Community and Public Health Advisory Committees Meeting

Wednesday, 18\textsuperscript{th} March 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
18th March 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: Ailsa Claire

AGENDA

KARAKIA

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

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

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

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES
2.05pm 2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 04/02/15 ................................................................. 7
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4 INFORMATION ITEMS
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5 STANDARD REPORTS
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* absent
* attended part of the meeting only
# absent on Board business
## REGISTER OF INTERESTS

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<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
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| **Lester Levy**  | Chair – Auckland District Health Board  
Chairman – Auckland Transport  
Independent Chairman – Tonkin & Taylor  
Chief Executive – New Zealand Leadership Institute  
Professor of Leadership – University of Auckland Business School  
Trustee - Well Foundation (ex-officio member)  
Director – Orion Health (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...

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<tr>
<th>Name</th>
<th>Position and Affiliations</th>
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<tr>
<td>Christine Rankin</td>
<td>Member - Upper Harbour Local Board, Auckland Council, Director - The Transformational Leadership Company, CEO - Conservative Party</td>
<td>17/05/13</td>
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<tr>
<td>Allison Roe</td>
<td>Member - Devonport-Takapuna Local Board, Auckland Council, Chairperson - Matakana Coast Trail Trust</td>
<td>02/07/14</td>
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<tr>
<td>Gwen Tepania-Palmer</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>
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<td>Elsie Ho</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>
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<tr>
<td>Rev Featunai Liuaana</td>
<td>To be advised.</td>
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<tr>
<td>Dr Tim Jelleyman</td>
<td>Member - Active Clinic Network for Greater Auckland Integrated Health Network, Member - ASMS, 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</td>
<td>22/04/13</td>
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2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 04th February 2015

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 04th February 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 04 February 2015

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.04p.m.

Part 1 - Items considered in Public Meeting

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Max Abbott (WDHB Board member) (present from 2.07p.m.)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member) (present from 2.30p.m.)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member) (present from 2.20p.m.)
Warren Flauntly (Committee Deputy Chair) (WDHB Board member)
Lee Mathias (ADHB Deputy Board Chair)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Allison Roe (WDHB Board member) (present from 2.07p.m.)
Elsie Ho (Co-opted member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT:

Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Tim Wood (ADHB and WDHB, Acting Director Funding)
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
Tanja Binzegger, Health Link North
Lorelle George, Comprehensive Care/Waitemata PHO
Charlotte Harris, Auckland PHO
Barbara Stevens, Auckland PHO

APOLOGIES:

Resolution (Moved Lee Mathias/ Seconded Christine Rankin)

That the apologies from Dr Lester Levy, Rev. Featunai Liuaana, Ailsa Claire and Debbie Holdsworth, together with an apology for late arrival from Sandra Coney, be received and accepted.

Carried
KARAKIA: Gwen Tepania-Palmer led the meeting in the karakia.

DISCLOSURE OF INTERESTS
There were no additions or amendments to the Interests Register.
There were no declarations of interests relating to the 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 26th November 2014 (agenda pages 7-17)

Resolution (Moved Jo Agnew/Seconded Judith Bassett)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 26th November 2014 be approved.

Carried

Matters Arising (agenda page 18)

No issues were raised.

2.07p.m – Max Abbott and Allison Roe present.

3 DECISION ITEMS
There were no decision items.

4. INFORMATION ITEMS
4.1 Maori Health Planning and Funding Report – Quarter One 2014/15 (agenda pages 19-49)

Sandra Coney and Peter Aitken arrived during the course of the consideration of this item.

Craig Heta (Maori Health Portfolio Manager) and Tracy Walters (Maori Health Analyst) presented this report. An apology was conveyed from Aroha Haggie. Dr Alison Leversha (Community Paediatrician, Auckland DHB) and Ruth Bijl (Manager, Women, Child and Health) were also present and assisted with answering some questions.

Craig Heta introduced the report. Matters that he highlighted included:

- The report provides the first quarter results for 2014/15. Some of the data in the report differs slightly from that in the Child, Youth and Women's Health Scorecard
report also on the agenda, as that was written slightly later with access to some more recent data in some areas.

- The excellent performance in terms of the advice to quit smoking target in hospitals and the sustained improvement in Primary Care advice to quit results, carrying on from Quarter 4 2013/14.
- The results for heart and diabetes checks (page 27 of the agenda).

Matters covered in discussion and response to questions included:

- With regard to performance results for treatment timelines for people admitted with acute coronary syndrome (ACS) (page 28 of the agenda) the difference between Auckland DHB results (83% for Maori and 90% for non-Maori) and Waitemata DHB results (53% for Maori and 67% for non-Maori) was noted. The reasons for this will be checked and an explanation provided.
- Concern was expressed at the continuing significant gap in PHO enrolment levels between Maori and Non-Maori for both DHBs (page 33 of the agenda). In response Tracy Walters advised that this partly reflects the issue with ethnicity data that has been reported on previously. The Ethnicity Data Tool process (EDAT) is being worked on with primary care to address ethnicity misclassification. Another initiative proceeding is to get PHO enrolment at point of birth.
- Concern was also expressed at the widening gap between Maori and non-Maori for diabetes management at Waitemata DHB (page 41 of the agenda) and the gap at both DHBs for Cervical Screening coverage (page 42 of the agenda). Tim Wood advised that for diabetes management, a report will be coming to CPHAC from the Alliance, probably to the next meeting, looking at the issues impacting on performance. There had been robust communication with the PHOs on this issue.

There was a discussion of the rheumatic fever programme and the role of public health nurses in school, including:

- Lee Mathias advised that the view at Counties Manukau DHB with the Mana Kids programme was that there might not have had much impact on rheumatic fever, but other aspects of the programme, such as treating sores, had been effective. At Counties Manukau DHB, merit was seen in developing the role of nurses used in schools for this programme into a fuller community nurse function.
- Dr Alison Leversha advised that with the rheumatic fever programme, they had done a prevalence study before starting the school based services. With those schools that had completed one year in the programme at the end of 2014, the strep rate had reduced considerably. There had also been a significant reduction in the number of skin infections. Comments from the school principals had also been highly supportive of the value of the programme. There were still some schools that had not quite completed 12 months in the programme. At the end of this term all schools will have completed 12 months and the programme will be evaluated.
- In answer to a question about the possibility of developing and re-defining the role of the nurses involved in the programme, Alison Leversha advised that basically the nurses are providing free primary care through the schools. There is a need to work more on the role. In her personal view it is essential to provide more in terms of this type of service and this needs to be explored. Ruth Bijl noted that providing this type of service would be dependent on whether the investment in it can be maintained.
- Comments by Committee members on this issue included: that the Did Not Attend Appointments rate shows that something is radically wrong and anything that can break that down is very good; finding more effective ways of preventing health problems developing is highly important; it is very important that the rheumatic
fever programme be evaluated; and the Well Foundation at Waitemata DHB might possibly be sympathetic to fundraising for this type of service.

- In response to questions, Allison Leversha advised that for the rheumatic fever programme, Counties Manukau DHB had used a mixed model of public health nurses and community nurses from the PHOs. Auckland and Waitemata DHBs had chosen to use public health nurses. These had a strong relationship with the schools. Much of the work had been focussed on the schools in the most deprived areas. She advised that the Health Research Council had funded a grant for a study to look at what model of care is most effective, covering the Auckland, Waitemata, Counties Manukau and Bay of Plenty DHBs. This would include looking at data such as the rate of strep throats, hospital advised rheumatic fever cases etc. There would be a lag time in producing the report of perhaps six to twelve months because of availability of hospital admissions data, but it probably would be possible to provide a preliminary report.

- Sandra Coney expressed the need for caution with reviewing the model of care before the regional review of the rheumatic fever programme is available.

- Lee Mathias noted that the key difference from the past is the extent to which families are engaging with the public health nurses under the current programme.

Other matters discussed included:

- The use of the term “smoking cessation” (page 24 of the agenda) was criticised as having less impact than “stopping smoking”. Tracy Walters advised that the word “cessation” will be avoided in future reports.

- In answer to a question, Tracy Walters advised that a large percentage of Maori mothers smoked. They are using the healthy babies futures programme to imbed the need to avoid smoking as part of the thinking of pregnant Maori women. The aim is to get them to quit smoking for good.

**Resolution** (Moved Jo Agnew/Seconded Max Abbott)

That the following action be approved: 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.

**Carried**

**Resolution** (Moved Chris Chambers /Seconded Robyn Northey)

That the Community and Public Health Advisory Committees note that this report was submitted to the Manawa Ora meeting on 28 January 2015 to summarise Māori health performance across the two District Health Boards (DHBs) for quarter one 2014/15.

**Carried**

4.2 **Child, Youth and Women’s Health Scorecard** (agenda pages 50-58)

Ruth Bijl (Manager, Women, Child and Youth), Dr Alison Leversha (Community Paediatrician, Auckland DHB), Dr Patricia Bolton (Public Health Physician, Waitemata DHB) and Natalie Desmond (Senior Programme Manager, Child Health) were present for this item.
Ruth Bijl introduced the report, acknowledging the contribution of Dr Tim Jelleyman and Alison Leversha to the development of the scorecard and Cleo Neville for the technical work on it. She noted that the scorecard had been a long time in development, with the concept first documented in the Child Health Improvement Plan in 2012. They were delighted to now have a scorecard which provided a fairly robust picture and the indicators will continue to be developed.

Alison Leversha commented that working from the Child Health Improvement Plan they had tried to focus first on the beginning of life, concentrating on pregnancy and early infancy, before progressing to older childhood. The emphasis was on “getting it right at the beginning” – very much a life course approach.

Patricia Bolton commented on the structure of the scorecard and the different time periods applying to indicators, related to the different sources, including the Ministry of Health. It had been decided that it was important to include the separate figures for Maori, Pacific and Asian populations.

Natalie Desmond noted that the immunisation performance information included not only the national health target at eight months, but also at two years and at five years. The immunisation results are very pleasing. A lot of work will be done to make sure that the rates at two years and five years remain high.

Matters covered in discussion and response to questions included:
- Natalie Desmond advised that while the Immunisation Governance Group is currently giving consideration to raising the rate for the five year old cohort, it had not discussed the issue of maintaining immunisation rates through the five to ten year old age group. She would raise that issue with the Group.
- In answer to a question, Ruth Bijl acknowledged the importance of breast feeding rates at six months and advised that measure would be put back in the scorecard. They are monitoring rates in hospital maternity, at three months and at six months.
- Alison Leversha advised of an interest in looking at dental health across the whole system.

There was a discussion on the impacts of immunisation which included:
- In answer to a question about concerns that the HPV vaccine may have safety issues, Natalie Desmond advised that impacts are closely monitored in New Zealand. There have been many studies over more than eight years and these indicated very good safety and a sustained response to the vaccine in terms of immunity. Fewer doses were now being looked at, as less than three doses seemed effective. As well as overseas research, the Ministry of Health and the technical HPV group are looking at these issues. The New Zealand monitoring programme operates from the University of Otago.
- Allison Roe expressed concerns that often adverse causal links are only proven over long periods of time. Sandra Coney commented that from her experience monitoring groups invariably decide that adverse reactions can’t be attributed to vaccination. The causal link is hard to pin down and the only way to do so is by large trials. The adverse effect of HRT in terms of breast cancer incidence had only been proven after 40 years. Also a key question with immunisation is does it reduce the ability of the immune system to fight off other diseases?
Alison Leversha advised that in general immunisation was established as highly cost effective, with benefits that outweigh any of the risks from a population perspective, although there will always be individuals who have adverse reactions.

The recent outbreak of measles at Disneyland was referred to as an example of what can go wrong when immunisation is relaxed.

Natalie Desmond commented that the questions raised are valid ones and it is important that research continues and those questions continue to be asked. There is a fairly sophisticated surveillance system, but it is not perfect.

Tim Jelleyman commented that clinicians will always be in a position of uncertainty and needing to make the best call on the information that they have at that point in time, while needing to acknowledge that it is still important to be asking the type of questions just discussed.

Ruth Bijl advised that with cervical screening and breast screening the next of these reports will show significant difference in results, as a result of new national census data. This has resulted in significant drops in Pacific screening results nationally. She also advised that with the HEEADSS coverage in the Auckland DHB funded school based health services (page 55 of the agenda), the screening rate should be corrected to 94.8%, an excellent result, with 1,582 Year 9 students having a HEEADSS assessment in 2014.

The Committee Chair acknowledged the authors for the report provided and data included and thanked the team for the way they reported to CPHAC and the leadership being shown.

Resolution (Moved Lee Mathias/Seconded Robyn Northey)

That the Community and Public Health Advisory Committee note that this report presents a new format for routinely reporting on key child, youth and women’s health indicators, namely by way of a scorecard with accompanying commentary.

Carried

4.3 2015/16 Annual Planning Update (agenda pages 59-62)

Simon Bowen (Director Health Outcomes) and Wendy Bennett (Planning and Health Intelligence Manager) presented this report.

Wendy Bennett introduced the report, noting that the Ministry’s expectations had been received, but that there was still some guidance to come. The timetable for the Annual Plan and the Maori Health Plan was provided in the report.

Warren Flaunty congratulated the team involved in the Waitemata DHB planning day in January for a very well-run and informative session.

It was noted that the first drafts of the Annual Plans will be available on Boardbooks for the February Board meetings. Simon Bowen advised that they had been mindful of the need to improve how the Plans are written and a lot of work had gone into that. They had also been trying to align the Plans with strategic priorities and Board priorities.
The Committee Chair thanked Wendy Bennett, Simon Bowen and the team working on the Annual Plans. She noted that it is well known how much work is involved in drafting and revising these documents.

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

That the report be received.

Carried

5. STANDARD REPORTS

5.1 Planning, Funding and Outcomes Update (agenda pages 63-69)

Simon Bowen (Director Health outcomes) and Tim Wood (Acting Director Funding) presented this report.

Simon Bowen referred to the section on community engagement in the report and acknowledged the work of Anne Curtis, who had recently resigned as the Health Link North Co-ordinator. Her contribution had been greatly appreciated. He also introduced Carol Hayward, the new Community Engagement Manager for Waitemata DHB and Sue Copas, the Auckland DHB Community Participation Manager, to the Committee. It was planned to bring a more detailed paper on community participation to CPHAC.

Simon Bowen also commented on the Health Needs Assessments which are coming to each Board meeting in February.

Matters highlighted by Tim Wood included:

- The Pacific Health Plan and actions (pages 66-67 of the agenda)
- The update on Home Based Support Services (pages 67-68 of the agenda)
- Dementia Care – in the following week an evaluation was due to be received on the Cognitive Impairment Pathway (for primary care) which has been trialled with ten general practices

Matters covered in discussion and response to questions included:

- Carol Hayward advised that the Waitemata DHB Patient Experience Manager is focused on patients in hospital and their treatment, while her own role is to do with community engagement, involvement with community representatives, obtaining community viewpoints. While not in the same team, her role involved working closely with the Patient Experience Manager. Sue Copas advised that at Auckland DHB they are moving more towards a community participation framework. She understood that it is intended to have a Director of Participation at ADHB in due course, which would cover both patient experience and community participation.
- In answer to a question, Simon Bowen advised that Wendy Bennett and her team are involved in planning and accountability reporting but also have a role in assessing the health needs of the population and how we are responding to them, which is what the term “health intelligence” refers to in her job title. He commented that he was very pleased with the capability of the team that had been formed over the last year.
• Pat Booth suggested that it would be good to see the Annual Plan move from a more scholarly approach to a more “human” approach. Simon Bowen confirmed that there was movement in that general direction.

• In answer to a question concerning Section 3.4 of the report, Tim Wood advised that when Long Term Support for Chronic Health Conditions had been devolved to DHBs, it was agreed by the regional DHBs to pool the budget supplied and collectively meet the costs of providing the service. After a couple of years, funding from the Ministry had been pulled back to population based funding, several million dollars less than previously. Each DHB had different impacts and they had collectively decided to go back to managing the financial risk at individual DHB level. This could have unforeseen IDF consequences. Lee Mathias advised that she understood that the DHBs’ Chief Financial Officers are reviewing this issue, as part of a discussion recognising that the way high level secondary and tertiary services are split up across the region at the moment is not sustainable. It was agreed as an action, that CPHAC keep a watching brief over IDF issues relating to its area of responsibility.

• Sue Copas advised that In Section 1.2 of the report relating to Community Participation – Auckland DHB, the term “power sharing” means sharing with communities the power to develop policies.

Resolution (Moved Sandra Coney/Seconded Max Abbott)

That the report be received.

Carried

6. General Business

There was no general business.

The Committee Chair thanked the public, PHO and Health Link and other representatives at the meeting.

7. Resolution to Exclude the Public (agenda page 70)

Resolution (Moved Lee Mathias /Seconded Allison Roe)

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>Waste Management</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982 S.9 (2) (i)</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. Official Information Act 1982 S.9 (2) (i)</td>
</tr>
</tbody>
</table>

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 18/03/15
<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>Information Act 1982.</td>
<td></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
</tr>
</tbody>
</table>

**Carried**

3.25p.m – 3.48p.m – public excluded session.

3.48p.m – the meeting resumed in open session.

The meeting concluded at 3.48p.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 04 FEBRUARY 2015

______________________________ CHAIR
## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 10th March 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 05/02/14</td>
<td>3.1</td>
<td>Healthy Eating and Physical Activity – request to ARPHS to bring back a report to CPHAC on opportunities for interventions in the promotion of products that influence levels of obesity.</td>
<td>William Rainger</td>
<td>CPHAC 29/04/15</td>
<td></td>
</tr>
<tr>
<td>CPHAC 15/10/14</td>
<td>4.2</td>
<td>Diabetes – Availability of Data – that Auckland and Waitemata DHB management work together on the issue of achieving co-ordination and availability of data relating to diabetes patients.</td>
<td>Tim Wood</td>
<td>CPHAC 18/03/15</td>
<td>Report on agenda.</td>
</tr>
<tr>
<td>CPHAC 04/02/15</td>
<td>4.1</td>
<td>Treatment Times for Acute Coronary Syndrome – reasons for difference between ADHB and WDHB results to be checked and an explanation provided.</td>
<td>Aroha Haggie/Craig Heta</td>
<td></td>
<td>See note below.</td>
</tr>
<tr>
<td>CPHAC 04/02/15</td>
<td>4.1</td>
<td>Rheumatic Fever Programme 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 10/06/15</td>
<td>Will provide an interim evaluation report with options for further evaluation at the June meeting.</td>
</tr>
<tr>
<td>CPHAC 04/02/15</td>
<td>4.2</td>
<td>Child, Youth and Women’s Health Scorecard – Breast feeding rates at six months to be put back in the Scorecard.</td>
<td>Ruth Bijl</td>
<td>CPHAC 29/04/15</td>
<td></td>
</tr>
<tr>
<td>CPHAC 04/02/15</td>
<td>5.1</td>
<td>IDEs – CPHAC to keep a watching brief over IDF issues relating to its area of responsibility.</td>
<td>Debbie Holdsworth</td>
<td></td>
<td>Noted.</td>
</tr>
</tbody>
</table>

**Note:** Treatment Times for Acute Coronary Syndrome:

The query resulted from Quarter One 2014/15 performance figures, with ADHB having much higher performance results than Waitemata DHB for that quarter (both for Maori and non-Maori).

Waitemata DHB has the highest volumes of Coronary angiography for inpatient Acute Coronary Syndrome (ACS) in the northern region. Review of early Q1 results for Waitemata DHB identified additional resource was required to meet the target. This has been achieved with additional angiography lists and a new cardiac interventionalist. Performance improved significantly at Waitemata DHB over Q1, and the target was met in Q2.

In terms of ethnic specific difference it is difficult to comment on this given the very small numbers (for Q1 there were 12 Māori in ADHB and 17 Māori in WDHB) leading to large fluctuations when considering proportional access by ethnicity. Given that the Q2 numbers for Māori were actually higher than non-Māori for this indicator (and both met the 70% target) we propose that in reviewing ethnic specific differences with 1 year’s worth of data (June 2015) we will be able to comment with more statistical confidence on whether there are ethnic specific differences for Māori that need investigating.
3.1 Alliance Diabetes and Cardiovascular Disease Clinical Indicators and Measures

Recommendation:

That the Community and Public Health Advisory Committee:

- Receives the report.
- Notes that the diabetes and cardiovascular disease clinical indicators and measures have been endorsed by the Waitemata and Auckland District Alliance Leadership Team and Metro Auckland Clinical Governance Forum.
- Endorses the proposed 22 diabetes and cardiovascular disease clinical indicators and measures.
- Notes the focus on five prioritised indicators.

Prepared by: Sarah Gray (Public Health Physician, on behalf of the Alliance Diabetes Working Group)
Endorsed by: Jagpal Benipal (Senior Programme Manager – Primary Care, Planning Funding and Outcomes Unit, Waitemata and Auckland DHBs) and Tim Wood (Deputy Director Funding and Manager Primary Care, Planning Funding and Outcomes Unit, Waitemata and Auckland DHBs)

Glossary

ACR - Albumin: Creatinine Ratio
ARB - Angiotensin Receptor Blocker
BMI - Body Mass Index
BP - Blood Pressure
CVD - Cardiovascular Disease
DHB - District Health Board
DSME - Diabetes Self-Management Education
eGFR - Glomerular Filtration Rate
HbA1c - Glycosolated Haemoglobin
HQSC - Health, Quality and Safety Commission
KPI - Key Performance Indicator
MACGF - Metro Alliance Clinical Governance Forum
NRDN - Northern Region Diabetes Network
PHO - Primary Care Organisation

Executive Summary

The Waitemata and Auckland District Alliance has identified diabetes and cardiovascular disease (CVD) as key areas on which to focus. A working group was convened to develop a list of diabetes and CVD clinical indicators and measures. These are presented in this report.

1 a blood test that shows the average level of blood sugar over the previous 3 months. This indicates how well an individual is controlling their diabetes.
It is envisaged that these indicators and measures will be used to monitor diabetes related health sector performance and to identify areas in which Waitemata and Auckland DHB are doing well and areas that require more intensive input. The measures will also be used to monitor health outcomes. Use of these clinical indicators and measures will thus enable the DHBs to optimise progress towards achieving the goals of improving the health of people with diabetes and CVD and reducing the prevalence of these conditions in the population.

The list contains a total of 22 indicators; 15 relating to diabetes management (5 of which also relate to CVD management) and 7 relating to prevention of diabetes and CVD.

Five indicators will be prioritised for implementation. It is planned to have a staggered roll out of the remaining indicators over time. The priority indicators are:

1. Percentage of people with diabetes who have good or acceptable glycaemic control
2. Percentage of people with diabetes that have uncontrolled high blood pressure (BP)
3. Percentage of people (with / without diabetes) aged <75 with a 5 year CVD risk >15% and < 20% on dual therapy
4. Percentage of people (with / without diabetes) who have had a CVD event and are on triple therapy
5. Percentage of people with diabetes who have appropriate management of micro albuminuria.

1. Introduction

The Waitemata and Auckland District Alliance Leadership Team (ALT) has identified diabetes and CVD as key areas on which to focus. The vision of the Alliance is that people living with diabetes and/or CVD are enabled to be leading partners in their own care within systems that ensure they can manage their condition effectively with appropriate support from proactive care teams.

The overarching goals are to improve the health of people with diabetes and CVD and reduce the prevalence of these conditions in the population.

As a first step the working group developed an intervention logic model for diabetes. A list of clinical indicators and measures were then developed that mapped into the domains of this intervention logic model. It is envisaged that using these clinical indicators to measure performance will enable DHBs and PHOs to monitor and optimise progress towards achieving the goals above. The Funder will be able to identify areas in which Waitemata and Auckland DHB are doing well and areas that require more intensive input.

2. Risks

Five indicators have been identified for priority implementation. Data will be requested quarterly from PHOs, collated and reported to ALT. There is a low risk that PHOs will have difficulty extracting the data from their patient management systems. There is also a low risk that the indicators will identify management issues that are complex to address.
3. Method

A comprehensive list of all the clinical indicators, performance and outcome measures relating to diabetes and/or CVD that are in current use in the Northern region was compiled. Sources included:

- Atlas of Variation (Health Quality and Safety Commission)
- Northern Region Diabetes Network
- Counties Manukau Health
- West Auckland Quality Improvement Team (QIT)
- ADHB and WDHB performance against agreement measures.

International performance measures and indicators were also researched.

The Ministry of Health has recently published a list of 20 quality standards for diabetes care. It is expected that these standards will be used by DHBs when planning and funding the delivery of diabetes services. These standards were therefore taken into consideration when developing the diabetes clinical indicators and measures.

The provisional list of clinical indicators and measures were presented to the Metro Alliance Clinical Governance Forum (MACGF) for feedback and were then presented to ALT for approval.

4. Indicators

In total 22 indicators were identified. There are 15 indicators that are designed to measure activities to reduce diabetes related morbidity and mortality in people with diabetes. Five of these can also be used to measure activities to reduce CVD morbidity and mortality in people at high risk of CVD or with pre-existing disease. There are 7 measures that are designed to measure how well we are doing at reducing the incidence of diabetes and CVD in the total population.

The indicators are presented in full in Appendix One and are summarised below:

**Indicator 1:** Measures the percentage of people with good, acceptable or poor glycaemic control (HbA1c). The specified HbA1c ranges align with the ranges that the Ministry of Health will be requiring DHBs to report on in 2015/16.

**Indicators 2 – 3:** Measure how the management of diabetes (glycaemic control) will be improved in order to achieve good glycaemic control.

**Indicators 4 to 9:** Measure the prevalence of risk factors for diabetes complications or CVD. Some of these indicators will also provide information on the denominator data required for indicators that look at the management of diabetes complications.

**Indicators 10-15:** Measure activities to identify, prevent and manage diabetes complications in people with established diabetes.

**Indicators 16-22:** Measure activities in the total enrolled population that aim to reduce the prevalence of risk factors for the development of diabetes or CVD or improve the management of high risk populations, thus in the longer-term reducing progression to type 2 diabetes and /or CVD.
5. **Priority Indicators**

Five Indicators will be prioritised for implementation. It is planned to have a staggered roll out of the remaining indicators over time. The priority indicators are:

1. Percentage of people with diabetes who have good or acceptable glycaemic control
2. Percentage of people with diabetes that have uncontrolled high blood pressure (BP)
3. Percentage of people (with / without diabetes) aged <75 with a 5 year CVD risk >15% and <20% on dual therapy
4. Percentage of people (with / without diabetes) who have had a CVD event and are on triple therapy
5. Percentage of people with diabetes who have appropriate management of micro albuminuria

6. **Conclusion**

It is envisaged that using these clinical indicators and measures to look at our performance in the areas of diabetes and CVD will enable us to monitor progress towards achieving our goals of improving the health of people with diabetes and CVD and reducing the prevalence of these conditions in the Auckland Region.
### Appendix 1

**PROPOSED ALLIANCE DIABETES AND CARDIOVASCULAR DISEASE INDICATORS AND MEASURES**

#### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACR</td>
<td>Albumin: Creatinine Ratio</td>
</tr>
<tr>
<td>ARB</td>
<td>Angiotensin Receptor Blocker</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>DSME</td>
<td>Diabetes Self-Management Education</td>
</tr>
<tr>
<td>eGFR</td>
<td>Glomerular Filtration Rate</td>
</tr>
<tr>
<td>HbA1c</td>
<td>Glycosolated Haemoglobin</td>
</tr>
<tr>
<td>HQSC</td>
<td>Health, Quality and Safety Commission</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NRDN</td>
<td>Northern Region Diabetes Network</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Care Organisation</td>
</tr>
<tr>
<td>PPP</td>
<td>Performance Management Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>

#### Diabetes

**Notes:**

- All indicators are by ethnicity - Ethnicity breakdown: Maori, Pacific, Indian, Asian, Other (or level 2 where appropriate)
- Denominator data from PHO data – enrolled patients coded as having diabetes
- It is anticipated that all indicators will be reported quarterly unless otherwise stated
- \( (P) = \) Priority Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>People with diabetes – Reducing morbidity and mortality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measures of Improvement in Glycaemic Control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1 \( (P) \) | HbA1c Glycaemic control | % of people with diabetes who have good or acceptable glycaemic control | Number of people with diabetes aged 15 years and over with the most recent HbA1c during the past 12 months of:  
|≤54 mmol/mol | 55 mmol/mol to 64 mmol/mol | 65 mmol/mol to 80 mmol/mol | 81 mol/mol to 100 mmol/mol | >100 mmol/mol | Total number of people aged 15 years and over with diabetes | **PRIORITY Indicator** |
| The Ministry will be requiring HbA1c levels to be broken down into these ranges from 2015/16 |
| Those aged 14 years and under are managed by Hospital Services |
### Measures of Improvement in the MANAGEMENT of diabetes (glycaemic control)

<table>
<thead>
<tr>
<th></th>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>HbA1C annual test</td>
<td>% of people with diabetes being monitored for HbA1c levels</td>
<td>Number of people aged 15 years and over with diabetes with a recorded HbA1c test (at least annual)</td>
<td>Total number of people aged 15 years and over with diabetes</td>
</tr>
<tr>
<td>3</td>
<td>Diabetic medications</td>
<td>% of people with type 2 diabetes on diabetic medications (including insulin)</td>
<td>Number of people with type 2 diabetes who have been prescribed diabetic medications (including insulin) in three or four quarters in the past year</td>
<td>Total number of people with type 2 diabetes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The NRDN and HQSC look at dispensed medications using test safe data. Prescribed medication is felt to better reflect clinical practice and is data that is available from PHOs. It may also be useful to observe differences between prescribed and dispensed rates.</td>
</tr>
</tbody>
</table>

### Measures of a reduction in prevalence of diabetes complications and risk factors

<table>
<thead>
<tr>
<th></th>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Smoking</td>
<td>% of people with diabetes that smoke</td>
<td>Number of people with diabetes aged 15 years and over that smoke</td>
<td>Total number of people aged 15 years and over with diabetes</td>
</tr>
<tr>
<td>5</td>
<td>Obesity</td>
<td>% of people with diabetes that are obese</td>
<td>Number of people with diabetes with a BMI ≥ 30 (age 18 and over or age adjusted BMI in younger people)</td>
<td>Total number of people with diabetes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>There are recognised limitations of using BMI to measure rates of obesity however data on waist circumference is suboptimal.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WHO recommendations are to use a universal cut off BMI of 30 although it is recognised that this is not ideal for some ethnic groups.</td>
</tr>
</tbody>
</table>
| 6 | High blood pressure (P)  | % of people with diabetes that have uncontrolled high blood pressure (BP)  | Number of people with diabetes with:  
  - a systolic BP of > 130 and/or a diastolic BP of > 80  
  - a systolic BP of > 145 and/or a diastolic of > 90 | Total number of people with diabetes |
|   |                          |                                                                             |                                                                           | PRIORITY Indicator  |
|   |                          |                                                                             |                                                                           | CMDHB use 140/90 as target cut off. Need to align across the region. |
| 7 | Retinopathy              | % of people with diabetes with moderate / severe                             | Number of people with diabetes with moderate / severe                       | Total number of people with diabetes that have had retinal |
|   |                          |                                                                             |                                                                           | Work in progress: There are issues with the quality of data currently |

Endorsed by the Alliance Leadership Team
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Eligibility Criteria</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Retinopathy or Mild Maculopathy</td>
<td></td>
<td>Severe retinopathy or mild maculopathy</td>
<td>Screening in the past 3 years</td>
<td>Available that will need to be resolved before this indicator can be reported on. Many patients are seen privately which may skew results.</td>
</tr>
<tr>
<td>High Risk Feet</td>
<td>% of people with diabetes with high risk feet</td>
<td>Number of people with diabetes with high risk feet</td>
<td>Total number of people with diabetes</td>
<td>Work in progress: There are possible issues with data quality that may need to be resolved before this indicator can be reported on.</td>
</tr>
<tr>
<td>Microalbuminuria</td>
<td>% of people with diabetes with microalbuminuria</td>
<td>Number of people with diabetes with an ACR $\geq 2.5$mg/mmol men or $\geq 3.5$mg/mmol women or eGFR $&lt; 60$ml/min/1.73m$^2$</td>
<td>Total number of people with diabetes</td>
<td>Measures of Improvement in the PREVENTION of complications</td>
</tr>
<tr>
<td>DSME</td>
<td>% of people with diabetes who have attended a DSME course in the past 5 years</td>
<td>Number of people with diabetes who have attended a DSME course in the past 5 years</td>
<td>Total number of people with diabetes</td>
<td>The time period of 5 years reflects the belief that many patients will benefit from repeated educational input over time and that the management of diabetes frequently becomes more complex for the patient the longer the condition has been present. DSME should be a high quality programme as per the national guidelines. Attended (as opposed to 'completed' or 'referred') has been chosen as a balance between these two options but may require an additional field to be added to the annual review template for some / all PHOs. MoH Quality Standard 1</td>
</tr>
</tbody>
</table>
## Measures of Improvement in the IDENTIFICATION of complications

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 11 | Diabetes annual review | % of people with diabetes who have had an annual review | Number of people with diabetes who have had an annual review in the past year | Total number of people with diabetes | The annual review needs to incorporate assessment of all complications of diabetes including:  
- Cardiovascular risk assessment  
- High risk foot assessment  
- Microalbuminuria screening  
If rates are found to be low then this indicator could be separated into three separate indicators reflecting the above components to provide more detailed information.  
MoH Quality Standards 3, 10 and 11 |
| 12 | Retinal screening | % of people with diabetes who have had regular retinal screening | Number of people with diabetes who have had retinal screening in the past 3 years | Total number of people with diabetes | There is a draft recommendation from the MOH that screening be carried out 3 yearly (in place of the current 2 yearly)  
MoH Quality Standard 9 |

## Measures of the Improvement in MANAGEMENT of complications

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 13 | CVD dual therapy | % dual therapy in people aged <75 with diabetes and 5 year CVD risk >15% and <20% | Number of people with diabetes aged <75 with a 5 year CVD risk > 15% and <20% who were prescribed dual therapy | Total number of people with diabetes and a 5 year CVD risk > 15% and <20% aged <75 | NRDN use dispensed test safe data (see notes for indicator 3)  
MoH Quality Standard 6 |
| 14 (P) | CVD triple therapy | % of people with diabetes who have had a CVD event and are on triple therapy | Number of people with diabetes who have been an inpatient with a cardiac event in the last 10 years, who had a recent health contact in the Northern Region (last 2 years) who have been prescribed triple therapy | Total number of people with diabetes who have been an inpatient with a cardiac event in the last 10 years, who had a recent health contact in the Northern Region (last 2 years) | PRIORITY Indicator  
NRDN use dispensed test safe data (see notes for indicator 3)  
MoH Quality Standard 6 |
## Cardiovascular Disease (CVD)

**Notes:**
- All indictors are by ethnicity - Ethnicity breakdown: Maori, Pacific, Indian, Asian, Other (or level 2 where appropriate)
- Denominator data from PHO data
- It is anticipated that all indicators will be reported quarterly unless otherwise stated
- (P) = Priority Indicator

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<tr>
<td><strong>People with CVD – Reducing morbidity and mortality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measures of a reduction in prevalence of CVD risk factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Smoking</td>
<td>% of people with a high CVD risk that smoke</td>
<td>Number of people with a 5 year CVD risk &gt;15% (including those with a previous CVD event) that smoke</td>
<td>Total number of people with a 5 year CVD risk &gt;15% (including those with a previous CVD event)</td>
</tr>
<tr>
<td>5</td>
<td>Obesity</td>
<td>% of people with a high CVD risk that are obese</td>
<td>Number of people with 5 year CVD risk &gt;15% (including those with a previous CVD event) with a BMI ≥ 30 (age 18 and over or age adjusted BMI in younger people)</td>
<td>Total number of people with a 5 year CVD risk &gt;15% (including those with a previous CVD event)</td>
</tr>
</tbody>
</table>
### Measures of Improvement in CVD management

<table>
<thead>
<tr>
<th></th>
<th>High blood pressure</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>% of people with a 5 year CVD risk &gt;15% (including those with a previous CVD event) that have uncontrolled high blood pressure (BP)</td>
<td>Number of people with a 5 year CVD risk &gt;15% (including those with a previous CVD event) with: • a systolic BP of &gt;130 and/or a diastolic BP of &gt; 80 • a systolic BP of &gt;145 and/or a diastolic of &gt; 90</td>
<td>Total number of people with a 5 year CVD risk &gt;15% (including those with a previous CVD event)</td>
<td>CMDHB use 140/90 as target cut off. Need to align across the region.</td>
</tr>
</tbody>
</table>

| 13 | CVD dual Therapy | % dual therapy in people aged <75 with a 5 year CVD risk >15% and <20% | Number of people aged <75 who have a 5 year CVD risk >15% and <20%, who do not have CVD, who are prescribed both a lipid lowering and a BP lowering agent | Total number of people aged <75 who have a 5 year CVD risk >15% and <20% | PRIORITY Indicator |

| 14 | CVD triple therapy | % of people who have had a CVD event and are on triple therapy | Number of people who have been an inpatient with a cardiac event in the last 10 years, who had had a recent health contact in the Northern Region (last 2 years) who have been prescribed triple therapy | Total number of people who have been an inpatient with a cardiac event in the last 10 years, who had had a recent health contact in the Northern Region (last 2 years) | PRIORITY Indicator |

### Prevention of Diabetes and Cardiovascular Disease

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population – Prevention of type 2 diabetes and CVD</td>
<td>Measures of the reduction in population prevalence of risk factors for diabetes and/or CVD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Obesity</td>
<td>% of the enrolled population who are obese</td>
<td>Number of people with a BMI ≥ 30 (18 years and over or age adjusted BMI in younger people)</td>
<td>Total enrolled population</td>
</tr>
<tr>
<td>17</td>
<td>Gestational diabetes</td>
<td>% of pregnant women who have gestational diabetes</td>
<td>Number of pregnant women with gestational diabetes</td>
<td>Total number of pregnant women</td>
</tr>
<tr>
<td>18</td>
<td>Pre-diabetes</td>
<td>% of the population who are diagnosed with pre-diabetes</td>
<td>Number of people with an HbA1c &gt;41mmol/mol and &lt; 49mmol/mol inclusive who have not been diagnosed as having diabetes</td>
<td>Total enrolled population</td>
</tr>
</tbody>
</table>

Endorsed by the Alliance Leadership Team
<table>
<thead>
<tr>
<th>Health promotion (PREVENTION)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>19</strong> Reducing obesity</td>
<td>Number of green prescriptions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screening of people at high risk of diabetes and cardiovascular disease (IDENTIFICATION)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>20</strong> Screening for diabetes and cardiovascular risk</td>
<td>% of eligible people who have had a cardiovascular and diabetes risk assessment in the last 5 years.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring of people at high risk of diabetes (MANAGEMENT)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>21</strong> Gestational diabetes</td>
<td>Management of women with gestational diabetes</td>
</tr>
<tr>
<td><strong>22</strong> Pre-diabetes</td>
<td>Monitoring of people with pre-diabetes</td>
</tr>
</tbody>
</table>

Endorsed by the Alliance Leadership Team
3.2 Waitemata and Auckland DHB Suicide Prevention and Postvention Action Plan 2015 - 2017

Recommendation

That the Community and Public Health Advisory Committee:

a) Note the Ministry of Health requirement that the Auckland and Waitemata DHBs submit to it a draft district suicide prevention and postvention plan by 20 April 2015.

b) Endorse the draft district suicide prevention and postvention plan attached as Appendix 1 to this paper.

c) Subject to any suggested amendments the Community and Public Health Advisory Committee may have, agree that the draft district suicide prevention and postvention plan attached to this paper as Appendix 1 be submitted to the Ministry of Health on or before 20 April 2015.

Prepared by: Manu Fotu (Programme Manager Suicide Prevention – Mental Health and Addictions, Waitemata and Auckland DHB)
Endorsed by: Tim Wood (Deputy Director Funding and Funding and Development Manager - Primary Care, Waitemata and Auckland DHB), Simon Bowen (Director, Health Outcomes, Waitemata and Auckland DHB), Dr Murray Patton (Clinical Director, Mental Health Services, Waitemata DHB), Dr Debbie Holdsworth (Director Funding)

Glossary

ADHB - Auckland District Health Board
CADS - Community Alcohol and Drugs Service
CASA - Clinical Advisory Services Aotearoa
CYFS - Child Youth and Family Service
CYMRC - Child and Youth Mortality Review Committee
DHB - District Health Board
E.D - Emergency Department
GP - General Practitioner
LGBTI - Lesbian, Gay, Bisexual, Transgender, Inter-sex
MoH - Ministry of Health
MoU - Memorandum of Understanding
MHSOA - Mental Health Services for Older Adult
MHF - Mental Health Foundation
NGO - Non-Government Organisation
NRA - Northern Regional Alliance
OECD - Organisation for Economic Co-operation and Development
PFO - Planning, Funding and Outcomes Unit
PHO - Primary Health Organisation
SPAP - Suicide Prevention Action Plan
SPPAP - Waitemata and Auckland DHB Suicide Prevention and Postvention Action Plan 2015-2017
SPC - Suicide Prevention Coordinator
SPINZ - Suicide Prevention Information New Zealand
SPRIG - Suicide Prevention Regional Inter-agency Group
1. Summary

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

In May 2013 the Government released a new SPAP 2013–2016, focusing on the following key areas:

- support families, whānau, iwi, and communities to prevent suicide
- support families, whānau, iwi, and communities after a suicide
- improve services and support for people at high risk of suicide who are receiving government services
- use social media to prevent suicide
- strengthen the infrastructure for suicide prevention.

The Ministry of Health (MoH) has stated that the role of all District Health Boards (DHB) in Suicide Prevention & Postvention is “to implement the New Zealand Suicide Prevention Strategy 2006-2016 and Suicide Prevention Action Plan 2013 - 2016”.

Suicide prevention and postvention activities are now included in the National Services Coverage Schedule expectations and in DHB Annual Planning requirements. Specifically, DHBs are expected to co-ordinate suicide prevention activities. This includes implementing a district suicide plan, facilitating and enhancing cross-agency collaboration in respect of suicide prevention, and when necessary, implementing a suicide postvention plan and a coordinated response to clusters/contagions.

This paper provides the Community and Public Health Advisory Committee (CPHAC) with some background data on suicide from the MOH and the Chief Coroner; and attaches a draft Waitemata and Auckland DHB Suicide Prevention and Postvention Action Plan 2015 – 2017, for submission to the MOH by 20 April 2015.

2. Introduction

The MOH expectations relating to DHB suicide prevention and postvention programmes are included in the National Service Coverage Schedule. This expectation states, as from 1st of July 2014:

‘DHBs are expected to co-ordinate suicide prevention activities. This includes implementing a district suicide prevention plan, facilitating and enhancing cross-agency collaboration in respect of suicide prevention, and when necessary, implementing a suicide postvention plan and a coordinated response to suicide clusters/contagion. Activities will support implementation of the New Zealand Suicide Prevention Strategy 2006-2016 and the New Zealand Suicide Prevention Action Plan 2013-2016, and any other guidance/toolkits provided by the Ministry’

This expectation was preceded by the New Zealand Suicide Prevention Action Plan 2008–2012 which translated the goals of the Suicide Prevention Strategy 2006 - 2016 into action. This resulted in the Ministry of Health funding five Suicide Prevention Coordinator (SPC) positions nationally. Auckland DHB was one of the five successful DHBs and through this pilot scheme appointed a Suicide Prevention Coordinator to oversee the suicide prevention programme. The focus of this role was to co-ordinate the development and implementation of a district suicide prevention Annual Action Plan. In 2011 Auckland DHB had a suicide prevention plan in place and more recently the Suicide Prevention and Postvention Action Plan 2013/14 was adopted and implemented by the Suicide Prevention
Coordinator in partnership with the DHB, various NGO and community groups. The Planning, Funding and Outcomes Unit (PFO) collaboration process provided an opportunity to create a joint role over both DHBs.

In October 2014, Manu Fotu (Programme Manager) joined the Mental Health & Addictions team in the PFO unit at Waitemata and Auckland DHBs. His primary responsibility is managing the Suicide Prevention and Postvention Programme. A Suicide Prevention Advisory Committee was formed and has met on three occasions to work on formulating a Suicide Prevention and Postvention Action Plan (SPPAP) for 2015 – 2017. It was agreed at an Advisory Committee meeting that the SPPAP be jointly developed to provide Waitemata and Auckland DHBs as well as the wider community, guidance for action on the SPAP 2013 - 2016.

This paper attaches a draft SPPAP as Appendix A. Once the SPPAP is approved by the respective DHBs and the MoH, it will become the guiding document not only for the DHB but also community postvention groups, suicide prevention agencies and the wider community. It focuses on priorities for the next two years, which aim to reduce the impact of suicide in our Waitemata and Auckland communities.

The MoH has set out requirements for the SPPAP, which include:

- a draft suicide prevention and postvention plan is due to the Ministry by 20 April 2015.
- the Ministry will review the plan and provide feedback so that final plan can be submitted by 20 July 2015.
- from July 2015 DHB will be required to select two or three actions to focus on. From December 2015, reporting will be by exception and focusing on highlights. Once the suicide prevention and postvention plan is confirmed, the actions selected for focus should be included in the 2015/16 DHB Annual Plan.

3. Suicide Data

Two national data sources exist from which suicide data is reported. The MoH publish data annually and report on suicides up to three years before the date of publication; the second source is the coronial data released annually by the Chief Coroner. The numbers of deaths from suicide recorded in the MoH publication differ from those released by the Chief Coroner. This is primarily due to the Chief Coroner’s data including all deaths initially identified at the coroner’s office as ‘intentionally self-inflicted’. Of these, only those deaths determined by local coroners following investigation to be ‘intentional’ will receive a final verdict of suicide. In addition, the Chief Coroner’s data covers different time periods (years ended 30 June rather than the calendar years used in the MoH publication).

3.1 Report from Coroner’s Office

National rates and international comparison

Annual coronial figures were first produced in 2007/08. Over this seven year period (July 2007 to June 2014), suicides peaked in 2010/11 when 558 deaths (12.7 per 100,000 population) were as a result of suicide. In subsequent years the number of suicides has declined yearly. In 2013/14 (Table 1), 385 males (17.4 per 100,000 population) and 144 females (6.2 per 100,000 population) died by suicide, a total of 385 deaths (11.7 per 100,000 population), which equates to an average of 1 death by suicide in New Zealand each day. Compared with other OECD countries, New Zealand’s overall suicide rate is similar to that observed in the USA, Austria and Chile, placing it towards the middle of all OECD countries. However, when a comparison is made across age groups, New Zealand has the

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1 For additional tables and statistics see the New Zealand Coronial Services website http://www.justice.govt.nz/courts/coroners-court/suicide-in-new-zealand

Auckland and Waitemata DHBs, Community and Public Health Advisory Committee Meeting 18/03/15

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**National rates by age and gender 2013/14**

Compared with the previous reporting year, the number of suicides in youth (those aged less than 24 years) was lower at 110 (11.8 per 100,000 population) compared with 144 (15.6 per 100,000 population) in 2012/13. The largest decline among youth has been within the 15 to 19 and 20 to 24 age groups, with 17 fewer suicides within both groups when compared with the previous year. The Chief Coroner Judge Maclean stated in his annual release of suicide statistics “The drop in teen suicide is good news. These are some of the toughest and most tragic cases coroners deal with”.

**Table 1. Provisional New Zealand Suicide deaths reported to the Coroner by age and sex between July 2013 and June 2014**

<table>
<thead>
<tr>
<th>Age Group (years)</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
</tr>
<tr>
<td>10 to 24</td>
<td>77</td>
<td>16.1</td>
<td>33</td>
</tr>
<tr>
<td>25 to 39</td>
<td>97</td>
<td>23.9</td>
<td>33</td>
</tr>
<tr>
<td>40 to 64</td>
<td>159</td>
<td>22.5</td>
<td>66</td>
</tr>
<tr>
<td>65+</td>
<td>52</td>
<td>17.3</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>385</td>
<td>17.4</td>
<td>144</td>
</tr>
</tbody>
</table>

A further observation from the 2013/14 statistics is the rise in suicides among older people. The number of suicides recorded in the population aged 65+ has increased from 51 in 2012/13 to 64 in 2013/14. This increase has been noted previously and is a significant observation made the Chief Coroner.

**National rates by ethnicity**

Māori are significantly overrepresented within national suicide statistics. Māori account for nearly half (43%) of all suicides among youth and nearly 20% of all suicides. Suicides among Māori have increased from 87 (15.4 per 100,000 population) in 2007/08 to 108 (18.1 per 100,000 population) in 2013/14. In 2011/12 there was a spike in suicides among Māori with 132 recorded during that year².

**Table 2. Provisional New Zealand Suicide deaths reported to the Coroner for Māori by age and sex between July 2013 and June 2014**

<table>
<thead>
<tr>
<th>Age Group (years)</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
</tr>
<tr>
<td>10 to 24</td>
<td>30</td>
<td>29.4</td>
<td>18</td>
</tr>
<tr>
<td>25 to 39</td>
<td>27</td>
<td>46.7</td>
<td>13</td>
</tr>
<tr>
<td>40 to 64</td>
<td>12</td>
<td>14.8</td>
<td>7</td>
</tr>
<tr>
<td>65+</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>27.1</td>
<td>40</td>
</tr>
</tbody>
</table>

* Rate not calculated where number of suicides is less than is less than 5
* Rates per 100,000 population

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² For additional tables and statistics relating to Māori suicide see the New Zealand Coronial Services website http://www.justice.govt.nz/courts/coroners-court/suicide-in-new-zealand
Within other ethnicities, suicide rates have remained relatively stable since 2007/08 with slight yearly fluctuations. However, variation exists when comparing suicide rates across ethnicities. In 2013/14, the rate in Asians was nearly four times lower than Maori, nearly three times lower than European/Other and half that of Pacific. The rate within Pacific was half that of Maori and lower than European/Other.

Table 3. Provisional Suicide deaths reported to the Coroner by ethnicity between July 2008 and June 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Asian Number</th>
<th>Asian Rate</th>
<th>Māori Number</th>
<th>Māori Rate</th>
<th>Pacific Number</th>
<th>Pacific Rate</th>
<th>European/Other Number</th>
<th>European/Other Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007/08</td>
<td>21</td>
<td>5.9</td>
<td>87</td>
<td>15.4</td>
<td>24</td>
<td>9.1</td>
<td>408</td>
<td>13.3</td>
</tr>
<tr>
<td>2008/09</td>
<td>10</td>
<td>2.8</td>
<td>95</td>
<td>16.8</td>
<td>26</td>
<td>9.8</td>
<td>400</td>
<td>13.0</td>
</tr>
<tr>
<td>2009/10</td>
<td>22</td>
<td>6.2</td>
<td>105</td>
<td>18.6</td>
<td>31</td>
<td>11.7</td>
<td>383</td>
<td>12.5</td>
</tr>
<tr>
<td>2010/11</td>
<td>19</td>
<td>5.4</td>
<td>101</td>
<td>17.9</td>
<td>22</td>
<td>8.3</td>
<td>416</td>
<td>13.5</td>
</tr>
<tr>
<td>2011/12</td>
<td>19</td>
<td>5.4</td>
<td>132</td>
<td>23.3</td>
<td>31</td>
<td>11.7</td>
<td>365</td>
<td>11.2</td>
</tr>
<tr>
<td>2012/13</td>
<td>28</td>
<td>7.9</td>
<td>105</td>
<td>18.6</td>
<td>24</td>
<td>9.1</td>
<td>384</td>
<td>12.5</td>
</tr>
<tr>
<td>2013/14</td>
<td>22</td>
<td>4.7</td>
<td>108</td>
<td>18.1</td>
<td>26</td>
<td>8.8</td>
<td>373</td>
<td>13.0</td>
</tr>
</tbody>
</table>

* Rates per 100,000 population

3.2 ADHB and WDHB Suicide Statistics

Despite yearly fluctuations, between 2008/09 and 2013/14, suicide rates within both Auckland and Waitemata DHBs, according to Coronial data, appear to be trending downwards (Table 4). Ministry of Health data over the five year period from 2007 to 2011 (Figure 1), shows Auckland DHB having the second lowest suicide rate (8.5 per 100,000 population, 207 suicides) in the country behind Capital and Coast (7.5 per 100,000 population, 117 suicides) and ahead of Waitemata (9.3 per 100,000 population, 265 suicides).

Table 4. Provisional Suicide deaths reported to the Coroner for Auckland and Waitemata DHBs between July 2008 and June 2014

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland Number</td>
<td>53</td>
<td>39</td>
<td>51</td>
<td>42</td>
<td>46</td>
<td>41</td>
<td>325</td>
</tr>
<tr>
<td>Auckland Rate</td>
<td>12.2</td>
<td>8.8</td>
<td>11.4</td>
<td>9.3</td>
<td>10.1</td>
<td>8.9</td>
<td>-</td>
</tr>
<tr>
<td>Waitemata Number</td>
<td>56</td>
<td>51</td>
<td>55</td>
<td>50</td>
<td>62</td>
<td>52</td>
<td>388</td>
</tr>
<tr>
<td>Waitemata Rate</td>
<td>10.8</td>
<td>9.7</td>
<td>10.4</td>
<td>9.3</td>
<td>11.4</td>
<td>9.4</td>
<td>-</td>
</tr>
</tbody>
</table>

* Rates per 100,000 population

Multiple risk factors and life events are involved in a person ending their life. The link between mental illness and suicidal behaviour is well known, but other risk factors include exposure to trauma, a lack of social support, poor family relationships and difficult economic circumstances. The prevention of suicide is both complex and challenging, and no single initiative or organisation can prevent suicide on its own. A comprehensive and coordinated approach is required across government and non-governmental organisations, and in partnership with the community.

With the over representation of Māori within suicide statistics, any action plan would include being responsive to Māori needs and ensure interventions are accessible, effective and appropriate for Māori. Involvement and participation of Māori has been embedded into each activity. We have also embedded the broad principles of Whānau Ora into this approach and so specifically incorporated the importance of family in the work of suicide prevention. We are therefore looking at ways, in the action plan, of how we can strengthen families and support them to reduce suicidal behaviour.

The New Zealand Suicide Prevention Action Plan (SPAP) 2013 – 2016 highlighted the shared society responsibility and builds on existing work in suicide prevention. There are 30 actions within this plan and eight government agencies including; MoH, Ministry of Youth Development, Ministry of Education, Police, Ministry of Social Development, Child Youth and Family, Ministry of Justice and Department of Corrections, will contribute to its implementation.

The Waitemata and Auckland DHB SPPAP 2015-2017 takes a population health and community development approach to suicide prevention, and highlights priority actions for suicide prevention and postvention in our districts. It aims to reflect current strategic directions and acknowledge national actions being delivered, while responding to local community needs and priorities. Emphasis has been placed on ensuring outcomes are realistic within identified timeframes. The SPPAP notes specific work needing to be undertaken alongside at-risk groups in our district including Māori, Pasifika, people who are lesbian, gay, bisexual, transgender or intersex (LGBTI), older people, migrants and the rural community.

This plan is also underpinned by the principles in the Strategy 2006-2016 so all activities should:

- be evidence based
- be safe and effective
- be responsive to Māori
- recognise and respect diversity
- reflect a coordinated multi-sectorial approach
- demonstrate sustainability and long-term commitment
- acknowledge that everyone has a role in suicide prevention
- have a commitment to reduce inequalities.

The evidence base for suicide interventions in general is limited and some of the proposed actions in this plan have been based on the Suicide Prevention Toolkit for District Health Boards 2015. The Toolkit was developed as a result of the Ministry of Health evaluation process of suicide prevention activities undertaken in New Zealand in the past 6 years, and to assist and guide DHBs in developing suicide prevention and postvention action plans. The Ministry acknowledged, “The Toolkit draws on existing suicide prevention initiatives in New Zealand and internationally with strong evidence base and others that are currently helping to build that base”.

The Suicide Prevention Advisory Committee is responsible for advising and guiding the Inter Agency Working Group (currently under construction) and Suicide Prevention Programme Manager to develop
and implement a comprehensive, integrated and evidence-based SPPAP for the Waitemata and Auckland District Health Board.

The Advisory Committee made a huge contribution to the design of the SPPAP, and played an integral part in overseeing its development, ensuring that the SPPAP reflected issues and solutions for the Auckland and Waitemata District Health Board populations.

Members of the advisory group include representation from various sectors including:

- Mental Health Planning and Funding
- Mental Health Services
- Primary Care Planning and Funding
- PHO
- Psychiatric Liaison Services
- CADS
- Youth Services
- Psych Liaison Service
- Maori
- Pacific
- Asian
- Provider Executive Group
- CYMRC – Child and Youth Mortality Review Committee
- MHSOA – Mental Health Service services for Older Adult.

The SPPAP endeavours to reflect ownership by the community, along with commitment from key stakeholders for its implementation for the next two years and beyond.

It is recommended that CPHAC endorse the draft SPPAP attached to this paper as Appendix 1, and subject to any amendments CPHAC suggest, agree that it be submitted to the Ministry of Health on behalf of Waitemata and Auckland DHBs on or before 20 April 2015.

Once the draft plan has been endorsed by both DHBs and the MOH, the DHBs are required to identify two or three actions to focus on. It is proposed that the Advisory Group identify these based on their expert view and where evidence exists as to what will have the greatest impact. These priorities will then come back to CPHAC for endorsement.
## Waitemata and Auckland District Health Boards

### Suicide Prevention and Postvention Action Plan 2015 - 2017

**Objective 1: Support families, whānau, hapū, iwi and communities to prevent suicide**

<table>
<thead>
<tr>
<th>Action area</th>
<th>Actions</th>
<th>Intended Outcomes</th>
<th>Timing</th>
<th>Lead Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Strengthen relationships with Maori, Pacific, Asian, Refugee, LGBT communities and work with them as well as appropriate NGOs e.g. Te Rau Matatini, Le Va, Rainbow youth etc. to tailor messages for specific communities.</td>
<td>1.1.1 Develop suicide prevention message and identify mechanisms for delivering messages to the diverse communities named.</td>
<td>a) Strengthen strong public health messages and contribute to workforce capacity and capability to deliver messages to the communities.</td>
<td>Completed by end of December 2015</td>
<td>Suicide Prevention Programme Manager</td>
</tr>
<tr>
<td>1.2 Build the capacity of families, whānau and communities to prevent suicide.</td>
<td>1.2.1 Develop positive and proactive relationships with family whānau and community groups to grow community capacity in suicide prevention.</td>
<td>a) Relationships with relevant family, whānau and community networks are identified, established and maintained to grow community capacity in suicide prevention processes. b) Develop Leadership capacity for Māori and Pacific community.</td>
<td>2015-2017</td>
<td>DHB Services, regional and local family/whānau and community groups and NGO organisations.</td>
</tr>
</tbody>
</table>
1.2.2 Develop a range of targeted resources in the community appropriate formats (e.g. visual, written, IT) to increase knowledge and access to both information and services related to suicide prevention.

| a) | Family, whānau and targeted community groups have easy access to information and services they need in the format that best suits them in order to increase their engagement in suicide prevention in their community. |
| 2015-2017 | Suicide Prevention Programme Manager, MHF, CASA |

| b) | Investigate the potential for mental health, and addictions, older people’s service, public health and other relevant DHB service specifications having a suicide prevention component. |
| c) | Develop a region-wide approach to reducing further risk to people who attempt suicide, in collaboration with mental health services, police and other relevant agencies. |
| d) | Work collaboratively with communities and funders to support projects and initiatives that increase community and individual psycho/social wellbeing resiliency and persistence. |

| 2015-2017 | Suicide Prevention Programme Manager, NRA, Waitemata and Auckland DHB MH and addictions portfolio manager, PHO |

| 2015-2017 | Suicide Prevention Programme Manager, NRA, DHB Planning and funding and provider arm, Government Agencies |

| 2015-2017 | Suicide Prevention Programme Manager |
### Objective 2: Support Families, whānau, hapū, iwi and communities AFTER a suicide

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Actions</th>
<th>Intended Outcomes</th>
<th>Timing</th>
<th>Lead Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Communities are supported to respond to the needs of family,</td>
<td>2.1.1 Waitemata and Auckland DHB to further develop policies, strategies and</td>
<td>a) Co-ordinated support for family/whānau to be inclusive of</td>
<td>2015 - 2017</td>
<td>Suicide Prevention Programme Manager, Suicide</td>
</tr>
</tbody>
</table>
whānau, friends and others following a suicide and reduce suicide contagion.

<table>
<thead>
<tr>
<th>Services that ensure better treatment, management and postvention is provided to families, whānau and friends of those who have suicided. (And to deliver early intervention and reduce variability of what is currently available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- assisting the survivors with the grief process</td>
</tr>
<tr>
<td>- identifying and referring those survivors who may be at risk of engaging in suicide behaviours themselves</td>
</tr>
<tr>
<td>- containing contagion</td>
</tr>
<tr>
<td>- promoting the health recovery of the affected community (building community resilience).</td>
</tr>
</tbody>
</table>

### 2.1.2 Develop a Communication Network

<table>
<thead>
<tr>
<th>2.1.2 Develop a communication network that provides communities, agencies and frontline staff with suicide prevention and postvention information; enabling protective interventions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) The Suicide Prevention Programme Manager provides regular network updates regarding;</td>
</tr>
<tr>
<td>- notification from Coroner</td>
</tr>
<tr>
<td>- pre and postvention information</td>
</tr>
<tr>
<td>- training opportunities</td>
</tr>
<tr>
<td>- local initiatives and other linkages like the Australian and American association of suicidology.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Prevention Regional Inter-agencies Group (SPRIG), Mental Health Services, MoE Traumatic Incident Team Manager, Bereavement Care Providers, Victim Support, PHO providers, Mental Health Foundation and suicide bereavement co-ordinators.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Suicide Prevention Programme Manager, Coronial Services, Victim Support, MoE Traumatic Incident Team Manager, Waitemata and Auckland DHB communication team, Equip, The Grief Centre, CASA, Mental Health</td>
</tr>
</tbody>
</table>
### 2.1.3 Increase access to timely postvention support services to vulnerable groups with special priority given to Māori and Pacific people to increase wellness, addressing suicidal behaviour and restore the balance of physical, emotional, intellectual and spiritual aspects of life.

| b) Strong relationships with the region’s Māori health providers and other Māori Services contracted to provide suicide prevention initiatives (e.g. Kia Piki Te Ora, Te Rau Matatini) ensuring best practice and reduced risk for Māori, Pacific and other risk groups such as the aged and the rural. |
| Foundation suicide bereavement co-ordinator, skylight trust. |
| c) Grow relationships with “at risk target groups” – e.g. Māori, Pasifika, LGBTT, Refugees, migrants, A&D, older people to work alongside identified projects. |
| Community Postvention group, Māori Health providers, training agencies, Public Health. |
### Appendix 1

#### 2.1.4 Develop referral pathway for those “survivors of suicide” to receive early bereavement intervention also accessible by children that ensures cultural support, emotional support, therapeutic exchanges and structured social supports are available.

- **a)** Provide guidelines for Best Practice after a suicide and a database of postvention services with a variety of support groups e.g. peer support, psycho-educational groups, and individual support for those bereaved by suicide.

- **b)** Waitemata and Auckland DHB investigate resourcing a group of community agency staff to be trained in suicide bereavement

- **c)** Develop an educational resource for staff to support families to tell children about a suicide in their family (SPINZ, Skylight)

- **d)** Support key community leaders (e.g. church Ministers and Kaumatua to talk about suicides in a non-judgmental way

### 2.1.5 Waitemata and Auckland DHB suicide response plan developed for the management of suicide clusters/contagion.

- **a)** Interagency (SPRIG) initiate early intervention that is guided by the suicide response plan and reduces suicide clusters/contagion.

- **b)** Increase

Suicide Prevention Programme Manager, mental health, promotion teams, relevant consumer groups

responsiveness to Counsellors in professional practice affected by client suicide and reduces stress symptoms, and hyper-vigilance.

c) Training on client suicide and related aspects provided in DHB orientation.

| Objective 3: Improve Services and support for people at high risk of suicide |
|---|---|---|---|---|
| Action Area | Actions | Intended Outcomes | Timing | Lead Agency |
| 3.1 Improve services and support of people experiencing mental health problems and alcohol and other drug problems. | 3.1.1 Support organisational workforce development plans to include recognising and managing common mental disorders, including depression, anxiety and substance abuse. | a) Suicide Prevention programme manager works alongside Health and Social Sector agencies to screen for and recognise depression and to offer advice on appropriate interventions.  
b) Support public health strategies in respect of alcohol use with emphasis on | 2015-2017 | HR/Education providers  
DHB MH services, PHO |
### 3.1.2 Develop service pathway processes to enhance transition from primary to secondary care mental health and addiction services.

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Work alongside the PHO and DHB mental health and addictions services and police to improve pathways and reduce the risk for people who attempt suicide or are at risk of suicide.</td>
<td>2015-2017</td>
<td>Mental Health and Addictions Network, Police, Mental Health and Addictions Provider arm.</td>
</tr>
<tr>
<td>c) The Waitemata and Auckland DHB undertake further work to enhance risk assessment and response within DHB Mental Health clinical teams including those clients who attempt suicide.</td>
<td>2015-2017</td>
<td>Waitemata and Auckland DHB Provider Arm.</td>
</tr>
<tr>
<td>d) Work alongside the Waitemata and Auckland PHO, community mental health providers and the mental health and addictions Provider Arm to facilitate the further development of suicide prevention in early intervention services</td>
<td>2015-2017</td>
<td>Waitemata and Auckland PHO, Waitemata and Auckland DHB Mental Health and Addictions Provider Arm.</td>
</tr>
<tr>
<td>e) Develop strategies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
for building resilience, and detecting at risk individuals in primary and community settings

f) Ensure that family/significant others are involved in assessment, treatment and discharge planning for at risk people.

**Objective 4: Strengthen the infrastructure for suicide prevention**

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Actions</th>
<th>Intended Outcomes</th>
<th>Timing</th>
<th>Leading Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Make better use of data related to suicide deaths and self-harm incidents</td>
<td>4.1.1 To develop a local database for data collation of completed and or suspected suicides and self-harm</td>
<td>a) Regional suicide data received continues to be recorded in an ethical way by the 2 DHBs</td>
<td>2015-2017</td>
<td>DHBs, Mental Health and Addiction Provider Arm, Suicide Prevention Programme Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Data is shared with relevant agencies on request and as per CASA Memorandum of Understanding.</td>
<td>2015-2017</td>
<td>Suicide Prevention Regional Inter-agencies Group (SPRIG, yet to be formed), CASA, Waitemata and Auckland DHB Services, Suicide Prevention Advisory Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) A year by year summary of suicide data in the 2 districts is collated by age, gender, ethnicity, sexual orientation and geographical location.</td>
<td>2015-2017</td>
<td>Suicide Prevention Regional Inter-agencies Group (SPRIG), Postvention</td>
</tr>
</tbody>
</table>
Data analysis will include identification of proportion of completed suicides by people receiving secondary mental health or AOD services. Emerging trends and risk groups are identified and documented for the Advisory Committee and Inter-agency working group.

d) Dedicated analysis of emerging trends, with potential identification of responses and/or solutions to alleviate impact.

| 4.2 Enhance infrastructure in the DHBs area for suicide prevention | 4.2.1 Support agencies within DHBs to implement the actions of the New Zealand Suicide Prevention Action Plan 2013-2016. | a) Investigate the development of a Regional Inter-agency working Group, which would include key stakeholder representation from community prevention and postvention groups e.g. CYFS, Police, MOE, primary care, older adult care, as well as high risk groups such as Maori, Pacifica, LGBTT, Refugee, and other relevant community groups. | 2015-2017 | Suicide prevention programme manager, Public Health Clinicians |
| | | b) Facilitate a ‘Lived Experience Advisory Group’ to provide advice to Waitemata | 2015-2017 | Suicide prevention programme manager, Mental Health Services, all key DHB and community stakeholders. |
| 4.3 Resourcing for cluster management. | 4.3.1 Resource proposal to MOH | a) DHBs work with the Ministry of Health to develop a model of resourcing for community postvention groups, in the event of a specified need to respond intensely to suicide clusters (likely via CASA). | 2015 - 2017 | Suicide Prevention programme manager, DHB Services, community funding agencies, community NGOs. |
| 4.4 Self-harm reduction in the district. | 4.4.1 Data is collected across the Waitemata and Auckland district to identify numbers and trends associated with self-harm. | a) Self-harm data assists with identification of the key issues, risks and opportunities for intervention to reduce self-harm. | 2015-2017 | Suicide Prevention programme manager, Waitemata and Auckland DHB Mental Health Provider Arm, NGOs, Suicide Prevention Regional Inter-agencies Group (SPRIG) |
### 4.4.2 Suicide Prevention

Coordinator identifies key stakeholders involved with self-harm intervention in the Waitemata and Auckland district.

<table>
<thead>
<tr>
<th>2015-2017 Suicide Prevention Programme Manager, DHB Mental Health Services Group, CYFS, MOH.</th>
</tr>
</thead>
</table>

b) The Suicide Prevention programme Manager works alongside DHB services, statutory and community agencies to investigate the development of a harm minimisation strategy for people who self-harm.
4.1 Mental Health and Addictions Quarter 2 Update on 2014/15

Recommendation

That the report be received.

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

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

Glossary

AP - Annual Plan
AOD - Alcohol and Other Drugs
CADS - Community Alcohol and Drug Service
CAMHS - Child and Adolescent Mental Health Services
CEO - Chief Executive Officer
CMO - Chief Medical Officer
DAP - District Annual Plan
DHB - District Health Board
EOI - Expression of Interest
HONOS - Health of the Nation Scale
IFHC - Integrated Family Health Centre
IY - Incredible Years (Intensive Parenting Programme)
KPI - Key Performance Indicator
MOU - Memorandum of Understanding
Navigate - The peak body for mental health NGOs in the northern region
NGO - Non-Government Organisation
NRA - Northern Regional Authority
PHO - Primary Health Organisation
QPR - Question, Persuade and Refer (Suicide detection training)
RFP - Request for Proposal
ROI - Registration of Interest
SDP - Service Development Plan (Rising to the Challenge)
SPAP - Suicide Prevention Action Plan
SST - Social Sector Trial
Triple P - Positive Parenting Programme
WSN - Waitemata Stakeholder Network
WHOQoL - World Health Organisation Quality of Life Scale

1. Summary

This report provides an update on key initiatives and achievements in the Mental Health and Addictions portfolio for Auckland and Waitemata DHB for the second quarter of the 2014/15
financial year. The report reflects the Government priorities and strategic directions that underpin the 14/15 DAP actions. The Government priorities and strategic directions are:

- Rising to the Challenge – The Mental Health and Addictions Service Development Plan 2012 to 2017
- the New Zealand Suicide Prevention Action Plan (SPAP) 2013–2016
- Welfare Reforms
- Drivers of Crime
- Healthy Beginnings.

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

This plan sets the national direction for mental health and addiction service delivery across the health sector until 2017. There are four overarching goals of the plan:

- actively using our current resources more effectively
- building infrastructure for integration between primary and specialist services
- cementing and building on gains in resilience and recovery for all populations
- delivering increased access to all populations.

Rising to the Challenge requires DHBs to maximise effective use of existing resources, increase access, intervene earlier, and strengthen system integration.

2.1 Rising to the Challenge - using our resources more effectively

Progress and Achievements - Support Hours Implementation

In the mental health NGO sector a major piece of collaborative work across both DHBs has been to reconfigure a range of different service specifications, into one service line of Support Hours. Pooling all these services into one line of support hours enables more flexible and responsive services, tailored to meet the needs of service users. The service specification in Waitemata DHB also gives some increased flexibility for NGOs to deliver support to people in primary care.

The model and payment methodology was moved from an FTE input based model to an output model, based on purchase of direct delivery of support hours. The methodology was based on buying “productive hours” with the expectation that 80% of productive time be spent in face to face delivery (including travel time). Table 1 is a snapshot of the combined Q1 and Q2 2014/15 data for Waitemata DHB NGOs that shows an average of 73.5% face to face (target is 80%).
Waitemata DHB has one mainstream and three Kaupapa Maori services yet to reconfigure. All four providers are in discussion about this and are planning to reconfigure their services by 1 July 2015.

The combined Q1 and Q2 2014/15 Auckland DHB data (see Table 2) shows an average of 60.1% of productive time was spent in face to face delivery (including travel time).

Table 2: Q1 and Q2 Snapshot of Auckland NGO Face to Face Percentage of Contact Time

Please note that Auckland DHB NGOs have only been using the reporting template since 1 July 2014 and issues have been identified with the reliability of data.

Review of Support Hours

A review of the Support Hours model in Waitemata and Auckland DHBs has begun in collaboration with Navigate and the NRA. Initial feedback from providers indicates that the transition to a Support
Hours model has increased service flexibility through the greater ability of NGOs to match support to needs, and increase access through a focus on staff activity. Feedback also indicates that providers are not achieving face to face contact targets due to:

- the delay in receiving new referrals
- mental health needs assessment services regularly request that providers reserve Support Hours for a forthcoming referral (this, for example, facilitates the transition from hospital of people requiring larger Support Hours packages)
- service users cancelling meetings and the provider is unable to use this time for another face to face visit

Over the course of the implementation of this model there has been some divergence in the Auckland and Waitemata service specifications and reporting requirements. The joint mental health funding team are seeking to re-align these by 1 July, 2015.

2.2 Rising to the Challenge - Building infrastructure for integration between primary and specialist services/Stepped Care

“Rising to the Challenge” - The Mental Health and Addictions Service Plan 2012-2017, requires a shared system response across primary and secondary services, with both agreeing on how they will work together to provide seamless and effective services for people experiencing mental health and addiction issues. Stepped Care is the foundation model to achieve this integration across the services. The Stepped Care model advocates efficient use of resources by ensuring that the treatment that is most effective, yet least resource intensive, is delivered first.

Progress/Achievements

Three projects are underway to address infrastructure issues and integration:

1. Maungakiekie-Tamaki Locality Project (Auckland DHB)
2. New Lynn/Totara House Integrated Family Health Centre (Auckland DHB and Waitemata DHB)
3. Raeburn House service reconfiguration (Waitemata DHB).

NGO support services are well placed to provide complementary services in primary care, and assist in addressing social determinants of health (e.g. family issues, finances, housing and employment) which can adversely affect mental health status. These projects will help inform understanding of whether applying more of this NGO resource to the primary care/early intervention part of the pathway improves outcomes, and helps to reduce exacerbation of mental health problems and the need for specialist secondary services.

Updates on these projects have been included in the Primary Care update paper to this committee meeting, and are not repeated here.

3. Suicide Prevention and Postvention Activities

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

- support families, whanau, hapū, iwi and communities to prevent suicide
- support families, whanau, hapū, iwi and communities after a suicide
• improve services and support for people at high risk of suicide who are receiving government services
• use social media to prevent suicide
• strengthen the infrastructure for suicide prevention.

**Progress/Achievements**
By April 2015, DHBs are expected to have provided the Ministry of Health with evidence of how they are developing district suicide prevention and postvention plans and facilitating integrated cross-agency collaboration in respect of local responses to suspected suicide clusters/contagion (Postvention). The Ministry will review the plans and provide feedback, so that the final plan can be submitted by July 2015. The plans will guide DHB activity for suicide prevention and postvention over the next two years.

A paper presenting the draft plan to this committee for approval is a stand-alone item for this meeting agenda, so is not repeated here.

4. **Welfare Reforms (links to Rising to the Challenge – Improving Social Inclusion)**

People with mental health conditions make up 40% of new and existing beneficiaries. Reducing the number of people with mental health problems receiving disability and/or unemployment benefits is a key Government priority. Employment promotes recovery and aids rehabilitation, improves quality of life and reduces social exclusion.

**Progress/Achievements**

4.1 **Auckland DHB and Waitemata DHB Employment Workgroup**

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

The Employment Workgroup has engaged a project manager funded equally by the Waitemata Stakeholder Network (WSN) and Auckland DHB (provider arm and funder). The plan is in development and is due to be released in March 2015. The plan uses the social outcomes employment data (see Tables 3 and 4 below) to develop baseline data.

4.2 **Social Outcomes Indicator Workgroup**

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

**4.3 Waitemata DHB Social Outcomes Indicators**

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

Currently the mental health provider arm is updating its collection of social outcomes to align with the WSN reporting format. The provider arm will report this data for Q1 2015/16.

Table 3 shows employment status at entry and exit of Waitemata NGO services for service users who exited in Q1 2014/2015 reported through the new template. This employment data highlights that the majority of people enter and exit NGO services without employment. This information is being used to inform the development of strategies to improve employment outcomes by the Auckland DHB and Waitemata DHB Mental Health Employment Project.

*Table 3: Waitemata DHB NGO employment data Q1 2014/2015*

<table>
<thead>
<tr>
<th>Employment on entering service</th>
<th>Employment at exit Not employed</th>
<th>Employment at exit Part time</th>
<th>Employment at exit Full time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Employed</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Part Time</td>
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<tr>
<td>Full Time</td>
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**4.4 Auckland DHB Social Outcomes Indicators**

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

Table 4 shows employment status at entry and exit of Auckland NGO services for service users who exited in Q1 2014/2015 reported through the new template. As above, this employment data highlights that the majority of people enter and exit NGO services without employment.
5. Drivers of Crime (links to Rising to the Challenge – increased resilience for young people)

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

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

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

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

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

- Over 50% of all offending is perpetrated by people who developed behaviour and conduct problems in early childhood
- Early onset behavioural problems also predict poor school readiness, low achievement, school failure and substance abuse.
Parent management training programmes are one of the most effective interventions to reduce severe conduct and behavioural problems in young children, improve health, education and social outcomes and reduce rates of criminal offending. Triple P is the only evidence-based parenting intervention that has developed a version of the programme tailored specifically for primary care settings and specialist settings.

Waitemata DHB is one of four national pilot sites for this service. The initial pilot period was December 2011 to December 2013. This has since been extended until June 2016. The aim of the service is to implement evidence-based parent management programmes through both primary care and specialist settings, and to provide additional mental health and AOD support to the most vulnerable parents through specialist settings.

Progress/Achievements

Te Whanau O Waipareira Trust has established a network of 103 practitioners across Waitemata who have completed the Triple P training. These practitioners come from a range of services including Plunket, Well Child providers, Mental Health NGOs, school social workers, Parents as First Teachers and Women and Family services.

Two nurses are employed by Te Whanau O Waipareira Trust to deliver the service. They provide ongoing support and supervision to the network of practitioners, as well as delivering the Triple P programme. In the 2014 calendar year (January to December) Triple P interventions have been delivered to 126 family and whanau. However this number is significantly under-reported. Te Whanau O Waipareira Trust is able to reliably report their activity, however the trained practitioners under report their activity, as there is no formal requirement or incentive for these practitioners to report this information.

5.2 Ranui Social Sector Trial

A second health-led deliverable in the Drivers of Crime policy is enhancing resource sharing and collaboration across Ministries and local organisations to reduce youth drug and alcohol use through the Social Sector Trials. The Ranui Social Sector Trial (SST) is one of 16 trials in New Zealand. Social Sector Trials are a collaborative initiative between the Ministries of Social Development, Justice, Education, Health and the New Zealand Police. The focus of these trials is to support decision making at the local level, build on existing networks and strengthen the co-ordination between Ministry services, and between Ministry services and communities.

Progress/Achievements

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

- reduced truancy
- reduced youth offending
- reduced drug and alcohol use
- increased engagement in education, training and employment.

Each outcome has an established working group to progress its goals. The Ranui Drug Strategy Working Group was established to progress the outcome of reducing drug and alcohol use and is chaired by a member of the funding team. Currently the group is working on two projects:
1. Achieving the DAP objective of establishing AOD (Alcohol and Other Drugs) outcome measures for youth as part of the Ranui SST

Data has been collected from 1 January 2014 on the number of Ranui youth (12 to 18 years old) seen by services. As reported by previous SSTs the collection of meaningful AOD data is problematic. The data required is often collected but only extractable by a manual search. For example the data provided by Waitemata DHB Emergency Departments requires searching for key words in patient notes. Such processes delay reporting and increase the rate of error. Currently data from High Schools is not available. The New Zealand Police have made changes to their data collection that now allows reporting of AOD related offences of young people that occur in Ranui (see Table 5).

Table 5: AOD Offences Committed by 12 to 18 year olds in Ranui

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

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

The New Zealand Blue Light project is to provide cannabis testing, support and counselling to Ranui youth in high schools. Testing is voluntary and used with young people wanting support to stop or reduce cannabis use, and as a means to keep young people in school who would otherwise be stood down or excluded for cannabis use. New Zealand Blue Light will support the family and/or whānau of those youth in the programme to support their young person. This support may include cannabis testing of family and/or whānau member(s) where requested by them. New Zealand Blue Light will also develop peer support within schools. Currently Blue Light is delivering this service within West Auckland Colleges and Alternative Education services where there is a significant population of enrolled Ranui youth.
6. Regional Activities

6.1 Healthy Beginnings (links to Rising to the Challenge – increasing access for mothers and infants)

In January 2012 the Ministry of Health published “Healthy Beginnings – Developing perinatal and infant mental health services in New Zealand”. This publication was developed as a guide to DHBs and describes the continuum of care and the service linkages required to effectively address the mental health and alcohol and other drug (AOD) needs of mothers and infants. “Healthy Beginnings” stresses the need for a comprehensive continuum of perinatal and infant mental health and addiction services. “Healthy Beginnings” has informed the development and implementation of the Regional Perinatal and Infant Mental Health Project.

Progress/Achievements

In March 2014 Auckland DHB and Waitemata DHB signed Crown Funding Agreements (CFA) with the Ministry of Health (MoH) to provide a Maternal Mental Health Acute Continuum. The “Northern Region Perinatal and Infant Mental Health Model of Care Guideline” was developed and a range of DHB and NGO services are in the implementation stage. These services include:

- Acute responsiveness enhancement to maternal mental health services to provide additional clinical and medical staffing. Auckland DHB has recruited to 2.6 FTE clinical positions and a further 0.4 FTE is currently being recruited to and a 0.5 FTE Senior Medical Officer has been appointed and commences employment in March. Waitemata DHB has recruited to 2.75 clinical FTE positions and a 0.5 FTE Senior Medical Officer.

- NGO Crisis Respite Beds and Packages of care services. Following a RFP process a successful provider has been identified and the CEOs have given their approval. A contract with the provider is being drafted. Support hours services will commence in April 2015. The respite house requires a new build, on a site in Te Atatu already owned by the provider. Architects, a building project manager and a builder have been employed to the build the facility. It is estimated that the build, and the consent processes will take 6 months.

- Mother and baby acute mental health care inpatient unit to provide hospital based specialist perinatal mental health assessment, treatment and support for three mother and infant dyads commenced operating in October 2014. The beds were well utilised in the first four months of operation, although there has been a dip in utilisation in February.

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

6.3 High and Complex needs (Regional)

The Regional Services Planning Group sponsored a High and Complex Needs Project in 2013. The project was driven by recognition by the Northern DHBs and the Ministry of Health that there were gaps in the service continuum, for people with high and complex needs, resulting in un-necessarily prolonged admissions to forensic inpatient beds at the Mason Clinic, and adult acute in-patient beds across the region. The MoH has already committed to the commissioning of five additional High and Complex beds within the Mason Clinic inpatient forensic services. In addition Waitemata DHB has
committed significant funding for the development of community based services for this group of people (see following section (High and Complex Needs – Waitemata DHB). The most significant current gap for Auckland and Waitemata DHBs is that of minimum secure beds.

6.4 High and Complex Needs (Waitemata DHB)

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

Progress/Achievements

A Registration of Interest to deliver the Services was advertised in early November 2014. The ROI closed on 5 December 2014 and on 19 December the panel shortlisted four organisations. These four organisations are being asked to submit a more detailed RFP response, in a closed process. The RFP will be released on 23 March, and closes on 6 May. The medium term individualised packages are anticipated to commence in mid-2015. The long-term accommodation and support options are anticipated to commence in late 2015/early 2016.
5.1 Primary Care Update Quarter 2, 2014/15

Recommendation

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

Prepared by: Tim Wood (Deputy Director Funding and Development Manager - Primary Care, Waitemata and Auckland DHBs), and Dr Stuart Jenkins (Clinical Director - Primary Care, Waitemata and Auckland DHBs)

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

Glossary

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

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

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

2. National Health Targets

Primary Care Scorecard

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

How to read the Scorecard

For each measure, the green bar reflects how well we are doing against the target for the period presented. The bar will begin to show green when the target has been partially achieved. For most indicators, this is once 60% of the target has been met. If performance is meeting target or better than target the bar will display as a solid green line. For the Health Targets, the scale is more sensitive as any variance is deemed to be significant. The bar will only begin to show green once 80% of the target is achieved. Where the bar is blank, this reflects very poor performance against the target or where no data is available or no target has been set.
The Scorecard above shows for each measure the actual performance of both DHBs during quarter two, 2014/15 against the target. This is described in detail as follows:

I. Better Help for Smokers to Quit – Primary Care Health Target (Q2, 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 MoH as a National Health Target and is part of the Integrated Performance Incentive Framework (IPIF, see 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 two results released by the MoH rank Waitemata DHB as the top performing DHB and Auckland DHB as the second. The results are also shown in the Scorecard under Health Targets as well as by the bar chart below:

- Auckland DHB 97.7%, ↓2.1% from the previous quarter; and
- Waitemata DHB 99.8% ↑0.6% from the previous quarter.
All PHOs are prioritising high needs populations in their programmes to support people to quit smoking.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB (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 report monthly to the DHBs on their performance against this target. PHOs have maintained achievement of the target for the previous three quarters. They are now working on embedding the provision of support to quit as a sustainable clinical intervention that is part of ‘usual care’ for general practices.

Auckland and Waitemata DHBs and the PHOs are building on the success of the brief advice ‘better help for smokers to quit’ Health Target, by also focussing on increasing the number of people that are receiving cessation support. As the reporting for the ‘better help for smokers to quit’ health target has been on ‘brief advice’ - this has been where the efforts of DHBs, PHOs and GPs have been focussed. However, for many this has not followed through into providing ‘support to quit’.

II. More Heart and Diabetes Checks Health Target (Q2, 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 Integrated Performance Incentive Framework (IPIF, see Section 3). The quarter two denominators are 144,190 for Waitemata DHB and 153,130 for Auckland DHB. The denominator increase between quarter one 2014-15 and quarter two 2014-15 for Waitemata DHB was 1087. The denominator increase between quarter one 2014-15 and quarter two 2014-15 for Auckland DHB was 993. The quarter two results released by the MoH are as follows (also shown in the Scorecard under Health Targets):
- Auckland DHB 91.9% (140,665 people CVD risk-assessed)
  - Total coverage ↑ 0.2% from quarter one. This is currently ranked first in the country.
  - Coverage for Māori ↑ by 0.2% (from 88.2% to 88.4%) and for Pacific ↑ by 0.3% (from 89.8% to 90.1%). Auckland DHB is first in the country for Māori coverage and is second in New Zealand for Pacific coverage.

- Waitemata DHB 90.2% (130,077 people CVD risk-assessed)
  - Total coverage ↑ 0.5% from quarter one. This is currently ranked fifth in the country.
  - Coverage for Māori ↑ 1% (from 83.5% to 84.5%) and for Pacific ↑ 0.5% (from 87.6% to 88.1%). Waitemata DHB is sixth in the country for Māori coverage and is third in New Zealand for Pacific coverage.

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

The increase in 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.

The CVD incentive funding for achieving the 90% target in the 2013-14 year has been received from the MOH. Four out of the five PHOs within the Waitemata/Auckland DHBs qualify for the incentive and their payment is being processed. The Primary Care team has agreed with the PHOs the deliverables required in order to receive this funding. This is focused on increasing assessment rates for Maori and Pacific people, workforce development and education and management of people with high risk profiles.

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, lab 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 (Q2 2014/15)

• Total DARs completed – 4,642
  o Maori 347
  o Pacific 1487
  o Indian 875
  o Asian 624

• 65% of patients who had a DAR completed had HbA1c <= 64mmol/mol (indicating good diabetes management)
  o Maori 68%
  o Pacific 59%
  o Indian 74%
  o Asian 69%
Waitemata DHB (Q2 2014/15)

- Total DARs completed – 3,314
  - Maori 286
  - Pacific 491
  - Indian 216
  - Asian 301

- 71% of patients who had a DAR completed had HbA1c <= 64mmol/mol (indicating good diabetes management)
  [ethnicity breakdown unavailable]

iv. Service Delivery Targets – PHO Enrolment

PHO enrolment for Auckland DHB is 92% and 95% for Waitemata DHB, which has remained unchanged from the previous quarter (Q1, 2014/15). Pacific enrolment is over target for both DHBs – 114% in Auckland DHB and 103% in Waitemata DHB. Māori enrolment rates are 79% for Auckland DHB and 81% 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 Māori enrolment.

The Auckland Regional Asian & MELAA Primary Care Working Group has developed an Action Plan to work towards increasing PHO enrolments and utilisation across the region for Asian, migrant and refugee populations. The working group members include key stakeholders across primary and secondary care, settlement support agencies, NGO providers, academia and immigration networks with a shared focus on improving primary care outcomes for the identified target groups across the region.

3. Integrated Performance Incentive Framework (PHO Performance as at Q2 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 DHB has just been informed that DHB Shared Services will produce a quarterly report on DHB Performance, which will provide a breakdown of IPIF information by ethnicity, high needs population and total population. The MoH is also in the process of developing a dashboard that will allow PHO’s to check their own performance information. The dashboard will be publicly available when completed and could be a useful resource for this work.

Phase One of IPIF (2014/15), is a transition year moving from the PHO Performance Programme. The Primary Care team will work with the Child, Women and Youth (CWY) team, to revise the way Health Targets and IPIF performance data (by DHB and PHO) is reported to CPHAC. This will ensure reporting of the most up-to-date data (by ethnicity and high needs), together with relevant clinical analysis from the Metro Auckland Clinical Governance Forum (MACGF).
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>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 toQuit (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.

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 2014/15 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 2014/15 Target</th>
<th>Q2 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q3 2014/15 Target</th>
<th>Q4 2014/15 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>Yes</td>
<td>89.3%</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>Yes</td>
<td>82.7%</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>Yes</td>
<td>93.7%</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>No</td>
<td>94.6%</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>Yes</td>
<td>80.0%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>
The Q1 and Q2 2014/15 target vs. actual for **ProCare** are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 2014/15 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 2014/15 Target</th>
<th>Q2 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q3 2014/15 Target</th>
<th>Q4 2014/15 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>Yes</td>
<td>89.0%</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>Yes</td>
<td>84.8%</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>Yes</td>
<td>94.5%</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>No</td>
<td>95.0%</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>No</td>
<td>79.7%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

The Q1 and Q2 2014/15 target vs. actual for **Waitemata PHO** are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 2014/15 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 2014/15 Target</th>
<th>Q2 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q3 2014/15 Target</th>
<th>Q4 2014/15 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>Yes</td>
<td>86.7%</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>Yes</td>
<td>81.7%</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>Yes</td>
<td>94.4%</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>No</td>
<td>94.5%</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>Yes</td>
<td>80.0%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>
The Q1 and Q2 2014/15 targets vs. actual for **Alliance Health Plus** (hosted by CMDHB) are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 2014/15 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 2014/15 Target</th>
<th>Q2 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q3 2014/15 Target</th>
<th>Q4 2014/15 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>Yes</td>
<td>88.5%</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>Yes</td>
<td>88.0%</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>Yes</td>
<td>94.2%</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>Yes</td>
<td>95.0%</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>No</td>
<td>78.0%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

The Q1 and Q2 2014/15 target vs. actual for **National Hauora Coalition** (hosted by CMDHB) are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 2014/15 IPIF Target</th>
<th>Q1 IPIF Result</th>
<th>Q2 2014/15 Target</th>
<th>Q2 IPIF Result</th>
<th>Quarterly IPIF Target Achieved</th>
<th>Q3 2014/15 Target</th>
<th>Q4 2014/15 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>Yes</td>
<td>87.9%</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>Yes</td>
<td>87.7%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Increased Immunisation – 8 Month Olds</td>
<td>88.9%</td>
<td>95.0%</td>
<td>90.9%</td>
<td>96%</td>
<td>Yes</td>
<td>93.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
<td>91.5%</td>
<td>94.7%</td>
<td>92.6%</td>
<td>93%</td>
<td>Yes</td>
<td>93.8%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>73.6%</td>
<td>72.1%</td>
<td>75.7%</td>
<td>72%</td>
<td>No</td>
<td>77.9%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>
4. **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.

The Auckland Waitemata Alliance Leadership Team (ALT) received a number of presentations during quarter two, including from Te Pou Matakan (the Whanau Ora Commissioning Agency for the North Island), and Pasifika Futures (the Pacific Whanau Ora Commissioning Agency).

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

- Development of an intervention logic framework to facilitate a common understanding regarding the resources available, the activities and strategies that are/can be implemented, and the clear outcomes we are looking to achieve
- Stocktake and gap analysis of current diabetes and cardiovascular services and funding across community services contracted by the DHB; services provided by the DHB and secondary care services
- Development of a comprehensive set of performance and outcome measures for diabetes and cardiovascular disease. These measures have been presented to the MACGF for endorsement and have received final sign off by the ALT. For further information regarding this, please refer to CPHAC Agenda 18 March 2015 paper entitled “Alliance Diabetes and Cardiovascular Disease Clinical Indicators and Measures.”

A process has commenced to align the terms of reference for the various service level alliances to the District Alliance, in terms of principles, priorities and key performance indicators. This work will also involve setting expectations, establishing the key performance indicators and reporting templates.

The annual planning guidance from the MoH states that DHBs are also expected to provide evidence that the ALT jointly developed and agreed those sections of the plan with a primary care or integration focus. The ALT therefore agreed to hold a separate facilitated session for the 2015/16 annual plan. The objective of the workshop is to allow the ALT an opportunity to explore and identify from an alliance perspective the strategic priority areas that need to be included in the 2015/16 Annual Plans of both Auckland and Waitemata DHBs.

II. **Auckland Waitemata Rural Service Level Alliance**

The Rural Service Level Alliance proposed scope has been consulted on with stakeholders. Feedback has been received by stakeholders and is currently being collated and incorporated into the proposed service level alliance document. The collated feedback will be presented back to the stakeholders and the Service Level Alliance document will be finalised. It is anticipated that the first meeting of the Rural Service Level Alliance leadership team will be held in April 2015.
III. Support Implementation of Phase 4 of the Community Pharmacy Services Agreement (CPSA)

a) Phase 4 payments
A meeting to provide information about the Phase 4 payments (Advance Service Fee, Quarterly Service Fee and Funding Envelope Annual Adjustment), to the Metro Auckland community pharmacies had a successful turnout on 18 November 2014, and was followed by an online webinar for those pharmacy managers or owners that were unable to attend that day. This meeting was run in collaboration with DHB Shared Services and the MoH. The topics discussed in the meeting included:

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

b) Medicines Adherence Support Services (MASS)
HSAGlobal provides an eShared Care Platform called the Connected Care Management System (CCMS). They established workshops with a group of pharmacists from 12 pharmacies across the Metro Auckland area to hone the platform to better meet the needs of community pharmacy. HSAGlobal has taken the input from these workshops and has developed, as part of the eShared Care platform, the Medicines Adherence Support Service (MASS) programme, designed to support the clinical workflow and documentation required to deliver the Pharmacy Long Term Condition (LTC) Service in an environment that allows for integration between the pharmacy, the patient and other care team providers.

The National Health Information Technology Board (NHITB), the MoH and the National Community Pharmacy Services Development Group have endorsed MASS. It will provide pharmacy with an opportunity to not only deliver their LTC Service ensuring they meet audit requirements, but to also prepare for the integration within a multidisciplinary team and sharing of patient information between pharmacists and GPs. Waitemata and Auckland DHBs are supportive of their community pharmacies using this tool.

IV. Complete Review of Health Services on Waiheke Island, 31 March 2015
A stocktake of services provided on Waiheke Island and subsequent gap analysis continues. Close engagement with key stakeholders is being maintained throughout this process, and an update will be provided to stakeholders in quarter three. This project will be a key focus of the Rural Service Level Alliance.

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

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

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 two 2014/15 is as follows:

- The total number Auckland Metro POAC referrals in quarter two (October - December 2014) were 15% below the target (see table below). Counties Manukau is 35% below target and Auckland is 21% below target while Waitemata is 29% above target volumes for the quarter.
- Overall, the total referrals received increased by 6% compared with the same period in the previous year of 4,946.
- 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, 84% of patients were safely managed in the community and avoided hospital presentation with 87% in Auckland and 88% in Waitemata.
- Total referrals year to date (July – December 2014):
  - Auckland DHB: 2,687
  - Counties Manukau DHB: 4,891
  - Waitemata DHB: 5,162

<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>2105 (1630)</td>
<td>1193 (1510)</td>
<td>1990 (3080)</td>
</tr>
<tr>
<td>Average cost per referral (excl. GST), budget $200.00</td>
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<td>$176.27</td>
<td>$212.85</td>
</tr>
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</table>

<table>
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<th>Pacific</th>
<th>Asian</th>
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<td>53%</td>
<td>14%</td>
<td>18%</td>
<td>11%</td>
<td>4%</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

During 2014, Procare Health Limited, Waitemata and Auckland DHBs, and the New Lynn Integrated Family Health Care Centre have been working on a pilot to establish and refine a collaborative stepped care model. 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 /NGO resources.

**Progress to Date**
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 on demand to the practice, and also conducts assessments on-site. DHB Community Mental Health Primary Care Liaison nurses are also based some of the time in the Centre. This allows for timely intervention and support for clients both exiting and entering secondary care, and at the interface between the two.

A psych-social assessment model is ready for trial and Malcolm Stewart (Clinical Psychologist) from Procare Health Ltd has developed clinical pathways for primary mental health, which are yet to be tested. A supported e-therapy programme has been developed and started, and self-management groups for mental health clients are in process.

b) **The Waitemata DHB Cognitive Impairment Clinical Pathway, evaluated by January 2015**

The University of Auckland’s Department of Geriatric Medicine completed all the Pathway Pilot evaluation interviews on time during quarter two. Meetings with the pilot participants and Clinical Reference Group to critique the draft report occurred during early February 2015, and the University is currently finalising the report. The Waitemata DHB Cognitive Impairment Clinical Pathway is included with nine other pathways on the Northern Region Clinical Pathways electronic pathway enabler (Neext), which is currently in pilot phase.

c) **Palliative Care Model agreed and implementation initiated by 1 April 2015**

**Waitemata DHB**
The Palliative Care model of care was approved and finalised in October 2013. A Clinical Governance Group has been in operation since March 2014 and is currently overseeing the work of a sub group. The subgroup is composed of Senior Medical Officers (SMOs) in palliative medicine.

The 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 HR, Hospice management and the DHB. This group will be working closely with Hospices and the Provider Arm to implement the collaborative model within the district.

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 will begin working on a second work stream of the Model of Care relating to clinical pathways and patient referrals into Palliative Care services.

**Auckland DHB**
A working group, together with a wide range of stakeholders, has been developing a direction for palliative care for the Auckland DHB area. The direction will be presented to CPHAC when it is available. However, there is an in principle agreement to move to an integrated model across DHB and Hospice services.
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). A procurement plan has been drafted and is in the final stages of approval by the members of the subgroup and their relevant organisations. The Register of Interests process will be initiated in March followed by a Request for Proposal process. This process has been 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 been delayed. This is due to a number of potential respondents to this being involved in the MoH process for telephone advice lines. It is not appropriate for them to be responding to two significant procurement processes simultaneously.

VIII. Localities Development

a) Tamaki locality

The working group completed all project proposals and submitted to these to the project manager for collation at the end of December. These project proposals cover the following initiatives:

- **Whole Person/Whole of Life Care**
  This proposal focuses on changing the relationship between the service user and the clinician/practice. A suite of options will be co-designed by service users and clinicians enabling whole person/whole of life information (such as relationship or financial issues), to be shared with healthcare professionals early in the relationship.

- **Dedicated NGO Resource for Primary Care**
  This proposal will prototype how general practice accesses NGO support hours for patients that are not connected with secondary care. Currently 10% of NGO support hours are allocated for primary care use, however there is wide variety and no clear model for how this resource is utilised.

- **Developing Primary and Secondary Care Integration in Tamaki**
  This project aims to improve the relationships between primary and secondary clinicians, improve the level of support that both service levels offer each other with the expectation that more clients with moderate-to-severe but stable needs will be managed in primary care and that primary care will have more access to advice and support. These initiatives aim to set to set the conditions for effective stepped care.

- **Linkage Service**
  This proposal strongly links with the Whole Person Care project, as patients (adults and youth) who identify as wanting support for complex health and social issues will be referred to this service for mentoring and be introduced to appropriate support (e.g. health and social agencies).

- **Developing Community Voice**
  This proposal focuses on developing the platform where the community can raise issues on an equal footing and guide the development of services from an end user perspective. In addition, senior management at ADHB have expressed a clear desire for the development of new clinical service delivery models, delivered in Tamaki, to be developed through a co-design platform in
partnership with the community. Again this is an initiative that requires support from beyond the health sector and Tamaki Redevelopment Company and local NGO’s such as Te Waipuna Puawai are willing to support this work.

- **Creating an Integrated Network of Wellbeing Hubs**
  The wellbeing hub represents a place where individual community members and the community as a whole can cultivate self-determination and ownership over their health and social outcomes. Glen Innes will be where the central ‘hub’ would be located, connected to a number of ‘spoke’ centres operating in the other main neighbourhoods in Tamaki. This proposal involves multiple stakeholders beyond the health sector, such as Maungakiekie-Tamaki Local Board and Tamaki Redevelopment Company (TRC). TRC has committed $50,000 for a feasibility study for this initiative and the Local Board are keen to discuss the re-purposing of the community centre in Glen Innes and possibly utilisation of the community centre in Panmure for this purpose also. Discussions have been held with Auckland Council to support the development of this initiative through existing Council facilities.

- **Development of a Tamaki Wellbeing Framework**
  This proposal focuses on developing a wellbeing framework for Tamaki through which projects that are undertaken in Tamaki, that impact the community, will be required to prioritise wellbeing as a key measure of success. The project team have already approached Tamaki Redevelopment Company about this initiative who have in turn approached Treasury about incorporating wellbeing as an important thread that should flow through the TRC measurement framework for their housing and social development work in Tamaki. ADHB is putting forward a representative to be part of the team consisting of Treasury representatives, MSD’s chief data scientist Richie Poulton, representatives from Social Policy and Evaluation Unit and community who will develop the wellbeing outcomes framework for Tamaki.

**Next Steps**
It is being proposed that the health focused initiatives outlined above can be developed through a Plan-Do-Stay-Act (PDSA) quality improvement framework based in-and-around four general practice sites in Tamaki. It is anticipated that the Wellbeing Hub project will be managed and resourced by a combined group of stakeholders including Local Board, Auckland Council and TRC with health playing a small supporting role. Furthermore, the Wellbeing Framework project has been taken on by TRC as part of the development of an outcomes framework for the area and health will be a contributing partner as discussed above.

**b) West Rodney Locality**
There are two main areas of focus during 2014-15: Child Oral Health and Access to Services. The Auckland North Localities Operational Group (LOG), as the project working group, is now refining specific projects to take forward this year. A summary, as at end of January 2015, is shown below.

**Child Oral health**
The overall goal of the Child Oral Health workstream is to connect services and inform families/whanau of the importance of oral health and services available at a local level. Project areas include:
Data and Evaluation project

- Work continues with Auckland Regional Dental Service (ARDS) to establish accurate baseline data on contracted oral dental services planned and provided for in West Rodney. ARDS is looking at ways to encourage and support more preschool children to utilise the service.
- A preschool oral health survey was sent out to West Rodney schools in September 2014, with the aim to collect data on behaviours and attitudes to caring for the health of young children’s teeth and gums, as well as access to services locally. Over 200 completed surveys have been received, and data analysis will be completed and findings presented at the February 2015 LOG meeting. This will allow the DHB to tailor the project work accordingly.

Health Literacy project

- It was agreed to develop an oral health information resource specific for the community after reviewing feedback from a West Rodney Locality Forum in 2014. Work is underway to engage with ARDS, Healthpoint and Health Link North to develop an appropriate resource tailored to the needs of the West Rodney community.

Multiple Newborn Enrolment Process

- To support national policy, the DHB has undertaken some initial work to investigate the feasibility and benefits of implementing a Multiple Newborn Enrolment (MNE) process. A single form could potentially enrol newborn babies with five key services: General Practice, Well Child provider, Oral Health provider, Newborn Hearing Screening, and the National Immunisation Register. A project scope was developed in late 2014 with members of the DHB’s Child Health team, and work is currently ongoing to take this project forward.

Access to Services

This workstream aims to improve local access to services and enhanced visibility of what services are provided in West Rodney. Project areas include:

Healthpoint and the West Rodney-NGO pilot

- During the latter part of 2014, the Healthpoint team have supported a West Rodney pilot for providing information on NGO services – with over 40 NGO providers now listed on Healthpoint.

Implementation Support Group Funding

- Work is ongoing to secure Implementation Support Group (ISG) funding for 2015-16 from the MoH. This funding will help support change management activities and initiatives in West Rodney (e.g. to increase capacity and capability of primary care and increased integration of services).

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

A data-sharing Memorandum of Understanding has been signed off by all of the PHOs participating in the initiative. Twelve general practices from the West Auckland area have agreed to participate in the diabetes improvement initiative. This initiative is primarily designed to improve Māori and Pacific population’s diabetes-related outcomes. A Diabetes Nurse Specialist is working closely with the participating practices, and has commenced the data collection process. Findings of the data will be used to establish baseline and to drive quality improvement activities.
5. Other

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

The Ethnicity Data Audit Tool (EDAT) implementation is well under way in all general practices under Auckland and Waitemata. Current implementation rates sit at 64%. The EDAT provides a resource for assessing the quality of ethnicity data in primary care settings including systems for ethnicity data collection, recording and output. The tool also provides guidance on quality improvement activities including the regular repetition of the EDAT and suggests remedial action for areas identified as requiring improvement.

The Maori Health Gain team has recently submitted a proposal to the MoH for the development of an electronic learning module on ethnicity designed for primary care frontline staff. If this is successful, its development and subsequent wide use in a primary care setting should, together with the EDAT tool, drive the quality improvement expected in ethnicity collection and recording. This in turn will, to some extent, better reflect ethnic-specific PHO enrolment rates. It is in fact believed that, for Maori in particular, some of the under-enrolment seen in PHOs is due to ethnicity misclassification.

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</th>
<th>CR</th>
<th>MRI</th>
<th>US</th>
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<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
<td>Actual</td>
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<tr>
<td>ADHB</td>
<td>90%</td>
<td>100%</td>
<td>85%</td>
<td>99%</td>
</tr>
<tr>
<td>CMH</td>
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<td>65%</td>
<td>85%</td>
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</tr>
<tr>
<td>WDHB</td>
<td>90%</td>
<td>100%</td>
<td>85%</td>
<td>99%</td>
</tr>
</tbody>
</table>

For ADHB the 2014/15 year-to-date expenditure is $153,000 against the allocated budget of $250,000 (i.e. underspent by $97,000). For the six months from 1 July to 31 December 2014, almost half of all referrals are of European ethnicity with Maori at 9% and Pacific at 15%. A quarter of referrals belonged to quintile 5.

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 18/03/15
6. Primary Mental Health

I. Stepped Care Model

The Primary Mental Health service specification outlines a stepped care model which is regionally consistent across Waitemata and Auckland DHBs, where possible. The service, with the exception of the Prime Minister’s Youth Mental Health Initiative, is targeted to Māori, Pacific and quintile 5 patients. Waitemata DHB and Auckland DHB have used similar service specifications for the adult primary mental health initiatives contracts with the PHOs. Additional funding has also been provided by the MoH to target alcohol screening and brief interventions in primary care settings. This funding supports and extends interventions that are already in place as part of existing primary mental health initiatives.

II. Auckland DHB

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

2014/15 quarter one and two volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland PHO</th>
<th>ProCare</th>
<th>Ah+</th>
<th>NHC</th>
<th>Youth Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q1</td>
<td>Q2</td>
<td>Q1</td>
</tr>
<tr>
<td>NZ European</td>
<td>53</td>
<td>139</td>
<td>1116</td>
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<tr>
<td>Māori</td>
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<tr>
<td>Pacific Island</td>
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<tr>
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<tr>
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<td>1470</td>
<td>228</td>
</tr>
<tr>
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<td>86</td>
<td>86</td>
<td>360</td>
<td>360</td>
<td>106</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 December 2014, Raeburn House service was reconfigured to support the PHO delivery of primary care interventions. This will support PHOs to deliver increased volumes
- In previous years, Waitemata DHB has funded PHOs by enrolled population. For 2014/15 Waitemata DHB has moved to funding by enrolled Māori/Pacific and quintile 5 population. Due to the significant changes in PHO funding this would cause, Waitemata DHB has agreed to phase this funding change over 2014/15
- 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 one and two volumes are as follows:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Waitemata PHO Q1</th>
<th>Waitemata PHO Q2</th>
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<th>ProCare Q2</th>
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</tr>
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<td>339</td>
<td>931</td>
<td>867</td>
<td>442</td>
<td>335</td>
</tr>
<tr>
<td>Targets</td>
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<td>320</td>
<td>553</td>
<td>553</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.
5.2 Planning, Funding and Outcomes Update

Recommendation

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

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Tim Wood (Funding and Development Manager Primary Care), Kate Sladden (Funding and Development Manager Health of Older People), Samantha Bennett (Manager Asian Health Gain), Aroha Haggie (Manager Maori Health Gain), Lita Foliaki (Manager Pacific Health Gain)

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

Glossary

ARRC - Age Related Residential Care
ARPHS - Auckland Regional Public Health Service
DHB - District Health Board
GP - General Practitioner
HBSS - Home Based Support Services
HNA - Health Needs Assessment
HOP - Health of Older People
NASC - Needs Assessment Service Coordination
RACIP - Residential Aged Care Integration Programme (RACIP)

Summary

This report updates the Committee on Auckland and Waitemata DHBs’ planning and funding activities not reported elsewhere in the agenda.

1. Planning

1.1 Planning

Health Needs Assessments (HNA) for both DHBs have been completed and submitted to both DHB Boards. These have been accepted with minor amendments.

Drafts of both Annual Plans were presented to respective Board meetings and feedback invited over the following week. All recommendations have been added into the plans along with the requirement to note that any financial information submitted to the MoH prior to Board sign-off be identified to the MoH that it is still subject to Board sign-off.

Further developments of Annual Plans continue, and in particular shortening and sharpening the introductions, amendments to outcomes framework (including further data collection and creation of graphs), reviewing and revising performance measures, responding to new Ministry advice and Module 2. We are also working to ensure that Module 2 in the ADHB plan aligns with developing ADHB strategy.
The 2015/16 Statement of Performance Expectations for both DHBs indicators and format have been revised; baseline data collection and target setting largely complete.

Challenge sessions have been held to enable those involved in developing Module 2 sections of the Annual Plans to check their content with senior management and MoU partners.

A feedback survey was also undertaken following the annual plan workshops which were well attended by stakeholders across the wider sector. A feedback report has been compiled from the 91 responses which were received. Key points from this feedback will be considered in the development of these workshops next year.

2. Health of Older People

2.1 Home Based Support Services (HBSS)

Joint Working Group
The Funder is working with a group of Waitemata and Auckland DHB clinical leads and service managers on a revised model of HBSS that will assist over 65 year olds to regain as much function and independence as appropriate within their respective conditions to enable them to live at home safely.

The DHBs are due to discuss the proposed model with a range of home based support service providers at workshops in March/April to determine feasibility from their perspective.

Comparisons have also been made with other DHB models particularly around the Needs Assessment Service Coordination function and the funding model. The redesigned model will be presented to both Boards for approval prior to procurement in 2015/16.

A report on values based contracting and applicability to HBSS is being prepared by consultants Francis Group International. The final report is due early March and will feed into the revised HBSS model.

In-between Travel Time
The Settlement Agreement for In-between Travel Time (that is, paying HBSS support workers for their time travelling between clients) has been ratified by all DHBs and will become effective on 1 July 2015. We are awaiting implementation detail from the Ministry of Health.

interRAI
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:

- 67.7% of Waitemata HBSS clients have had an interRAI assessment (previous quarter – 56.2%)
- 94.6% of Auckland DHB HBSS clients have an interRAI assessment (previous quarter – 95.1%)

2.2 Dementia Care Pathway
The Department of Geriatric Medicine at the University of Auckland has provided a draft evaluation report on the Waitemata DHB Cognitive Impairment Clinical Pathway Pilot that ran from 4 November 2013 to 31 July 2014. The report is currently being critiqued by the pilot participants (GPs, practice nurses, Waitemata DHB community and HOP secondary care services) and HOP clinical directors. The final report will be taken through formal approval processes at both
Waitemata and Auckland DHBs before being presented to both Boards for approval to rollout to GPs.

At Auckland DHB, a hospital dementia project will link with the regional Cognitive Impairment Clinical Pathway. A dementia specialist role (nurse or allied health) has been advertised for a 12 month appointment. The specialist will work with key stakeholders to improve the pathway of care for patients with dementia across the hospital.

A regional sub-committee for dementia education in primary care has participated in discussions with the other three regions resulting in consensus to pool some funding to develop nationally consistent resources.

A draft policy for secure dementia unit design is being reviewed by the Regional Dementia Working Group. There is growing evidence of the impact of environmental design on the day-to-day living experience of people with dementia and considerable literature to support dementia-friendly facility design. The purpose of the policy is to provide consistency and transparency on how the Northern Region DHBs will review and approve dementia units to ensure they are designed to benefit the health and wellbeing of residents.

### 2.3  Aged Related Residential Care (ARRC)

#### Auckland DHB

All Auckland DHB aged residential care facilities are engaged in interRAI (standardised clinical assessment) training as follows:

- 40% (26) are fully competent (required number of nurses trained)
- 32% (21) are competent (at least one nurse trained)
- 8% (5) are currently training
- 12% (8) are scheduled for training
- 8% (5) have signed an engagement agreement.

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

ADHB Gerontology Services will continue to deliver quarterly ARRC study days to registered nurses and health care assistants during 2015.

#### Waitemata DHB

All Waitemata DHB ARRC facilities are now engaged with interRAI (standardised clinical assessment) training as follows:

- 40% (24) fully competent (required number of nurses trained)
- 49% (30) competent (at least one nurse trained)
- 5% (3) in training
- 3% (2) booked in training
- 3% (2) signed an engagement agreement.
ARRC facilities continue to meet bi-monthly as part of the Residential Aged Care Integration Programme (RACIP) work group. Current RACIP projects included developing resources for end stage lung disease and end stage heart disease to provide information to residents and families to support decision making.

The following onsite education topics will be offered to ARRC facilities during 2015 - falls; medication management; delirium; and pain management. The quarterly off-site education topic for February/March is assessments and care planning for registered nurses.

**Asian ARRC Support Group**
An initial meeting has been held to scope a forum for Asian owned and operated ARRC facilities. The aim of the forum is to better understand the issues faced by these providers so appropriate support can be provided and to increase their engagement in DHB ARRC programmes e.g. cluster groups, education sessions, study days etc. Bi-monthly meetings are scheduled for 2015.

**Regional Falls and Pressure Injury Programme**
The proportion of ARRC providers fully participating in the regional Falls and Pressure Injury Programme remains low for ADHB and Waitemata DHB at 24% and 30% respectively. This compares unfavourably with Northland DHB, which has achieved 75%. The programme has the following elements:

- a relevant assessment tool to identify residents at risk
- intervention guides/plans for use with residents who are identified as being at risk
- participation in approved training e.g. First, Do No Harm, NZACA, DHB/CNS training etc
- data capture and reporting of falls and pressure injuries

It is acknowledged that there are facilities engaged in falls and pressure injury programmes at a facility or a provider level that may not have participated in the regional programme or submitted data. Notwithstanding, work is underway to see how we can better support all providers to submit falls and pressure injury data so we can monitor progress in this area. It is important to note that this is not a contractual requirement but rather an example of quality improvement where we need to work in partnership with providers to achieve better outcomes for residents.

### 2.4 Older Adults and Vulnerable Adults

**Waitemata DHB**
The Waitemata DHB Older Adults and Vulnerable Adults Abuse and Neglect Policy has been finalised and is available on-line. The Policy has been shared with Auckland DHB. Current work areas include:

- developing an e-learning tool for Waitemata DHB staff to heighten awareness of the indicators of abuse and the effect of ageist attitudes
- establishing a forum where practitioners can consult and gain guidance from Age Concern coordinators, the Police Abuse Prevention Officer, District Inspectors and legal advisors when they are working with cases of alleged abuse.

**Auckland DHB**
The Auckland DHB Older and Vulnerable Adult Safeguarding Policy is in draft and having its first round of consultation. Auckland DHB is also planning to establish a multi-disciplinary/multi-agency practice forum. There is a focus on aligning the policy and practice with Waitemata DHB.
3. **Maori Health Gain**

3.1 **Planning**
The development of the 2015/2016 Maori Health Plans is well underway. The Funder has received input from our Memorandum of Understanding (MOU) partners, Primary Health Care Organisations and Maori Providers. Opportunities for on-going input will continue to be provided throughout the development process. The Maori Health Plans will be presented for Board approval to submit to the National Health Board with the Annual Plans. The Maori Health Plans have also been supplied to the Maori Health Gain Advisory Committee members for feedback due 6 March 2015. This may result in amendments to the Maori Health Plans prior to final submission to the National Health Board on 13 March 2015.

3.2 **Ethnicity Data Audit Tool (EDAT)**
Implementation of the Ethnicity Data Audit Tool (EDAT) Project is progressing well with all of the DHB led training requirements having been delivered. To date, EDAT has been implemented in 159 general practices. This represents an implementation rate of 66%. The Funder is confident that it will reach 95% implementation rate by the end of the project (June 2015) as stipulated by contract with the Ministry of Health.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of EDAT</td>
<td>66%</td>
<td>95% of General Practitioner Practices have implemented EDAT</td>
</tr>
</tbody>
</table>

3.3 **Healthy Babies Healthy Futures**
The Healthy Babies Healthy Futures Programme continues to build momentum with support from the Maori Health Gains team. The Collective implementing the programme continues to be a leader nationally in service delivery. The Funder is in the process of organising the Healthy Babies Healthy Futures National Conference which will be held on 27 March 2015. The Conference will provide an opportunity for the various Collectives to come together and be up-skilled and share learning and information. Current service delivery stands at:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people in the HBHF programme</td>
<td>511</td>
</tr>
<tr>
<td>Number of people on TextMATCH</td>
<td>229</td>
</tr>
<tr>
<td>Number of staff trained in Healthy Conversations Skills Training</td>
<td>29</td>
</tr>
<tr>
<td>Number of activities/workshops delivered</td>
<td>35</td>
</tr>
<tr>
<td>Number of media events delivered</td>
<td>24</td>
</tr>
</tbody>
</table>

3.4 **High and Complex Mental Health Service**
The Funder continues to provide input to the development of the new High and Complex Mental Health Service for Waitemata District Health Board, by participating in the Steering Group who is overseeing the development of the procurement process. The Funder is also involved in the evaluation panel for both the Registration of Interest and Request for Approval processes.
4. Pacific Health Gain

The Pacific Health Action Plan 2013 - 2016 (PHAP) has six priorities. The following is an update on the progress of PHAP’s implementation:

4.1 PHAP - Priority 1

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

- Continued participation in the Auckland Family Violence Project Board (with Police, Justice, Corrections and Ministry of Social Development) has resulted in the Project Board supporting the Incredible Years (IY) parenting programme, delivered through Pacific churches and communities, as one of the primary prevention activities that it will support in order to reduce violence against children in their families. It is considering a budget of $295,000 to be allocated for this activity in the 2015/16 financial year.
- Continued relationship with Ministry of Social Development specifically its Pacific programme of Proud Pasifika, who also has parenting education as a priority.
- Relationship with Ministry of Education (MOE) is established with the Ministry agreeing to have Pacific staff who are trained IY facilitators deliver the programme for our Enua Ola and HVAZ churches / communities using Ministry resources.
- The first IY programme is currently being delivered in a Tongan Methodist Congregation in Ranui by bi-lingual Tongan/English speaking facilitators. Twenty parents are participating in the programme.
- The second group will be delivered by Samoan/English speaking IY facilitators, one is a clinical psychologist employed by the Ministry of Education.
- In relation to the development of a programme to address family violence, Sr. Cabrini Makasiale, psychotherapist with the Catholic Social Services (CSS) has developed a six week programme which she has presented to the working group that has been set up to work with her on this development. The working group, consisting of two church ministers and two community leaders are currently considering the content of the programme and will provide feedback at its next meeting this month. The programme will train church/community members to deliver the programme to their own churches / communities with professional oversight and mentoring provided by CSS. The working group will also examine how effectiveness of the programme will be measured.
- The Funder is on track to deliver at least two parenting support programs by the end of the current financial year as required by DAP 2014/15 and further develop the family violence prevention programme.

4.2 PHAP Priority 2

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

- The next WERO quit smoke group competition will start on 1st April 2015.
- Pacific Heartbeat (National Heart Foundation) has agreed to provide training for smoke-free church/community champions to support participants in the WERO group quit smoke competition and to work towards a totally smoke-free church.
- Pacific Quit Smoke Service (ARPHS) will offer quit support to groups / individuals who decide to become part of the competition.
4.3 PHAP Priority 3

The third priority is that Pacific people eat healthy and stay active. The weekly physical activities and nutrition training is continuing. Weight loss, encouraged through the Aiga Challenge, has been used as a proxy for improved health but this is inadequate. The parish community nurses (PCNs) (two in West Auckland and one on the North Shore) are currently working with Enua Ola churches / groups to systematically take individuals’ blood pressure and glucose levels in the community. This will allow individuals as well as groups to be better informed about their Cardio VD risk. The nurses will provide group education as to the meaning of CVD risk and will provide individual education for those with high risk and will actively refer them to their GPs. The nurses will also track individuals as well as groups’ CVD risk over time.

4.4 PHAP Priority 4

The fourth priority is that we seek help early. A key function of the PCNs is to improve the health literacy of Pacific communities / individuals. The three PCNs speak Samoan, Tongan and Niuean, bringing a depth to their ability to communicate with Pacific peoples. In addition to education, the nurses will link people to primary care and any other service that people may need, facilitating a process where people will seek medical and other help earlier than is the current reality. Whilst there is increasing evidence of Pacific people being engaged with primary care (immunisation and CVD risk assessment results), there are still high rates of hospital admissions for primary preventable illnesses and management of chronic conditions is still a major challenge.

The PCNs will also work with churches and community groups to develop a health plan for each church/group, to reflect how the churches/communities will contribute to the achievements of health targets and also address what maybe priorities for the churches/groups. Currently there are many health education programmes that are being delivered in churches/groups but not in a coherent or co-ordinated way. The health plan and its implementation will bring about a more logical and systematic way of delivering health education, more awareness and earlier connection to treatment pathways.

A working group has been established for the PCN service and a major focus is the development of measures of effectiveness.

Whilst the PCN service works at a group/community level, we are configuring contracts with AH+ PHO to focus on delivery at a family/household level. We are doing this in collaboration with our primary care team as well as Counties Manukau DHB Pacific Team. The key elements of the service are: assessment and immediate response to a high need individual (the primary client), then engagement and assessment of the health needs of members of the family/household, the development of a family health plan, implementation of the plan over a period of time and the achievement of named outcomes. We have not contracted this way before but we believe that this is appropriate and can be an effective approach to working with individuals/families with high medical and social support needs, in a whanau ora way. By identifying the health needs of family members of a high need individual, the service will be able to respond to the needs of those family members in a preventative way and/or assist them to access services earlier.

The challenge is pricing such a service. Alliance Health+ PHO (AH+) engaged PricewaterhouseCoopers (PWC) to undertake a review of where the public sector is in relation to contracting/pricing for family outcomes and PWC reported that the public sector has not developed a funding formula for such contracts and that we need to establish our own costing, building on the costs of specific elements of the service. Whilst we can establish an estimated cost for the
assessment and the development of the family plan component, it is difficult to anticipate the cost of the service/s required to implement the plan and to achieve identified outcomes. However, we are working collaboratively with AH+ and we may reach agreement to trial the service at a certain price/volume schedule (average cost of a package of care per family for a certain number of families) over a period of time, and test this out in practice, with contract review processes identified. We are working towards having the contract in place by 1 July 2015. We intend to bring a paper to Audit and Finance Committee if required, prior to contracting.

4.5 PHAP Priority 5

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

4.6 PHAP Priority 6

The sixth priority is that Pacific families live in warm healthy houses that are not overcrowded. The intention of the Pacific team is to link to housing advocacy groups in West Auckland and Central Auckland and to facilitate participation of Pacific community leaders in these groups. The Ministry of Business, Innovation and Employment is a connection that we will make as it runs a seminar series looking at different aspects of improving the economic situation of Pacific people including finding solutions for its housing needs.

5. Auckland Regional Public Health Service (ARPHS)

ARPHS has completed and submitted seven submissions (five submissions to central government agencies and two to Auckland Council) during February. These were:

- Waterview Shared Path (Notified Consent) submission through to Auckland Council
- Eligibility and Registration of Housing Providers to Ministry of Business, Innovation and Employment
- Enforcement Officer Qualifications (EPA Notice) to Environmental Protection Agency
- Health (Protection) Amendment Bill 2014 to the Ministry of Health
- FSANZ Labelling Review: Nutrition Information Panel to Ministry of Primary Industries
- Water Supply and Wastewater network By-law to Auckland Council
- Classification, Labelling, Safety Data Sheets and Packaging (EPA Notices) to Environmental Protection Agency.

Anticipated submissions for March 2015

In March ARPHS expects to submit on the following four matters:

- Auckland Council (Notified Consent) City Rail Link Britomart to Wyndham St Section – 5 March (Completed)
- Auckland Council’s Long Term Plan (also known as the 10yr Budget) – 16 March
- Auckland Transport’s Draft Long Term Regional Transport Plan – 16 March
- The Food Act 2015 – due with the Ministry of Primary Industries – 31 March.

It is important to note that these may not be the final numbers for March as we may pick up more submissions through our screening process.
Unitary Plan

The table below indicates the Unitary Plan activities during the period February and March arranged by issue and type of meeting (Pre-Hearing, Mediation or Hearing). It is important to note that there are a number of process steps that are involved prior to these dates.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Prehearing</th>
<th>Mediation</th>
<th>Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous Substances</td>
<td>23/02/2015</td>
<td>25/03/2015</td>
<td></td>
</tr>
<tr>
<td>Contaminated Land</td>
<td>23/02/2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport Objectives, Policies, Rules &amp; Others</td>
<td>10/03/2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centre Zones, Business Parks, Activities &amp; Controls</td>
<td>10/03/2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Infrastructure</td>
<td></td>
<td>11/03/2015</td>
<td></td>
</tr>
<tr>
<td>Water Quality</td>
<td></td>
<td>12/03/2015</td>
<td></td>
</tr>
<tr>
<td>Infrastructure</td>
<td></td>
<td>13/03/2015</td>
<td></td>
</tr>
<tr>
<td>Natural Hazards &amp; Flooding</td>
<td></td>
<td></td>
<td>18/02/2015</td>
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<tr>
<td>Regional Policy Statement General Notification</td>
<td></td>
<td></td>
<td>27/02/2015</td>
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<tr>
<td>Artworks, Signs &amp; Temporary Activities</td>
<td>20/02/2015</td>
<td></td>
<td>27/03/2015</td>
</tr>
<tr>
<td>General Coastal Marine Zone and Activities</td>
<td></td>
<td></td>
<td>25/03/2015</td>
</tr>
<tr>
<td>Air Quality</td>
<td></td>
<td></td>
<td>2/03/2015</td>
</tr>
</tbody>
</table>

During February ARPHS was involved with five matters:
- Hazardous Substances – Prehearing
- Contaminated Land – Prehearing
- Natural Hazards and Flooding – Mediation
- Regional Policy Statement – Mediation
- Artworks, Signs and Temporary Activities – Mediation.

We anticipate ARPHS will be involved in nine matters during March 2015. They are:
- Hazardous Substances – Mediation
- Transport Objectives, Policies, Rules & Others – Prehearing
- Centre Zones, Business Parks, Activities & Controls – Prehearing
- Social Infrastructure – Prehearing
- Water Quality – Prehearing
- Infrastructure – Prehearing
- Artworks, Signs & Temporary Activities – Hearing
- General Coastal Marine Zone and Activities – Hearing
- Air Quality – Hearing.
**Auckland Council Update**

- The Council’s draft Long Term Plan (LTP) 2015-25 and draft Regional Land Transport Plan (RLTP) is in public feedback stage.
- As part of the LTP and RLTP process, Aucklanders are being consulted on their preferred level of transport investment and options to pay for a potential increase in spending. There are two transport investment programmes proposed which are the:
  - Basic transport programme – reduced spending to previous RLTP
  - ‘Auckland Plan’ transport programme – requires an additional $12 billion over 30 years.
- To fund the ‘Auckland Plan’ transport programme two alternative funding options have been presented
  - A motorway user charge of around $2 each time people enter Auckland’s motorway system depending on the day and time (free at night)
  - An additional increase in rates and fuel tax.
- Both options outlined above would require Government approval.
- With regards to the alternative transport funding proposals, the Council will commission an independent public opinion survey in addition to the standard Council consultation process.
- Auckland Transport have recently announced they are investigating a light rail option for Auckland and this could be included in the final version of the RLTP.

**Social and Emergency Housing Stocktake**

Ministry of Social Development is leading a stocktake on Social and Emergency Housing initiatives in Auckland. ARPHS representatives are participating in a social sector agency meeting to inform this stocktake, which is to be completed for Ministers by the end of June 2015.