative and a service representative. There will also be a Tamaki Clinical Advisory Group.

b) West Rodney Locality

The Auckland North Localities Operational Group (LOG), as the project working group, will be refining specific projects to take forward for the remainder of this year. The previous focus during 2014-15 has been Child Oral Health and Access to Services, but this may change as a consequence of reviewing and updating the Terms of Reference for the LOG. This review is currently work-in-progress.

In the meantime, the following work is currently underway within the Primary Care Team:
• Improving oral health resources for West Rodney – fostering closer engagement between Healthpoint, Auckland Regional Dental Services (ARDS) and Health Link North to improve access, visibility and service provision for children’s dental services in West Rodney.
• Healthpoint and the West Rodney-NGO pilot – continued support and refinement by Healthpoint to provide information on NGO services to its users.

c) West Auckland Diabetes Pathways - Implementation of the Quality Improvement Team (QIT)

Thirteen general practices from the West Auckland area are participating in the diabetes improvement initiative. This initiative is primarily designed to improve Māori and Pacific population’s diabetes-related outcomes.

A Diabetes Improvement Coordinator is working closely with the participating practices, and has commenced the data collection process. Baseline data and process mapping to better understand
the management of diabetic patients have nearly been completed for 8 out of 13 of the practices. In order to improve the management of patient management processes and outcomes, Plan-Do-Study-Act cycles of improvement have also commenced.

Outstanding practices for baseline data/process mapping are predominantly those with the practice management systems (PMS) - My Practice PMS and Medtec Evolution PMS. Issues with regard to outstanding baseline data are expected to be resolved by the end of May 2015.

4. Other

I. Improving PHO Enrolment (especially among high needs populations)

One of the areas of work is connecting up PHO enrolment with the findings from the implementation of the Primary Care Ethnicity Data Audit Tool (EDAT). The Māori Health Gain Team is implementing EDAT with support from the Primary Care Team.

EDAT implementation is well under way in all general practices within Auckland and Waitemata DHBs. Current completion rates sit at 89%, with 213 general practices having completed the audit tool. The EDAT provides a resource for assessing the quality of ethnicity data in primary care settings including systems for ethnicity data collection, recording and output.

A range of data and technical issues have been highlighted in both the training of PHOs and practices in EDAT, and the results so far of the audit itself to date. A paper outlining these technical issues has been sent to relevant departments at the MoH and these issues are likely to contribute significantly to the misclassification of ethnicity in primary care.

A range of quality improvement recommendations will be provided in the final EDAT project report. One of the recommendations will be the development of an e-learning module for frontline administrative staff in primary care. A proposal for funding the development of the e-learning module was sent to the MoH in March but no decision has been received to date. However, other options for the development of the e-learning module are being investigated. One possibility is to work with Counties Manukau DHB on a shared approach through Ko Awatea.

Associated with EDAT, the Māori Health Gain Team has undertaken a stocktake of studies, projects and audits of ethnicity data that may relate to ethnic-specific PHO enrolment rates. When EDAT is complete (June 2015), the results will also inform this analysis. To date this work suggests a significant proportion of under-enrolment of Māori which may be due to misclassification (i.e. data quality issues). The findings of this analysis will be reported to CPHAC when complete. EDAT is the appropriate vehicle through which to work on data quality improvement with primary care, and improving the quality of ethnicity data will help better reflect the ethnic-specific PHP enrolment rates, in order to work on improving enrolment for our high needs populations.

II. Access to Diagnostics - Radiology

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

The actual versus regionally agreed target regarding wait time for accepted routine community referred radiology is as follows:

<table>
<thead>
<tr>
<th>DHB</th>
<th>CT Target</th>
<th>CT Actual</th>
<th>CR Target</th>
<th>CR Actual</th>
<th>MRI Target</th>
<th>MRI Actual</th>
<th>US Target</th>
<th>US Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
<td>90%</td>
<td>63%</td>
<td>85%</td>
<td>81%</td>
<td>85%</td>
<td>52%</td>
<td>75%</td>
<td>36%</td>
</tr>
<tr>
<td>CMH</td>
<td>90%</td>
<td>66%</td>
<td>85%</td>
<td>92%</td>
<td>85%</td>
<td>47%</td>
<td>75%</td>
<td>51%</td>
</tr>
<tr>
<td>WDHB</td>
<td>90%</td>
<td>95%</td>
<td>85%</td>
<td>97%</td>
<td>85%</td>
<td>82%</td>
<td>75%</td>
<td>64%</td>
</tr>
</tbody>
</table>

During February 2015, ADHB had problems with the provision of ultrasounds with only 29% of patients receiving ultrasound investigations within target timeframes. During March, radiology wait times for ultrasound improved from 29% to 36% of patients receiving investigations within target timeframes.

For ADHB the 2014/15 year-to-date expenditure is $216,300 against the allocated budget of $375,000 (i.e. underspent by $158,700). For the nine months from 1 July 2014 to 31 March 2015, over half of all referrals are of European ethnicity, with Maori at 7%, Pacific at 14% and Asian at 25%. Twenty-four percent of referrals were quintile 5 patients.

5. Primary Mental Health

I. Stepped Care Model

The Primary Mental Health services delivered by the PHOs are based on the stepped care model, as articulated in Rising to the Challenge (the Mental Health and Addictions Service Development Plan, 2012 – 2017). The services, with the exception of the Prime Minister’s Youth Mental Health Initiative, are targeted to Māori, Pacific and quintile 5 patients. Waitemata and Auckland DHBs use similar service specifications for the adult primary mental health initiatives contracts with the PHOs, and apply the available funding to the PHOs weighted towards the Maori, Pacific and quintile 5 populations. Additional funding has also been provided by the MoH to target alcohol screening and brief interventions in primary care settings. This funding supports and extends interventions that are already in place as part of existing primary mental health initiatives.

II. Auckland DHB

The Primary/Secondary Integration Strategic Group and the linked Tamaki Locality Mental Health Project continue to look at opportunities for increased integration between primary and secondary mental health services (see also section 3, Tamaki Locality work) and the Youth Alliance, led by ProCare PHO, provides primary mental health interventions to youth (aged 12 to 19 years).
2014/15 Quarter 1, 2 and 3 volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland PHO Q1</th>
<th>Auckland PHO Q2</th>
<th>Auckland PHO Q3</th>
<th>ProCare Q1</th>
<th>ProCare Q2</th>
<th>ProCare Q3</th>
<th>AH+ Q1</th>
<th>AH+ Q2</th>
<th>AH+ Q3</th>
<th>NHC Q1</th>
<th>NHC Q2</th>
<th>NHC Q3</th>
<th>Youth Alliance Q1</th>
<th>Youth Alliance Q2</th>
<th>Youth Alliance Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>53</td>
<td>139</td>
<td>141</td>
<td>1116</td>
<td>574</td>
<td>750</td>
<td>25</td>
<td>1</td>
<td>21</td>
<td>18</td>
<td>100</td>
<td>90</td>
<td>42</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td>Māori</td>
<td>117</td>
<td>38</td>
<td>33</td>
<td>405</td>
<td>268</td>
<td>316</td>
<td>11</td>
<td>4</td>
<td>24</td>
<td>88</td>
<td>19</td>
<td>11</td>
<td>26</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>133</td>
<td>19</td>
<td>18</td>
<td>310</td>
<td>178</td>
<td>209</td>
<td>136</td>
<td>95</td>
<td>75</td>
<td>69</td>
<td>14</td>
<td>15</td>
<td>59</td>
<td>59</td>
<td>86</td>
</tr>
<tr>
<td>Asian</td>
<td>27</td>
<td>48</td>
<td>43</td>
<td>186</td>
<td>241</td>
<td>272</td>
<td>18</td>
<td>3</td>
<td>17</td>
<td>5</td>
<td>50</td>
<td>25</td>
<td>13</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>82</td>
<td>68</td>
<td>325</td>
<td>209</td>
<td>234</td>
<td>38</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>5</td>
<td>51</td>
<td>6</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Totals</td>
<td>333</td>
<td>326</td>
<td>303</td>
<td>2342</td>
<td>1470</td>
<td>1781</td>
<td>228</td>
<td>106</td>
<td>141</td>
<td>180</td>
<td>188</td>
<td>192</td>
<td>146</td>
<td>135</td>
<td>164</td>
</tr>
<tr>
<td>Target</td>
<td>86</td>
<td>86</td>
<td>86</td>
<td>360</td>
<td>360</td>
<td>360</td>
<td>106</td>
<td>106</td>
<td>106</td>
<td>77</td>
<td>77</td>
<td>77</td>
<td>104</td>
<td>104</td>
<td>104</td>
</tr>
</tbody>
</table>

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

### III. Waitemata DHB

In previous years, Waitemata DHB has funded PHOs by enrolled population. For 2014/15 Waitemata DHB has moved to funding by enrolled Māori/Pacific and quintile 5 populations (using the same methodology as used by ADHB). Due to the significant changes in PHO funding this would cause, Waitemata DHB has agreed to phase this funding change over 2014/15. This funding arrangement will be reviewed for 2015/16, when utilisation data is analysed.

HealthWest provide primary mental health interventions to youth (aged 10 to 24 years), as part of the Waitemata DHB Youth Health Hub.

2014/15 Quarter 1, 2 and 3 volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Waitemata PHO Q1</th>
<th>Waitemata PHO Q2</th>
<th>Waitemata PHO Q3</th>
<th>ProCare Q1</th>
<th>ProCare Q2</th>
<th>ProCare Q3</th>
<th>HealthWest Q1</th>
<th>HealthWest Q2</th>
<th>HealthWest Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>339</td>
<td>260</td>
<td>126</td>
<td>450</td>
<td>418</td>
<td>568</td>
<td>205</td>
<td>163</td>
<td>189</td>
</tr>
<tr>
<td>Māori</td>
<td>45</td>
<td>33</td>
<td>25</td>
<td>272</td>
<td>255</td>
<td>289</td>
<td>160</td>
<td>103</td>
<td>103</td>
</tr>
<tr>
<td>Pacific</td>
<td>17</td>
<td>18</td>
<td>5</td>
<td>91</td>
<td>63</td>
<td>77</td>
<td>43</td>
<td>39</td>
<td>35</td>
</tr>
<tr>
<td>Asian</td>
<td>26</td>
<td>17</td>
<td>7</td>
<td>46</td>
<td>61</td>
<td>63</td>
<td>13</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>11</td>
<td>18</td>
<td>72</td>
<td>70</td>
<td>110</td>
<td>21</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>444</td>
<td>339</td>
<td>181</td>
<td>931</td>
<td>867</td>
<td>1107</td>
<td>442</td>
<td>335</td>
<td>364</td>
</tr>
<tr>
<td>Targets</td>
<td>320</td>
<td>320</td>
<td>320</td>
<td>553</td>
<td>553</td>
<td>553</td>
<td>357</td>
<td>357</td>
<td>357</td>
</tr>
</tbody>
</table>

Utilisation of services is currently under review. The DHB and the providers are working together to better understand utilisation against the current Agreement.
IV. Metro Auckland Collaborative for training primary care nurses in mental health and addictions

Auckland Metro 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.

A Collaborative approach has been undertaken to:
- Directly respond to the Government’s priority agenda of integration and mental health needs of our communities
- Foster positive cross-working and joint-working approaches to provide one programme of learning to the primary health care nursing workforce
- Endeavour to provide a service delivery model which can be sustained over the next 2-5 years as an example of innovative integration to both serve community need and support workforce gaps.

An initial ‘pilot’ credentialing programme will be developed and delivered, adapted from the successfully evaluated Manaia PHO work. The programme will draw together 10 primary health care nurses from each DHB area (a total of 30 nurses) and integrate their opportunity to develop new knowledge and skills within one central programme of learning.

The programme focus is on supporting nurses to translate knowledge and skills into their everyday practice, and will include:
- Six study days over a 6 month period (June - November 2015)
- On-going reflective practice
- Group supervision sessions (in the period between study days)
- Preparation for assessment through portfolio presentation to the Te Ao Māramatanga New Zealand College of Mental Health Nurses (NZCMHN).

The programme will be independently evaluated to assess programme of learning, the service model of delivery and future programme sustainability.
5.2 Planning, Funding and Outcomes Update

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Manager - Planning and Health Intelligence), Kate Sladden (Funding and Development Manager - Health of Older People), Aroha Haggie (Manager - Maori Health Gain), Lita Foliaki (Manager - Pacific Health Gain), Aroha Haggie (Manager - Maori Health Gain), Manu Fotu (Programme Manager Suicide Prevention – Mental Health and Addiction), 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

Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata DHBs’ planning and funding activities and areas of priority. It is generally limited to matters not already dealt with by other Board committees or elsewhere on the CPHAC meeting agenda.

1. Planning

1.1 Annual Plans
Both Auckland and Waitemata District Health Boards submitted second draft Annual Plans to the National Health Board on 26 May 2015, and the Planning team is awaiting feedback.

1.2 Annual Reports
Initial work on the 2014/15 Annual Reports has commenced and requisite audit work has been completed.

1.3 Engagement
Development of the Community and Patient and Whanau Engagement Strategy continues and full detail is provided in the Community Engagement Update paper on this agenda.

1.4 Budget 2015
The two significant items included in budget 2015 are:

- Bowel Cancer Screening Pilot
$12.4 million to extend the Waitemata DHB bowel cancer screening pilot until December 2017. The original pilot was four years and was due to finish June 2016. The evaluation of the pilot will not be available until 2017 when it is anticipated a decision will be made regarding a national roll out. This interim funding allows the programme to continue in the meantime thereby ensuring the expertise
Waitemata has gained is not lost while awaiting a decision re a national rollout. At an operational level this is extremely positive as we were starting to lose valued staff coming to the end of fixed term contracts and looking for certainty of employment.

- **Palliative Care**

$76.1 million nationally over four years to help hospices expand their palliative care services and support 60 new nurse specialists, palliative care educators and support roles.

Of this, $13 million per annum is being allocated to hospices via DHBs, on a population based funding approach, to help hospices expand their community palliative care services so they can better support terminally ill people at home and in aged-care facilities.

There is separate funding of an additional $3.1 million in 2015/16, rising to $7 million from 2016/17, to support the recruitment of 60 new nurse specialists, palliative care educators and other roles at hospices. These nurses are to help train, mentor and support staff across aged residential care, GP practices and home-based support services.

2. **Health of Older People**

2.1 **Home Based Support Services**

The HBSS contracts for Auckland and Waitemata DHBs are being rolled over for 2015/16; during this time an RFP will be undertaken for an aligned HBSS model across both DHBs.

In-between travel time (paying health care assistants for their time travelling between clients) will start on 1 July 2015. Initially the funding will be dispersed centrally (MoH) as part of an interim approach. The funding will be devolved once an agreed sustainable payment mechanisms is in place.

There has been an increase in the proportion of Waitemata DHB HBSS clients with an interRAI (standardised clinical assessment). The most recent report (one quarter in arrears) shows:

- 75.6% of Waitemata HBSS clients have an interRAI assessment (previous quarter – 67.7%)
- 94.6% of ADHB HBSS clients have an interRAI assessment (previous quarter – 95.1%)

2.2 **Aged Residential Care**

All Auckland DHB and Waitemata DHB aged residential care facilities are engaged in interRAI training as detailed in the table below.

<table>
<thead>
<tr>
<th>interRAI Training</th>
<th>ADHB % (n)</th>
<th>WDHB % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully competent (required number of nurses trained)</td>
<td>54% (35)</td>
<td>56% (34)</td>
</tr>
<tr>
<td>Competent (at least one nurse trained)</td>
<td>35% (23)</td>
<td>39% (24)</td>
</tr>
<tr>
<td>Currently training</td>
<td>8% (5)</td>
<td>3% (2)</td>
</tr>
<tr>
<td>Booked for training</td>
<td>3% (2)</td>
<td>2% (1)</td>
</tr>
</tbody>
</table>

Certification periods are a reflection of ARRC performance in audits; four years is the maximum period a facility can be certified for. All facilities will have a surveillance audit (unannounced) midway through their certification period. All new facilities will only be certified for one year initially.

The table below shows the current certification periods for ARRC facilities in Auckland and Waitemata DHBs.
<table>
<thead>
<tr>
<th>Certification Period</th>
<th>ADHB % (n)</th>
<th>WDHB % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months</td>
<td>0</td>
<td>8% (5)</td>
</tr>
<tr>
<td>24 months</td>
<td>12% (8)</td>
<td>14.5% (9)</td>
</tr>
<tr>
<td>36 months</td>
<td>65% (45)</td>
<td>63% (39)</td>
</tr>
<tr>
<td>48 months</td>
<td>23% (16)</td>
<td>14.5% (9)</td>
</tr>
</tbody>
</table>

3. **Maori Health Gain**

3.1 **Planning**
The 2015\16 Maori Health Plans for Auckland and Waitemata DHBs were submitted to the National Health Board on 26 May 2015. Final feedback will be received in the week starting 8th June.

3.2 **Integrated contracts**
Original support for integrated contracts was advised in June 2014. Since then, a first generation integrated contract was developed. Following a review of the development process, a second generation, 3 year 3 phase integrated contracting strategy has been developed. Sir Mason Durie was engaged as part of the strategy, to develop a Maori health outcomes framework – Nga Painga Hauora for Auckland and Waitemata DHBs. Service specifications have been developed to align to the Nga Painga Hauora framework and an ongoing monitoring and development strategy has been put in place.

3.3 **Ethnicity Data Audit Tool**
The target of 95% implementation of the Ethnicity Data Audit Tool in General Practices across Auckland and Waitemata DHBs has been achieved.

4. **Pacific Health Gain**
The implementation of Pacific Health Action Plan (PHAP) is on target for Priorities 1 – 5, as follows:

4.1 **PHAP Priority 1 – Children are safe and well and families are free of violence**
The Healthy Babies Healthy Futures (HBHF) Pacific Collective met recently to review the programme implementation. The MoH has advised Waitemata DHB it will be renewing the contract for 12 months with a variation to the service specifications. Meetings with MOH and HBHF providers have resulted in agreement for MOH, DHB and providers to co-design the service for 2015/16.

4.2 **PHAP Priority 2 – Pacific People are smoke-free**
The Pacific Health Gain Team has met with the ARPHS Pacific Quit Smoke team about the Pacific smoking cessation contract underspend and utilisation of it to improve services for Pacific in the future. A workshop is being organised to consider how to improve quit rates for Tongan men and Cook Island women. Pacific Heartbeat will undertake focus groups with Pacific pregnant women.

4.3 **Priority 3 – Pacific people are active and eat healthy**
The Pacific Health Gain Team is in the process of setting up a working group to consider how to respond to the needs of severely obese Pacific children, and their families.

4.4 **PHAP Priority 4– People seek medical and other help early**
The Pacific Health Gain Team is finalising the draft AH+ Integrated service contract.
The Parish Community Nursing service is progressing well, but a system for clinical data collection and data analysis needs to be developed.

3.5 PHAP Priority 5 - Pacific people use hospital services when needed
The General Manager for Pacific Hospital Services reports on this priority.

4.6 PHAP Priority 6 – Families live in houses that are warm and adequate
No further action has occurred with respect to this priority since the last Committee meeting. The Pacific Health Team intend to discuss with the Pacific community at the PHAP Progress report back in June.

4.7 General Comments
It is a year from when the current PHAP was launched. A community event has been arranged for the Funder to report back on the progress of the Plan’s implementation in June 2015. The Funder will take the opportunity to further converse with the community as to what they think could be done through the PHAP to address housing needs.

5. Mental Health

The draft Waitemata and Auckland DHB Suicide Prevention and Postvention Action Plan (SPPAP) 2015 – 2017 was presented to CPHAC on 18 March 2015 and submitted to the Ministry of Health on 20 April 2015. The MOH provided the following feedback and recommendations:

“Thank you very much for submitting your plan. It has made for interesting reading and shows a great deal of thought, planning and consultation. It is good to see a plan designed to cover the wider region, especially given the populations of each area have similarities but also important differences.

Strengths:
- Good identification of at-risk groups
- Good breakdown of populations
- Clear governance responsibility identified
- Three priority areas noted and woven through the plan
- Excellent to see that evaluation is built into the plan
- Clear programme of activity with timelines and lead agencies identified
- Good links with local Māori.

Recommendations for the final plan:
- A description of the key stakeholders who engaged in the development of the plan.
- Are there any differences within the populations over the region that needs to be taken into account?
- How is your postvention response managed currently?
- How are you planning to manage a potential cluster/contagion situation?”

At its meeting of 18 March 2015, CPHAC recommended that “any underlying issues that the Suicide Prevention Advisory Committee considers will be useful for the DHBs to take action on, including possibly at a national level, be brought back to CPHAC for consideration”. This will be given ongoing consideration until the SPPAP is finalised and implemented from July.
A final draft of the Waitemata and Auckland DHB SPPAP 2015 – 2017 will be tabled with CPHAC when available before submitting to the Ministry of Health on 20 July 2015.

6. Auckland Regional Public Health Service

6.1 Submissions

Auckland Regional Public Health Service (ARPHS) has made five submissions during April and May 2015, as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 April</td>
<td>RMA Consent – Application for Discharge of Contaminants into Air</td>
<td>Issues were around the discharge to sensitive receivers (schools, neighbours, childcare centres). There are potential risks of accidental and fugitive discharges of matter less than 10um in diameter – having more of an impact on children.</td>
</tr>
<tr>
<td></td>
<td>(Waikato Regional Council)</td>
<td></td>
</tr>
<tr>
<td>24 April</td>
<td>Car Sharing Proposals in Auckland (Auckland Transport)</td>
<td>This submission endorsed the approach taken by Auckland Transport to pilot a car sharing scheme.</td>
</tr>
<tr>
<td>7 May</td>
<td>Review of the Poultry NMD Programme’s Campylobacter Performance Targets (Ministry of Primary Industries)</td>
<td>This submission was supporting of steps to reduce the incidence of Campylobacter cases.</td>
</tr>
<tr>
<td>7 May</td>
<td>Food Safety Law Reform (Ministry of Primary Industries)</td>
<td>Advised the principle of food safety is paramount over reputational issues. Advised that further consultation documents and food notices should discuss and evaluate public health impacts. Supported regime to ensure verifiers’ independence obligations are appropriately monitored.</td>
</tr>
<tr>
<td>22 May</td>
<td>Animal Products (Specifications for products intended for Human Consumption) (Ministry of Primary Industries)</td>
<td>Submission agreed that there should be clear guidance and direction for health of personnel when preparing animal products for human consumption. Research indicated that Maori have higher rate of food borne illnesses than non-Maori. Measures to reduce food borne illnesses are important contributing factors to helping improve Maori Health equity.</td>
</tr>
</tbody>
</table>

Submissions anticipated for June are as follows:
There may be more submissions identified for June through our screening process.

### 6.2 Proposed Auckland Unitary Plan

ARPHS continues to be engaged in the Unitary Plan process. ARPHS’s full submission on the Proposed Auckland Unitary Plan is in three parts and is available [here](http://www.arphs.govt.nz/about/submissions).

During the April - May period ARPHS has been in mediations regarding the following topic areas:

- Public Open Spaces
- Lakes, Rivers and Streams
- Water Quality and Quantity
- Transport Objectives, Policies, Rules, and other.

In May, ARPHS was involved in the Contaminated Land hearing.

ARPHS will be involved in the following mediations and hearings throughout June:

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Hearing or mediation</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 June</td>
<td>Discharges, Stormwater and Wastewater</td>
<td>Mediation</td>
</tr>
<tr>
<td>04 June</td>
<td>Retirement and (Housing) Affordability</td>
<td>Mediation</td>
</tr>
<tr>
<td>08 June</td>
<td>Centre Zones, Business Parks, Activities and Controls</td>
<td>Mediation</td>
</tr>
<tr>
<td>10 June</td>
<td>Hazard Substances</td>
<td>Hearing</td>
</tr>
<tr>
<td>18 June</td>
<td>Aquifers and Ground Water</td>
<td>Mediation</td>
</tr>
<tr>
<td>23 June</td>
<td>Major Recreation Zones and Precincts</td>
<td>Mediation</td>
</tr>
<tr>
<td>29 June</td>
<td>Natural Hazards and Flooding (Round 2)</td>
<td>Mediation</td>
</tr>
</tbody>
</table>

### 5.3 The Provisional Local Alcohol Plan

The Auckland Council developed a draft Local Alcohol Plan in 2014 and this was consulted on under the Special Consultative Procedure outlined in the Local Government Act. The draft policy received close to 2,700 written submissions and the Hearings Panel heard oral submissions from over 115 individuals and organisations at the end of last year.

In March 2015 the Hearings Panel discussed the submissions and deliberated on their recommendations for Auckland’s Provisional Local Alcohol Plan.

The key policies in the Provisional Local Area Plan are as follows:

- Opening hours:
• Restrictions on the location of new licence:
  o a Local Impacts Report for higher-risk licence applications, which will include reporting on local schools and land uses.
  o a two-year freeze on new off-licences in the Priority Overlay and the City Centre.
  o a presumption against granting new off-licences in Neighbourhood Centres, and in the Priority Overlay and the City Centre once the freeze expires.

• A Local Impacts Report for the renewal of higher-risk licences in the Priority Overlay to help with setting conditions.

• A range of discretionary conditions able to be applied to licences¹.

For more information please see Appendix A.

On 13 May 2015, the Regional Strategy and Policy Committee of Auckland Council adopted the Provisional Local Alcohol Plan and this was publically notified on 19 May. This notification triggers the 30 day statutory time frame to lodge an appeal.

Grounds for appeal can only be made on elements within the Provisional Local Alcohol Plan that are “unreasonable in light of the object” of the Sale and Supply of Alcohol Act 2012.

The objects of the Act are that:

(a) The sale, supply and consumption of alcohol should be undertaken safely and responsibly;
(b) The harm caused by the excessive or inappropriate consumption of alcohol should be minimised.

Staff from ARPHS met with representatives from our key partners in the alcohol harm minimisation sector (NZ Police, Alcohol Healthwatch, Hapai Te Hauora and Te Whanau O Waipareira Trust) on the 18 May to discuss our approach towards a possible appeal.

Following some discussion on each of the key elements of the Provisional Local Alcohol Plan, we identified two main areas of concern that could form a basis for an appeal, and from a public health perspective may be “unreasonable in light of the object” of the Act.

These are:

• Maximum trading hours – on-licences
• The deletion of Onehunga from the Priority Overlay areas.

¹www.aucklandcouncil.govt.nz/EN/licencesregulations/alcohol/alcoholpolicies/Pages/helpshapeaucklandsalcoholpolicy.aspx#overview
It was also established that ARPHS wishes to register as interested parties in support of Auckland Council against a probable appeal by the supermarkets against off-licence hours.

The discussion with key partners is continuing and will inform ARPHS role in any appeal.

5.4 Health in All Policies

Health in All Policies (HiAP) is a form of “intersectoral action” that aims to include the promotion of health in government initiatives across sectors. This World Health Organisation framework has been implemented internationally, such as in Sweden, Quebec and South Australia. It has also been in operation in Christchurch for nearly 10 years.

ARPHS and Auckland Council are working together to investigate ways to adopt a “Health in All Policies” approach to complex challenges in the region.

This is in anticipation of a planned Refresh of the Auckland Plan – scheduled for later this year.

We are jointly developing a plan of action to guide our actions towards hosting a Health in All Policies workshop in October 2015 among key decision-making organisations within the Auckland Region and the next steps beyond the workshop.

We are also scheduling a joint planning session to focus on the health elements within the current Auckland Plan and how we can make them more obvious, with targets and performance measures.
Appendix A

Summary of changes to Draft Local Alcohol Policy recommended by Hearings Panel

<table>
<thead>
<tr>
<th>Policy Elements</th>
<th>Draft LAP as notified for public consultation</th>
<th>Provisional LAP proposed by Hearings Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Three broad areas:</td>
<td>General policies for Auckland region, with special needs for:</td>
</tr>
<tr>
<td></td>
<td>• &quot;Broad Area A&quot; — Central Auckland</td>
<td>• &quot;City Centre&quot; — as per Unitary Plan (neighbourhoods &quot;Broad Area A&quot;)</td>
</tr>
<tr>
<td></td>
<td>• &quot;Broad Area B&quot; — rest of region</td>
<td>• &quot;Priority Overlay&quot; — areas with highest alcohol-related harm</td>
</tr>
<tr>
<td></td>
<td>• &quot;Priority Overlay&quot; — areas with highest alcohol-related harm</td>
<td>Also some special provisions based on Unitary Plan zoning for Neighbourhood Centres and Metropolitan Centres.</td>
</tr>
<tr>
<td><strong>Privacy Overlay areas</strong></td>
<td><strong>Priority Overlay areas</strong>:</td>
<td><strong>Privacy Overlay areas</strong>:</td>
</tr>
<tr>
<td></td>
<td>• CBD Streets: Fort Street/Fort Lane, Queen Street between Victoria and Wellesley streets</td>
<td>• CBD Streets: Fort Street/Fort Lane, Queen Street between Victoria and Wellesley streets</td>
</tr>
<tr>
<td></td>
<td>• Central Avenue, Glen Eden, Glen Innes, Henderson</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mangere, Manurewa East, Manurewa, Papatoetoe, Alington,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Manurewa, Mt Wellington, Orakei, O'Connell, Papakura, Papatoetoe, Pakuranga, Waitakere,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Papatoetoe, Pt Chevalier, Pakuranga, Waitakere, Papatoetoe,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Papatoetoe</td>
<td></td>
</tr>
<tr>
<td><strong>Density</strong></td>
<td>Regulate location and density of NEW OFF-LICENCES as follows:</td>
<td>Regulate location and density of NEW OFF-LICENCES as follows:</td>
</tr>
<tr>
<td><strong>whether</strong></td>
<td>Environmental and Cumulative Impacts Assessment</td>
<td>Environmental and Cumulative Impacts Assessment</td>
</tr>
<tr>
<td><strong>further</strong></td>
<td>Required for all other applications except Very Low Risk under regulations.</td>
<td>Required for all other applications except Very Low Risk under regulations.</td>
</tr>
<tr>
<td><strong>licences</strong></td>
<td>Report on sensitive social issues, surrounding land use, site objectives, existing amenity values, and levels of alcohol-related harm.</td>
<td>Report on sensitive social issues, surrounding land use, site objectives, existing amenity values, and levels of alcohol-related harm.</td>
</tr>
<tr>
<td><strong>should be</strong></td>
<td>The new licence is to be issued in Broad Area A and Priority Overlay.</td>
<td>The new licence is to be issued in Broad Area A and Priority Overlay.</td>
</tr>
<tr>
<td><strong>issued</strong></td>
<td></td>
<td>The new licence is to be issued in Broad Area A and Priority Overlay.</td>
</tr>
<tr>
<td><strong>Renewals</strong></td>
<td>Applications for RENEWAL — ON-LICENCES and OFF-LICENCES:</td>
<td>Applications for RENEWAL — ON-LICENCES and OFF-LICENCES:</td>
</tr>
<tr>
<td></td>
<td>The Draft LAP did not include any particular policies relating to renewals.</td>
<td>The Draft LAP did not include any particular policies relating to renewals.</td>
</tr>
<tr>
<td></td>
<td>Note: The Draft LAP cannot be used as grounds to refuse the renewal of an existing licence but can be considered when setting conditions.</td>
<td>Note: The Draft LAP cannot be used as grounds to refuse the renewal of an existing licence but can be considered when setting conditions.</td>
</tr>
<tr>
<td><strong>OFF-LICENCE</strong></td>
<td>OFF-LICENCE hours: 9am to 10pm. Monday to Sunday for all types of off-licences. Remote sellers may deliver between 9am and 10pm on Fridays, Saturdays, and Sundays.</td>
<td>OFF-LICENCE hours: 9am to 10pm. Monday to Sunday for all types of off-licences. Remote sellers may deliver between 9am and 10pm on Fridays, Saturdays, and Sundays.</td>
</tr>
<tr>
<td><strong>ON-LICENCE</strong></td>
<td>Open 11am to 7pm. Monday to Saturday, 11am to 5pm. Sunday.</td>
<td>Open 11am to 7pm. Monday to Saturday, 11am to 5pm. Sunday.</td>
</tr>
<tr>
<td><strong>Maximum hours</strong></td>
<td><strong>Bread Area A</strong>: from 11am to 7pm. <strong>Bread Area B</strong>: from 9am to 10pm. <strong>Priority Overlay</strong>: same as underlying bread area, but to consider shorter hours.</td>
<td><strong>Bread Area A</strong>: from 11am to 7pm. <strong>Bread Area B</strong>: from 9am to 10pm. <strong>Priority Overlay</strong>: same as underlying bread area, but to consider shorter hours.</td>
</tr>
<tr>
<td><strong>SPECIAL LICENCE</strong></td>
<td><strong>EXTENSIONS</strong>: from 4pm to 7pm.</td>
<td><strong>EXTENSIONS</strong>: from 4pm to 7pm.</td>
</tr>
<tr>
<td><strong>Disciplinary</strong></td>
<td><strong>CONDITIONS</strong>: Range of conditions recommended, depending on size of event.</td>
<td><strong>CONDITIONS</strong>: Range of conditions recommended, depending on size of event.</td>
</tr>
</tbody>
</table>

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 10/06/15