Community and Public Health Advisory Committees Meeting

Wednesday, 14th October 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
14th October 2015

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

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

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

Apologies: Lester Levy, Warren Flaunty, Tim Jelleyman, Elsie Ho and Dale Bramley

AGENDA

KARAKIA

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

Items to be considered in public meeting
2.00pm (please note agenda item times are estimates only)

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES
2.05pm
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3.05pm
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3.25pm 6 GENERAL BUSINESS

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 14/10/15
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* ✓ leave of absence
* ✓ absent on Board business
* ✓ ex-officio member
## REGISTER OF INTERESTS

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

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<th>Member</th>
<th>Role and Affiliations</th>
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| **Christine Rankin** | Member - Upper Harbour Local Board, Auckland Council  
Director - The Transformational Leadership Company | 15/07/15 |
| **Allison Roe** | Member - Devonport-Takapuna Local Board, Auckland Council  
Chairperson - Matakana Coast Trail Trust | 02/07/14 |
| **Gwen Tepania-Palmer** | 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 | 10/04/13 |
| **Co-opted Members** | | |
| **Elsie Ho** | 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 | 03/09/14 |
| **Rev Featunai Liuaana** | Chairperson – Congregational Christian Church Samoa Sandringham Trust Board  
Trustee – Congregational Christian Church Samoa Trust  
Chairperson – Mothers and Daughters Health – HVAZ and Alliance Health Plus  
Committee Member – Working Group for Pacific Health Action Plan (ADHB and WDHB)  
Deputy Chairperson – Working Group Pacific Family Violence (ADHB and WDHB)  
Member – MIT Pasifika Students Forum  
Secretary - Negotiation Committee – EFKSNZ Trust  
Secretary – EFKSNZ Trust | 29/04/15 |
| **Dr Tim Jelleyman** | Clinical Chair - Child Health Network, Northern Regional Health Plan  
Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland  
Member-Board of Kaipara Medical Centre  
Community Paediatrician, Waitakere Hospital  
Member – ASMS | 14/04/15 |
2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 02\textsuperscript{nd} September 2015

Recommendation:

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

Community and Public Health Advisory Committees

Wednesday 02 September 2015

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.03p.m.

PART I - Items considered in Public Meeting

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Jo Agnew (ADHB Board member)
Judith Bassett (ADHB 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) (until 3.45pm)
Allison Roe (WDHB Board member)
Elsie Ho (Co-opted member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT: Ailsa Claire (ADHB, Chief Executive)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Tim Wood (ADHB and WDHB, Deputy Director Funding)
Andrew Old (ADHB, Chief of Strategy/Participation and Improvement)
Ruth Bijl (ADHB and WDHB, Funding and Development Manager, Child, Youth and Women’s Health)
Peta Molloy (WDHB, Acting 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
Craig Murray, Waitemata PHO
Aroha Hudson, Te Puna Manawa HealthWest
Gaylene Sharman, Te Puna Manawa HealthWest

APOLOGIES:

Resolution (Moved Lee Mathias /Seconded Jo Agnew)

That the apologies from Lester Levy, Max Abbott, Peter Aitken and Rev Featunai Liuaana be received and accepted.

Carried
WELCOME: The Committee Chair gave a warm welcome to all those present.

KARAKIA: The Committee Chair led the meeting in the Karakia.

ACKNOWLEDGEMENT
The Committee Chair extended special thanks from the Committee in acknowledgement of the hospital staff experiencing an extra burden of work at both the Auckland DHB and Waitemata DHB hospitals over the winter months. With increased illness, hospital services have been stretched and staff are working hard at all levels. She also extended appreciation to the PHOs who are also experiencing increased work in the community during the winter period.

DISCLOSURE OF INTERESTS
With regard to the Interests Register, Lee Mathias advised that she is no longer a director of iAC IP Ltd.

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, except for a matter of general business that was considered after item 3.3.

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 22nd July 2015 (agenda pages 17-17)

Resolution (Moved Judith Bassett/Seconded Jo Agnew)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 22nd July 2015 be approved.

Carried

Matters Arising (agenda page 18-20)

No issues were raised.

3 DEcision Items
3.1 Primary Health Care Nursing Strategic Framework for Auckland and Waitemata DHB Regions (agenda pages 21-25)

Jean McQueen (Primary Health Care Nursing Director) and Rachel Calverley (Director of Nursing, Waitemata PHO) were present for this item.
Jean McQueen introduced the report. Matters she highlighted included:

- That the primary healthcare nursing group meets monthly and includes a number of members from both the Auckland and Waitemata districts.
- The group has developed the ‘Primary Health Care Nursing Strategic Framework’ (page 24 of the agenda). All areas of the framework were summarised and included the: Professional Foundation Blocks, Focus on People, Focus on Our Profession, Population priority work and the Strategic Purpose.
- The group now intends to look at how to implement the plan and setting one, two and three year goals.

Rachel Calverley supported the summary given by Jean McQueen and noted that the framework signals where nursing has moved to and how nurses can more readily meet the needs of patients in a different manner.

Matters covered in discussion and response to questions included:

- In response to a question it was noted that as part of continuing education a nurse is required to complete 20 nursing hours per year or 60 hours per three years to meet Annual Practicing Certificate requirements.
- A nurse practitioner is required to complete a Clinical Masters and present a portfolio to be regulated. It was noted that there are approximately 160 nurse practitioners in New Zealand, approximately 90 of which are within primary health care.
- That consideration be given to the use of the term ‘community nursing’ to avoid confusion with secondary care nurses. It was also noted that it is important to think about the wording of the Framework to ensure the intent is clear.
- In response to a comment about strategies at other DHBs, Jean McQueen noted that the Framework had been shared with Counties Manukau DHB and that information is being shared across the region, including Northland DHB.
- In response to a question about obtaining ‘buy in’ of the Framework from other health professionals, Jean McQueen noted that the Framework was presented to and supported by the Alliance Leadership Team (PHO Chief Executives and Clinical Directors). It was also noted that the Framework is a work in progress.

The Committee Chair thanked Jean McQueen and Rachel Calverley for their report.

**Resolution** (Moved Jo Agnew/Seconded Warren Flaunty)

That the Community and Public Health Advisory Committee:

a) Note a high level Strategic Framework for Primary Health Care nursing across Auckland and Waitemata District Health Board regions has been developed by a Primary Health Care Nursing Reference Group.

b) Endorse the Framework for implementation in primary health care nursing activity across the Auckland and Waitemata District Health Board regions, subject to consideration being given to the Committees’ feedback.

**Carried**
3.2  **A Standardised Approach to Health Literacy across Auckland and Waitemata District Health Boards** (agenda pages 26-31)

Tim Wood (Deputy Director Funding and Chair of the health Literacy Steering Group, Auckland and Waitemata DHBs) presented. Matters that were highlighted or updated included:

- Acknowledgement of the work undertaken by the team in preparing this standardised framework for health literacy.
- In preparing the framework various overseas models were looked at, along with the Ministry of Health framework.
- Both the Auckland and Waitemat a DHB executive teams have supported the framework and that once the framework is endorsed by the Committee the suggested next steps (page 31 of the agenda) can be actioned.

Matters covered in discussion and response to questions included:

- In response to a query, it was noted that Samantha Dalwood (Disability Advisor, Waitemata DHB) was involved with the preparation of the proposed framework and that the proposed framework will presented to the Auckland DHB and Waitemata DHB Disability Support Advisory Committees Meeting for feedback.
- That whilst Maori and Pacific care is specifically addressed in Health Plans, it is intended that health literacy activities are culturally appropriate, and there are ongoing process for engaging Maori and Pacific.
- With regard to the definition and framework of health literacy it was agreed that the New Zealand definition (page 27 of the agenda) be adopted and item b) of the resolution be amended to note this.

**Resolution** (Moved Lee Mathias/Seconded Robyn Northey)

That the Community and Public Health Advisory Committee endorse:

- a) A standardised approach to health literacy across the Auckland and Waitemata DHBs.
- b) The use of New Zealand definition and framework of health literacy being: 

  "the ability to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions”.

- c) The proposed next steps outlined in this paper.

**Carried**

3.3  **School-based Rheumatic Fever Prevention Programmes** (agenda pages 32-51)

Ruth Bijl (Funding and Development Manager), Dr Tom Robinson (Public Health Physician), Dr Alison Leversha (ADHB Community Paediatrician), Dr Tim Jelleyman (WDHB Community Paediatrician) and Alison Hudgell (Rheumatic Fever Programme Manager) were present for this item.

Ruth Bijl introduced the report.
Matters that were highlighted or updated included:

- Focus has been given to the primary school based component of the programme.
- The report responds to the query about the role of the public health nurses, this matter is specifically addressed on pages 36 and 50 of the agenda.
- In response to a question specifically about FTE it was noted that Auckland DHB has 30.65 FTE and Waitemata DHB has 23.85 FTE.
- The report presents the results of the evaluation information for both Auckland and Waitemata DHBs. Since writing the report, it was noted that new information from the Ministry of Health includes results of national interim evaluation, key findings of that interim evaluation shows that there is evidence of a decline in hospital admissions from 2015.
- Requesting that endorsement be given to continuing the school-based programme to get results from further evaluation.
- It was noted that the problem has always been greater that just Rheumatic Fever and includes skin infections and the health culture in schools.
- It was noted that school nurses, particularly in low decile schools, continue to provide care for children who do not otherwise access health care. A recent conversation highlighted the matter of dental health and the high number of five and six year old children who do not have tooth brushes.

Matters covered in discussion and response to questions included:

- That the work of the school nurses appears to be broader and that a review of the school nursing programme is required.
- Concern was expressed at the ratio of school nurses to students which was noted in secondary schools at 1:750 and in the Rheumatic Fever programme it was 1:400.
- That a longer evaluation period is required to measure the reduction in Rheumatic Fever as it is a relatively rare disease. A well implemented programme is shown to reduce Rheumatic Fever.
- That the matter of health care for children in schools requires a ‘deeper dive’ and that the Committee needs to look at this in order for a paper to be presented to both Boards.

Resolution (Moved Warren Flaunty/Seconded Jo Agnew)

That the Community and Public Health Advisory Committee:

a) Note that Acute Rheumatic Fever disproportionately affects young Pacific and Māori people.

b) Note that the Rheumatic Fever prevention programme is funded from a range of additional Ministry of Health, additional District Health Board, and redirected District Health Board resources; and that Ministry of Health resourcing will decrease from 2016/17.

c) Note that the programme in Auckland and Waitemata DHBs has not been running for as long as the programme in Counties Manukau DHB.

d) Note that initial school-based Rheumatic Fever programme evaluation findings are positive.
e) Note that the school-based programme will need to be given more time to demonstrate an effect in reducing Acute Rheumatic Fever.

f) Note that a further evaluation is planned in 2016, but may still not be definitive.

g) Endorse the proposal to maintain the school-based Rheumatic Fever programme in both Auckland DHB and Waitemata DHB at current levels at least till the end of the June 2017, subject to wider DHB budgetary approvals and constraints.

Carried

4. INFORMATioN ITEMS

4.1 Waitemata and Auckland District Health Board 2015/16 Maori Health Plans (agenda pages 53-56)

Aroha Haggie (Maori Health Gain Manager) and Craig Heta (Policy and Planning Manager Maori Health Gain) were present for this time.

Matters that were highlighted or updated included:
- The paper provides the Committee with a summary of progression and highlights between the 2014/15 and 2015/16 Maori Health Plans.
- The key highlights for 2014/15 were noted (page 53 of the agenda) and include the ethnicity data tool, better help for smokers to quit – primary care, Kaumatua action plan and the Maori workforce development strategy. It was noted that the Kaumatua action plan was submitted to the Manawa Ora Committee where it was endorsed with minor changes. The plan will now be submitted to both the Auckland and Waitemata DHB Boards for approval.
- The new indicators for 2015/16 Maori Health Plans were noted (page 54 of the agenda) and include obesity, cardiovascular disease and workforce development.
- Areas of focus for this financial year include cervical screening and breast screening.

The Committee Chair acknowledged the work of the team and recommended that the paper be submitted to both the Auckland DHB and Waitemata DHB Boards for information.

Resolution (Moved Robyn Northey/Seconded Allison Roe)

That the report be received and the paper be submitted to both the Auckland DHB Board and Waitemata DHB Board for information.

Carried

4.2 Review of Health Services – Waiheke Island (agenda pages 57-62)

Tim Wood (Deputy Director Funding) was presented this item. Matters that were highlighted or updated included:
• The paper is to provide an update to the Committee on the review underway. A Health Needs Assessment was last completed in 2009 with little change taking place to improve access on Waiheke Island.
• That it has been difficult to attract an appropriate workforce to the Island and that the quality of service may not be at an expected standard.
• It is proposed to undertake an engagement process with the community and providers on the Island to identify perceived gaps in the health services available and gain insight into how the services could be better configured to meet the community needs.

Matters covered in discussion and response to questions included:
• In answer to a question about what services are not appropriate, Tim Wood noted that with a particular contract it has been difficult to identify the level of service being provided and that the right people are accessing services. Another example is afterhours care, individual practitioners have an after hours roster and that rates vary per GP on call. It was noted that there is room for improvement within the existing services on the Island.
• Work is being done with the Providers to ensure accountability for funding provided by the DHBs. It was noted that in isolated areas it was not uncommon for providers to respond to what they think the needs of the local community.
• It was noted that there is a deprived population on the Island and that some families are required to move from their rental accommodation in the summer months to allow the property to be rented at a higher rate.
• It was noted that there is a need from an older population group in isolated areas and their access to services and support is difficult. In response Tim Wood noted that a Rural Alliance group had recently been set up and was working with GPs in rural areas about access to services-the group is scheduled to hold their second meeting.
• The Committee Chair noted that there did not appear to have been any change on Waiheke Island in the past twenty years. Overall the funding relationship is about being aware, reflective, mindful and examining. It is important to build on local strengths and those that are committed.

Resolution (Moved Lee Mathias/Seconded Robyn Northey)

That the Community and Public Health Advisory Committee:

a) Note the reasons for undertaking a review of health services on Waiheke Island

b) Note progress to date, which includes an internal stocktake of services and an internal stakeholder engagement process

c) Note that the Auckland DHB Executive Leadership Team (ELT) has endorsed:

i. a public engagement process with key external stakeholders, including the community, who are impacted by health service delivery on Waiheke Island
ii. the development of a report identifying key findings and recommendations to inform current and future health service configuration on Waiheke Island likely to be developed in consultation with the Auckland Waitemata Rural Alliance.

Carried

5. STANDARD REPORTS

5.1 Primary Care Update (agenda pages 63-74)

Tim Wood (Deputy Director of Funding) and Dr Stuart Jenkins (Clinical Director, Primary Care) were present for this item.

Matters that were highlighted or updated included:

- The Safety in Practice Programme (page 63 of the agenda), Counties Manukau DHB was acknowledged in initiating this programme and inviting both Auckland and Waitemata DHBs to join. The programme aim is to enhance the quality improvement capability of general practices, and whilst still in its early stages there are currently eight practices within the Waitemata DHB region and ten within the Auckland DHB region who are participating. A programme has now entered its second year, a preliminary evaluation has been undertaken of the first year and the results have been positive. There has been anecdotal evidence on improvements seen within practices. It is anticipated that this programme will increase and that there is potential to expand the programme.

Matters covered in discussion and response to questions included:

- With regard to nursing and change management, Stuart Jenkins noted that there is an opportunity for nurses to be involved in the care they provide and primary care in general. Stuart Jenkins endorsed the work around primary care nursing being undertaken by Jean McQueen.
- A challenge in GP workforce survey was noted in that the number of full time GPs has reduced from 84 GPs to 74 GPs per 100,000 people over the last ten to twelve years, of which 35% intend to retire within the next ten years (within the Auckland DHB district 41% of GPs intend to retire within the next ten years and 35% in the Waitemata DHB district).
- With regard to the ‘Free Under 13s Scheme’ (page 65 of the agenda), the programme would be monitored to identify which population groups are utilising the scheme. It was noted that there is a process for monitoring practice fees to ensure that when fees are reduced for one age group they are then not increased for another. PHOs are also required to advise the DHB if fees are increasing significantly at a practice, the DHB has a regular operational meeting with each PHO where matters like this are discussed. Craig Murray (Waitemata PHO) gave the Committee assurance that Waitemata Pho actively monitors fees.
- Note the Integrated Performance Incentive Framework (pages 70-72 of the agenda) and that results were pleasing on the whole.

3.45pm Christine Rankin retired from the meeting.
Resolution (Moved Lee Mathias/Seconded Jo Agnew)

That the report be received.

Carried

5.2 Planning, Funding and Outcomes Update (agenda pages 75-82)

Debbie Holdsworth (Director Funding), Simon Bowen (Director Health Outcomes) and Tim Wood (Deputy Director of Funding) presented this item.

Matters that were highlighted or updated included:
- A key piece of work underway is the development of the Waitemata DHB Health Services Plan. The ten year plan primarily focusses on provider services.
- The Annual Reports for both Auckland DHB and Waitemata DHB are progressing and have been submitted to each DHBs Audit and Finance Committee.
- Note the four submissions ARPHS have completed and submitted (page 80 of the agenda) during July and August 2015.
- Note ARPHS continues to be engaged in the Unitary Plan process, the topics ARPHS were involved with during July and August are noted on page 80 of the agenda.
- Note the update to the Committee on the range of services Waitemata and Auckland DHB provide to address the needs of children who have parents with mental illness and/or addiction (pages 77-79 of the agenda).

Matters covered in discussion and response to questions included:
- With regard to the ARPHS submission on ‘Retirement and Housing Affordability’ and the strong recommendation around greenfield development (page 81 of the agenda), it was noted that there was no recollection of either the ADHB or WDHB Boards or Committees commenting on that matter and that ARPHS may make a submission on a matter that is not aligned with either of the Boards view. In response to this matter, Simon Bowen noted that the Unitary Plan is very detailed and would request that an update report be provided to the Committee on this matter.
- In response to a query about there being no detail in the Committee report on the ARPHS submission with regard to ‘Public Open Spaces’ (page 80 of the agenda), Simon Bowen advised that this would be provided to the Committee via email.
- In answer to a question about the ‘Hunua Ranges 1080 aerial pest control operation’ (page 81 of the agenda) and who is responsible for monitoring water quality and drinkability of water, Simon Bowen advised that ARPHS is responsible for approving the application from Council and have the role of monitoring the water supply. Further information will be provided to the Committee on this matter.
Resolution (Moved Jo Agnew/Seconded Warren Flaunty)

That the report be received.

Carried

6 General Business

Dr Lee Mathias introduced an item of general business about a Cabinet Minute concerning changes to the Fence of Swimming Pool Act.

Dr Alison Leversha (ADHB Community Paediatrician) was present for the discussion.

Dr Lee Mathias requested that the Committee recommend that a paper be submitted to both the Auckland DHB and Waitemata DHB Boards outlining the changes to the Fence of the Swimming Pool Act and requesting that the Boards refer the matter to ARPHS for appropriate action. The Committee agreed to this request.

It was noted that there had been a reduction in drownings from approximately ten children to two or three a year. Allison Leversha (as Chair of the Auckland DHB Child and Youth Mortality Group) advised that at Auckland DHB there had not been a death from drowning in a pool for a number of years. Allison was in support of the Committee recommending this matter to the Boards for consideration and comment.

Sandra Coney noted that she is not aware of these changes and that the Local Council Boards approve swimming pool fencing and are very involved in the process.

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

The meeting concluded at 4.03p.m.
## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 05th October 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 10/06/15</td>
<td>5.1</td>
<td>Primary Care Update: to include reporting on Primary Mental Health reconfiguration on an ongoing basis.</td>
<td>Tim Wood</td>
<td>CPHAC 25/11/15</td>
<td>Complete reporting not available for 02/09/15, to be included in the 25/11/15 update report.</td>
</tr>
</tbody>
</table>
| CPHAC 22/07/15 | 5.1 | Issues of Homelessness and Deprivation:  
- An approach to be made to the Well Foundation to see if it would support a project to raise awareness and funding to help assist with these issues.  
- Ongoing updates to be provided to CPHAC on the Western Caravan Park.  
- Report to be provided to CPHAC on the broader housing issues in Auckland with recommendations about any actions the DHBs could take to address them. | Simon Bowen | CPHAC 25/11/15 |
| CPHAC 02/09/15 | 5.2 | ARPHS Submissions:  
- submission on ‘Retirement and Housing Affordability’ (specifically around greenfield development. Provide update on submission and whether it reflects with either Boards view.  
- detail on the submission related to ‘Public Open Spaces’ to be emailed to the Committee  
- information to be provided to the Committee on the ‘Hunua Ranges 1080 aerial pest control operation’ and who is responsible for monitoring (particularly monitoring water quality and drinkability of water). | Simon Bowen | 14/10/15 | Actioned. See paragraphs 6.3, 6.4 and 6.6 of the ‘Planning, Funding & Outcomes Update to CPHAC’ of this agenda. |
| CPHAC 02/09/15 | General Business | A paper is to be submitted to both ADHB and WDHB Boards outlining changes to the Fence of the Swimming Pool Act and requested that the Boards refer the matter to ARPHS for appropriate action | Simon Bowen | 14/10/15 | Actioned. See item 4.4 of this agenda. |
4.1 Auckland DHB Integrated Child and Youth Mental Health and Addiction Direction 2013 - 2023 Update

Recommendation

That the Community and Public Health Advisory Committee:

a) Receives the report.

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

Prepared by: Hilary Carlile (Project Manager), Tim Wood (Chair of Child and Youth Mental Health and Addictions Direction Implementation Governance Group, Acting Funding and Development Manager Mental Health and Addictions), Michelle Atkinson and Shreya Rao

Endorsed by: The ADHB Child and Youth Mental Health and Addictions Direction Implementation Governance Group

Glossary

ADHB - Auckland District Health Board
CAMHS - Child and Adolescent Mental Health Services
CADS - Community Alcohol and Drug Service (a regional service run by WDHB)
CPHAC - Community and Public Health Advisory Committee
Direction - ADHB Integrated Child and Youth Mental Health and Addictions Direction 2013-2023
DHB - District Health Board
ED - Emergency Department
ELT - Executive Leadership Team
ESBHS - Enhanced school-based health services
HoNOSCA - Health of the Nation Outcome Scales Child and Adolescent
MH&A - Mental Health and Addictions
PHO - Primary Health Organisations
PMH&A - Primary Mental Health and Addictions
PRIMHD - Programme for the Integration of Mental Health Data
SMT - Senior Management Team
TRC - Tamaki Redevelopment Company
WDHB - Waitemata District Health Board
WHO - World Health Organisation
YSALT - ADHB Youth Health Service Alliance

1. Executive Summary

In November 2013, the Auckland District Health Board (ADHB) approved the implementation of the ADHB Integrated Child and Youth Mental Health and Addictions Direction 2013-2023 (the Direction). An update was presented to the Community and Public Health Advisory Committee (CPHAC) in October 2014. CPHAC directed the Funder to develop a scorecard to measure the effect of implementing the Direction and report back on such in October 2015.

This paper recommends CPHAC note the approach the Funder took to develop the scorecard and outcomes framework; and the progress the Funder has made on implementing the Direction over the last year.

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 14/10/15
2. Introduction

The Direction sets out the strategy for the development of Child and Youth Mental Health and Addictions services in Auckland DHB for the next ten years.

The vision is:
“All children, young people and their families living in the Auckland DHB area experience and enjoy good mental health and emotional wellbeing”.

This will be achieved through six workstreams each with a clear outcome:

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening the Voice</td>
<td>Child, youth and family / whanau voices should be authentically listened to and engaged in improving services.</td>
</tr>
<tr>
<td>Intervening earlier</td>
<td>Children and youth can access services earlier in the life course and early where there is a need.</td>
</tr>
<tr>
<td>Addressing inequalities</td>
<td>Maori, Pacific and other minority groups can access age and culturally appropriate services when and where they are needed.</td>
</tr>
<tr>
<td>Fostering innovation</td>
<td>Children, young people and family / whanau experience services as innovative and child and youth centric.</td>
</tr>
<tr>
<td>Workforce development</td>
<td>To grow and develop the workforce so it reflects the diversity of our population and so we have the right people with the right skills in the right places</td>
</tr>
<tr>
<td>Working better together</td>
<td>To achieve integrated processes and access to appropriate services across our partner agencies and organisations</td>
</tr>
</tbody>
</table>

The implementation has progressed steadily with the focus being on three key pieces of work:
- ensuring the youth voice is authentically heard on key projects such as the Tamaki Localities Project
- the Outcomes Framework

3. Outcomes Framework and Scorecard

Work has progressed to develop an outcomes framework and scorecard to measure the impact of implementing the Direction. A results based accounting (RBA) approach has been taken dividing indicators into Population Accountability and Performance Accountability.

The Funder has worked with its regional colleagues in Child and Youth health to leverage their work to date where appropriate.

The Population accountability is reflected in the Vision:
“All children, young people and their families living in the ADHB area experience and enjoy good mental health and emotional wellbeing”.

This is measured by three indicators which indicate the mental wellbeing of children and youth and their social engagement:
- number of youth suicides
• number of referrals from the Emergency Department for child and youth intentional self-harm
• rates of suspension and exclusion from school.

The Performance accountabilities have been developed to measure the performance of each work stream and its outcome and are listed in Attachment 1.

The Challenge
There have been a number of challenges with this process. These include:

• Establishing reliable data as a baseline that will reflect the impact of the implementation rather than the continuation of the current state.
• Existing targets and data collection do not necessarily reflect the direction signalled.
• Accessing reliable consistent data that reflects the whole system rather than the individual services.
• In some cases there is no data so these have been left in the outcomes framework as aspirational

Scorecard status
The scorecard remains a work in progress. The measures provided to date are giving the Governance group the framework and baseline data to look at the decisions needing to be made to address the gaps across the system to implement the Direction and meet the needs of children and young people.

Youth Innovation Forum
Look Up is a key initiative of the Fostering Innovation Workstream – fostering best practice and the use of technology.

Look Up is happening on 16th October from 10am-2.30pm at Te Oro in Glen Innes.

www.lookup.org.nz

Look Up will explore innovative ways to work with young people who are interested in wellbeing, helping mates who are having a tough time and those experiencing a tough time; through creativity, technology and service innovation. It is an event like no other, it is no talk fest. It is the opportunity for young people and those working with young people to experience, share feedback and learn together.

Look Up has been co-created with young people and the many opportunities for feedback will inform the implementation of the Direction. People and organisations have been generous with their time and funding to bring this event together e.g. Auckland DHB, ACC, ProCare, Youth Health Alliance, Pathways, Toi Ora and Changing Minds.
### Attachment 1 – Scorecard

<table>
<thead>
<tr>
<th>ADHB Integrated Child and Youth Mental Health and Addictions Direction Performance and Outcomes Scorecard</th>
<th>WORK IN PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Overall Youth population mental health</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Youth suicide numbers</td>
<td></td>
</tr>
<tr>
<td>1.2 Child and youth self-harm ED referral numbers</td>
<td></td>
</tr>
<tr>
<td>1.3 Child and youth school suspension and exclusion rates</td>
<td></td>
</tr>
<tr>
<td><strong>B. Strengthening the voice</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Child and youth satisfaction with ability to influence their own care</td>
<td></td>
</tr>
<tr>
<td><strong>C. Intervening earlier</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 Numbers of youth seen by the PMH&amp;A services</td>
<td></td>
</tr>
<tr>
<td>3.2 Numbers of youth seen for mental health / alcohol or drug related issues by ESBHS</td>
<td></td>
</tr>
<tr>
<td>3.3 Child and youth HoNOSCA severity scores on admission to provider arm MH&amp;A services</td>
<td></td>
</tr>
<tr>
<td>3.4 Proportion of new child and youth referrals seen within 3 weeks by provider arm MH&amp;A services</td>
<td></td>
</tr>
<tr>
<td><strong>D. Addressing inequalities</strong></td>
<td></td>
</tr>
<tr>
<td>4.1 Child and youth HoNOSCA severity score changes during a care episode, by ethnicity</td>
<td></td>
</tr>
<tr>
<td>4.2 Child and youth perception of being respected by health care professionals, by ethnicity</td>
<td></td>
</tr>
<tr>
<td>4.3 Child and youth access to provider arm MH&amp;A services by ethnicity</td>
<td></td>
</tr>
<tr>
<td><strong>E. Fostering innovation</strong></td>
<td></td>
</tr>
<tr>
<td>5.1 Child and youth MH&amp;A care service delivery settings</td>
<td></td>
</tr>
<tr>
<td>5.2 Number of new initiatives funded</td>
<td></td>
</tr>
<tr>
<td>5.3 Child and youth referral to and use of e-therapy tools (SPARX)</td>
<td></td>
</tr>
<tr>
<td><strong>F. Workforce development</strong></td>
<td></td>
</tr>
<tr>
<td>6.1 Workforce competency</td>
<td></td>
</tr>
<tr>
<td>6.2 Workforce diversity</td>
<td></td>
</tr>
<tr>
<td>6.3 Number of youth and peer support advisors</td>
<td></td>
</tr>
<tr>
<td><strong>G. Working better together</strong></td>
<td></td>
</tr>
<tr>
<td>7.1 Child and Youth discharge transition plans signed off</td>
<td></td>
</tr>
<tr>
<td>7.2 Proportion of TRC relocation assessments that have a health assessment</td>
<td></td>
</tr>
</tbody>
</table>
Attachment 2 - Health Outcomes

A. Overall Youth population mental health

Outcome: All children, young people and their families living in the ADHB area experience and enjoy good mental health and emotional wellbeing.

Opportunity: To enable children and youth to have improved mental health and to fully engage in school and community life.

1.1: Number of youth suicides

Rationale: Suicide numbers can be an indicator of health status at a population level. Some suicides may be prevented through the implementation of the Direction.

Target: Downward trend over time.

Definition: Number of deaths in those aged 24 years or under, determined by the Child and Youth Mortality Review group to be suicides.

Data Source: Child and Youth Mortality Review Database

Analysis

<table>
<thead>
<tr>
<th>3 yearly rolling average number of youth suicides in ADHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>9.3</td>
</tr>
</tbody>
</table>

The average number of youth suicides 2012 – 2014 was 10. The youngest was 14 years of age.

Approximately 2/3 of all cases in 2014 were NOT known to the CAMHS or addiction services.

These numbers include some undetermined cases or those where the coroner had determined the threshold for suicide has not been met. This may possibly result in over estimation of the number of suicides.

Comments

There are several limitations in using suicide numbers to measure the effectiveness of the C&Y MH&A Direction. These include these numbers being subject to:

- small number variation
- influence by factors outside the control of the health sector
- changes due to variation in size and composition of the population over time.

The Child and Youth Mortality Review Group database was used as the source of suicide data as there is a significant delay before validated data becomes available from the Coroner/ Ministry of Health.

The three yearly rolling average numbers of suicides has been calculated. Numbers are too small to show trends by ethnicity. Approximately one third of suicides are female and two thirds male.
1.2: Number of referrals from ED for child and youth intentional self-harm

**Rationale:** Intentional self-harm numbers can be an indicator of health status at a population level. Some instances of self-harm may be prevented through the implementation of the Direction. Presentation to ED with self-harm may be influenced by factors such as availability or otherwise of community support for the individual.

**Target:** Downward trend over time.

**Definition:** Number of ED referrals to adult liaison psychiatry or the Starship consult liaison team for intentional self-harm for 0-24 year olds inclusive.

**Data Source:** ADHB data

**Comments**
Limitations of using this data include that:
- self-harm behaviour can be influenced by factors outside of the control of the health sector
- numbers may change with underlying changes in size and composition of the population over time.

Self-harm can be an event in its own right or can be a precursor to suicide.

The majority of referrals for self-harm are seen by adult liaison psychiatry.

Approximately three quarters of ED referrals for self-harm are for females and one quarter males.

---

**Analysis**

**Referrals in ED for self-harm in 0-25 year olds**

<table>
<thead>
<tr>
<th></th>
<th>2014/15 Q1</th>
<th>2014/15 Q2</th>
<th>2014/15 Q3</th>
<th>2014/15 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACH</td>
<td>84</td>
<td>63</td>
<td>78</td>
<td>62</td>
</tr>
<tr>
<td>SSH</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

**ED referrals for self harm by ethnicity, ACH**

<table>
<thead>
<tr>
<th></th>
<th>2014/15 Q1</th>
<th>2014/15 Q2</th>
<th>2014/15 Q3</th>
<th>2014/15 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>38</td>
<td>25</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td>Maori</td>
<td>13</td>
<td>14</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Pacific</td>
<td>7</td>
<td>9</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Asian</td>
<td>15</td>
<td>9</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>6</td>
</tr>
</tbody>
</table>
1.3: Rates of suspensions and exclusions from school

**Rationale:** The rates of school suspensions and exclusions help provide an indication of student engagement in productive learning which is critical to student wellbeing and achievement. The measures also provide an indication of the prevalence of certain behavioural issues in the school age population.

**Target:** Downward trend over time.

**Definition:** A suspension is a formal removal of a student from a school until a school Board of Trustees decides the outcome at a suspension meeting. If the student is aged under 16, the Board may decide to exclude the student from the school, with the requirement that the student enrols elsewhere.

**Data Source:** educationcounts.govt.nz website

**Analysis**

**Age-standardised suspension rate per 1,000 students**

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4.9</td>
<td>4.4</td>
</tr>
<tr>
<td>Female</td>
<td>1.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>5.2</td>
<td>5.5</td>
</tr>
</tbody>
</table>

**Comments**

Suspensions and exclusions can be a response to a wide range of concerning behaviours including drug and alcohol abuse and violence. In 2013 25.7% of suspensions and 15.5% of exclusions nationally were due to drugs (including substance abuse). In 2014 continual disobedience was the reason for 23.5% suspensions and 34.7% of exclusions. Most suspensions and exclusions occur at ages 13 to 15 years. The rates for the Auckland region are lower than the national average.

Note: Currently this data is for the total Auckland Region. The Ministry of Education will be providing us with ADHB specific data including rates by ethnicity.
B. Strengthening the voice

Outcome: Child, youth and family / whanau voices should be authentically listened to and engaged in improving services.

Opportunity: Services are seen as more accessible and responsive by children, young people and their families / whanau.

<table>
<thead>
<tr>
<th>2.1: Child and Youth satisfaction with their ability to influence their own care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale:</strong> Services are more likely to be effective if child and youth service users are able to have input into their own care.</td>
</tr>
<tr>
<td><strong>Target:</strong> 95% of child and youth report satisfaction at their ability to influence their own care.</td>
</tr>
<tr>
<td><strong>Definition: Current:</strong> The proportion of Kari centre users who feel able to complain about their care and / or contribute their opinions and ideas into their own care plan (Q6 and Q8, Annual Mental Health Services Consumer Survey).</td>
</tr>
<tr>
<td><strong>Future:</strong> Proportions of people using the Marama – Mental Health Commission’s (MHC) real-time feedback tool in the Kari centre who are satisfied with their input into their own care and their families involvement (Questions on decisions and family see below)</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Annual Mental Health Services Consumer Survey. The Marama – MHC real-time feedback tool will replace this in 2016/17.</td>
</tr>
<tr>
<td><strong>Analysis</strong></td>
</tr>
<tr>
<td><strong>Question 8: (Child and Adolescent) I did not feel able to complain</strong></td>
</tr>
</tbody>
</table>

DNA | Does not apply |
---|---|
D  | Disagree |
SD | Strongly disagree |
IB | In between (neither agree or disagree) |
A | Agree |
SA | Strongly agree |

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 14/10/15
Question 6: (Child and Adolescent) My opinions and ideas are included in my treatment plan

<table>
<thead>
<tr>
<th>Year</th>
<th>DNA</th>
<th>SD</th>
<th>D</th>
<th>IB</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
<td>31%</td>
<td>58%</td>
</tr>
<tr>
<td>2011</td>
<td>14%</td>
<td>2%</td>
<td>2%</td>
<td>10%</td>
<td>26%</td>
<td>42%</td>
</tr>
<tr>
<td>2012</td>
<td>3%</td>
<td>0%</td>
<td>2%</td>
<td>3%</td>
<td>38%</td>
<td>54%</td>
</tr>
<tr>
<td>2013</td>
<td>7%</td>
<td>0%</td>
<td>2%</td>
<td>7%</td>
<td>32%</td>
<td>45%</td>
</tr>
<tr>
<td>2014</td>
<td>0%</td>
<td>1%</td>
<td>6%</td>
<td>9%</td>
<td>37%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Notes: The real time feedback tool pilot started in July 2015. Two questions that could be utilised here are:

**Decisions** - I am involved in decision making

**Family** - My family / whanau are given information and encouraged to be involved

Potential limitations are that it will not be possible to determine who has used the real time feedback tool and in particular whether some consumers are using it multiple times during an admission / contact. Benefits include the greater number of service users whose feedback will be captured and that responses will be captured by age group, service and ethnicity.
C. Intervening Earlier

**Outcome:** Children and Youth can access services earlier in the life course and early where there is a need.

**Opportunity:** There will be a decreased incidence of mental health and addiction issues later in life.

### 3.1: Number of young people accessing the PMH&A PHO based services

**Rationale:** The PMH&A funding enables youth to access care closer to home, therefore reducing some of the known barriers to accessing care.

**Target:** Increasing trend of service utilisation.

**Definition:** Number of 12 to 19 year olds inclusive seen in the PMH&A service per quarter.

**Data Source:** Quarterly PMH&A reporting template data from PHOs.

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of 12-19 year olds seen in the PHO PMH&amp;A service by ethnicity</strong></td>
<td>The total number of 12 to 19 year olds seen in the PHO PMH&amp;A service was 314 in Quarter 1 2015 rising to 505 in Quarter 2. These are not all new referrals as a proportion of consumers will be seen across more than one quarter. This service is provided to both adults and youth. Total service capacity is capped by contract volumes. There is no specific target volume for Child and Youth. YSALT have recently increased the number of schools the service visits and the number of hours – this will translate into an increase in number of young people that are seen. YSALT – ADHB Youth Health Service Alliance PHO PMH&amp;A – PHO based Primary Mental Health and Addictions service</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PHO PMH&amp;A utilisation by 12 to 19 year olds by service type</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ext Consult = Extended Consultations (Nurse or GP)
BIC = Brief intervention counselling
ABI = Alcohol brief intervention
Gp therapy = Group Therapy
POC = Packages of care

---

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 14/10/15
3.2: Number of young people referred for mental health / alcohol or drug related issues via enhanced school-based health services

**Rationale:** The purpose of the Enhanced School Based Health Service (ESBHS) is to assist youth in reaching their full potential and to thrive in their communities. Assessing and advising youth in a school setting reduces some of the known barriers to accessing care.

**Target:** Not applicable

**Definition:** Number of 12 to 19 year olds inclusive that are seen by the enhanced school-based health services for mental health / drug and alcohol issues per quarter.

**Data Source:** Quarterly ESBHS reporting template.

**Analysis**

<table>
<thead>
<tr>
<th>Year</th>
<th>Ext Ref</th>
<th>Int Ref</th>
<th>ESBHS Nurse</th>
<th>ESBHS GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>5</td>
<td>37</td>
<td>71</td>
<td>10</td>
</tr>
<tr>
<td>Q2</td>
<td>3</td>
<td>20</td>
<td>77</td>
<td>8</td>
</tr>
</tbody>
</table>

**Comments**

Enhanced school based health services (ESBHS) are provided in designated schools in ADHB (primarily schools that are decile 1-3). Existing ESBHS cater for nearly 9,000 young people through defined mainstream schools, alternative education facilities and teen parent units.

The majority of Mental Health / Alcohol or Drugs (AOD) issues are managed by the Nurse. Other options are to be seen by the GP or school guidance counsellor. Approximately 10 students per quarter require referral to external services.

Ext Ref = External referral for mental health / AOD related issues
Int Ref = Internal referral to school guidance counsellor for mental health / AOD related issues
ESBHS Nurse = Nurse-led advice for mental health / AOD related issues
ESBHS GP = GP-led advice for mental health / AOD related issues
3.3: HoNOSCA severity scores on admission to MH&A services

**Rationale:** The Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA) score can measure the severity of mental illness at the time of admission. If children and young people can be seen earlier in the course of their illness on a population level then this may be reflected by a reduction in HoNOSCA scores on admission over time.

**Target:** A downwards trend in the proportion scoring severe in the HoNOSCA severity score on admission, over time

**Status:**

**Definition:** Proportion of admissions in each HoNOSCA severity score range. Subclinical = all items <2, mild = at least 1 item >1 and all <3, moderate = at least 1 item >=3, severe = at least 2 of the first 13 items >=3. Not rated = HoNOSCA score not completed

**Data Source:** ADHB PRIMHD data

**Analysis**

<table>
<thead>
<tr>
<th>HoNOSCA scores on admission</th>
<th>2014/15 Q1</th>
<th>2014/15 Q2</th>
<th>2014/15 Q3</th>
<th>2014/15 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Rated</td>
<td>14.3%</td>
<td>22.2%</td>
<td>30.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Sub-Clinical</td>
<td>28.6%</td>
<td>22.2%</td>
<td>0.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Mild</td>
<td>14.3%</td>
<td>11.1%</td>
<td>10.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Moderate</td>
<td>7.1%</td>
<td>11.1%</td>
<td>10.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Severe</td>
<td>35.7%</td>
<td>33.3%</td>
<td>50.0%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

*Inpatient = the Child and Family Unit*

**Comments**

Factors other than children and young people being seen earlier in the course of their illness may result in a decrease in average HoNOSCA severity scores over time. Currently in community settings HoNOSCA is not reliably completed for admissions. In fact during 2014/15 there has been an increase in the proportion of admissions that are not rated. It is highly possible that admissions that have HoNOSCA completed differ in severity from those that do not. Changes in completion rates of HoNOSCA over time may result in changes to overall severity scores. Proportions of admissions in each severity score range would be expected to differ across services. The proportions of admissions in each severity have remained reasonably stable throughout 2014/15 with the exception of Q3 for the inpatient admissions when there were no admissions that scored in the subclinical range and a rise in proportion of admissions in the severe range.

<table>
<thead>
<tr>
<th>HoNOSCA Scores on admission</th>
<th>2014/15 Q1</th>
<th>2014/15 Q2</th>
<th>2014/15 Q3</th>
<th>2014/15 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Rated</td>
<td>31.6%</td>
<td>25.5%</td>
<td>31.8%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Sub-Clinical</td>
<td>1.7%</td>
<td>3.0%</td>
<td>1.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Mild</td>
<td>10.8%</td>
<td>13.9%</td>
<td>10.3%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Moderate</td>
<td>20.5%</td>
<td>18.4%</td>
<td>22.6%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Severe</td>
<td>35.4%</td>
<td>39.3%</td>
<td>33.7%</td>
<td>29.4%</td>
</tr>
</tbody>
</table>

*Community = Kari Centre*  

**PRIMHD - Programme for the Integration of Mental Health Data**
3.4: Waiting times for secondary care Child and Youth MH&A services

**Rationale:** Intervening earlier is about being able to offer timely access to care.

**Target:** 80% new referrals seen within 3 weeks (MoH)

**Definition:** The proportion of all new referrals for those aged 25 years and under, to secondary care mental health services, that are seen within 3 weeks. (New referrals are referrals for individuals who have not been seen by any mental health service nationwide in the past year).

**Data Source:** ADHB and WDHB (CADS) data

**Analysis**

<table>
<thead>
<tr>
<th></th>
<th>2014/15 Q1</th>
<th>2014/15 Q2</th>
<th>2014/15 Q3</th>
<th>2014/15 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-25Y CAMHS</td>
<td>82.3%</td>
<td>83.3%</td>
<td>81.8%</td>
<td>79.9%</td>
</tr>
<tr>
<td>0-25Y Adult</td>
<td>95.7%</td>
<td>91.1%</td>
<td>92.1%</td>
<td>91.9%</td>
</tr>
<tr>
<td>0-25Y All services</td>
<td>89.2%</td>
<td>87.0%</td>
<td>86.9%</td>
<td>85.8%</td>
</tr>
<tr>
<td>Target</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

**Comments**

The Ministry of Health target is that all referrals to Mental Health services for individuals who have not been seen anywhere in the country in the past year should be seen within 3 weeks. Within ADHB this target has been met overall. A slightly higher proportion of referrals of 0-25 year olds to Adult CAMHS are seen within 3 weeks than referrals to CAMHS. CADS also meets this target for ADHB residents.
D. Addressing Inequalities

Outcome: Maori, Pacific and other minority groups can access age and culturally appropriate services when and where they are needed.

Opportunities: To ensure that the unique societal structures, primarily in Maori and Pacific communities do not act as a barrier to access services. Services will be more responsive to Maori and Pacific.

### 4.1: Change in average number of clinically significant HoNOSCA items during a care episode by ethnicity

**Rationale:** Change in the HoNOSCA scores at admission and discharge for different ethnic groups provides an indication of outcomes achieved by ethnicity

**Target:** Equal outcomes across ethnic groups

**Definition:** Change in the HoNOSCA score range between admission and discharge by ethnicity (Maori, Pacific, Asian, Other).

**Data Source:** ADHB PRIMHD data

**Analysis**

#### Change in HoNOSCA score during care episode (community)

<table>
<thead>
<tr>
<th></th>
<th>Q1 2014/15</th>
<th>Q2 2014/15</th>
<th>Q3 2014/15</th>
<th>Q4 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>34.6%</td>
<td>41.9%</td>
<td>43.9%</td>
<td>40.5%</td>
</tr>
<tr>
<td>No Change</td>
<td>9.3%</td>
<td>9.0%</td>
<td>8.2%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Worsened</td>
<td>2.0%</td>
<td>2.2%</td>
<td>1.2%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

#### Change in HoNOSCA score during care episode (inpatient)

<table>
<thead>
<tr>
<th></th>
<th>Q1 2014/15</th>
<th>Q2 2014/15</th>
<th>Q3 2014/15</th>
<th>Q4 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>0.0%</td>
<td>36.4%</td>
<td>33.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>No Change</td>
<td>16.7%</td>
<td>18.2%</td>
<td>33.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Worsened</td>
<td>16.7%</td>
<td>27.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Inpatient – CFU – Child and Family Unit
Community – Kari Centre

Note: Quarterly data (rolling years end) by ethnicity is being provided - awaited.

Comments

The quality of this data is a challenge with the need for matching pairs to make a real assessment. There are a limited number of matching pairs. The proportion admissions that have matching discharge data needs to be monitored. Low compliance with completing the HoNOSCA will reduce the validity of the results as the severity of illness and improvement over time of those having a HoNOSCA completed or not may differ. Community compliance is affected by crisis teams doing triage / brief assessment only.

In Quarter One 2014/15 only 46% of community services and 34% of inpatient CFU inpatients had both admission and discharge HoNOSCA scores completed.

Of those with matching data in the community services on average 40% of consumers have an improvement in HoNOSCA score during their care episode. For inpatients the proportions that have improved scores is more variable by quarter and slightly lower on average.
### 4.2: Respect secondary MH&A service users experience

| Rationale: | Consumers that perceive that they are being treated with respect will feel more engaged with the service delivering their care |
| Target: | Increasing trend over time |
| Definition: | The proportion of Child and Youth service users who feel they are treated with respect, by ethnicity |
| Data Source: | The Marama – Mental Health Commission real-time feedback tool. |
| Analysis | Tool was implemented in August 2015 |
| Comments | Data will not be available until 2016 |
4.3: Access to Services by ethnicity

**Rationale:** Access is a key contributor to health inequalities

**Target:** To meet the MOH targets

**Definition:** The proportions of the total 0-19 year old ADHB population seen by mental health services nationwide and by ADHB mental health providers

**Data Source:** Ministry of Health

**Analysis**

![Chart showing Access - % of total 0-19 year old ADHB population seen](chart1)

![Chart showing Access - % of total 0-19 year old ADHB population seen by ADHB provider arm mental health services](chart2)

**Comments**

The Ministry of Health monitor the proportion of 0-19 year olds that are accessing Mental Health services nationwide. The target for Maori is 5.5% and for other ethnicities and total is 3.0%.

The target is for the proportion of ADHB residents seen by any mental health provider nationwide. ADHB fell just short of meeting these targets in 2014/15.

The second figure shows the proportion of the ADHB child and youth population seen by ADHB provider arm Mental Health services. This shows that less than half of ADHB resident child and youth mental health secondary service users are seen within ADHB. A proportion of those seen in other DHBs will be those seen in the regional CADS service. This will impact on the ability of ADHB strategies to influence the care being provided to their population.
E. Fostering Innovation

**Outcome:** Children, young people and family / whanau experience services as innovative and child and youth centric.

**Opportunity:** Children, young people and their families / whanau will directly benefit from a culture of innovation and new approaches.

### 5.1: C&Y MH&A service delivery settings

**Rationale:** Providing services where children and young people feel comfortable in attending and that are easy to attend will improve engagement.

**Target:** Increase in services provided in community  

**Definition:** A count of all contacts with service users and/or their families by location of the contact.

**Data Source:** ADHB MH&A Quarterly data

**Analysis**

<table>
<thead>
<tr>
<th>Location</th>
<th>CAMHS Contacts by Setting</th>
<th>Period: 1 July 2014 to 30 June 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kari Centre</td>
<td>11181</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>828</td>
<td></td>
</tr>
<tr>
<td>Other Community</td>
<td>544</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>430</td>
<td></td>
</tr>
<tr>
<td>Waiheke Island</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Emergency Department</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>YTP House</td>
<td>1436</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>6186</td>
<td></td>
</tr>
<tr>
<td>SMS/TEXT</td>
<td>184</td>
<td></td>
</tr>
<tr>
<td>Letter</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td>2507</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>23443</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Comments**

This data reflects the settings that the CAMHS Clinicians work in. The data does not reflect unique clients. Some clients may have had multiple contacts with multiple CAMHS Clinicians. It does not include the contacts made by the Enhanced School Based Health Service. CADS and Altered High data is to be included.

### 5.2: Number of new initiatives funded

**Rationale:** Providing services where children and young people feel comfortable in attending and that are easy to attend.

**Target:** Increase in services provided in community

**Definition:**

**Data Source:** Werry Centre 2014 ICAMHS_AOD Stocktake

**Analysis:**

![Graph showing funding per head, infant, child & adolescent population by DHB area (2004-2014)](image)

**Comments**

When looking at individual DHBs, the calculation does not reflect inter DHB referrals including referrals to regional services. This data may also include the regional services that CAMHS provide. More work needs to be done to understand this data.
5.3: Uptake of e-therapy tools

**Rationale:** E-tools are an innovative and cost-effective way of providing care to young people and engage them with effective care.

**Target:** Increase in uptake and completion of the programme from previous quarter

**Definition:** SPARX is a self-help e-therapy tool that teaches young people the key skills needed to combat depression and anxiety.

**Data Source:** Ministry of Health

**Analysis**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2015 Q1</th>
<th>2015 Q2</th>
<th>2015 Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>European/Other</td>
<td></td>
<td></td>
<td>122</td>
</tr>
</tbody>
</table>

**Comments**

SPARX was developed by a team of researchers from the university of Auckland and has been made freely available through the PM Youth Mental Health Project. Overall numbers of youth using SPARX are increasing but numbers of Maori and Pacific remain low. There were a total of 159 self-identified ‘young person’ new users from the Auckland Region in Q2 2015. The target age range is 12 to 19 years. Greatest uptake was in the 15 to 17 year old age group. There is no ability to split out DHBs within the Auckland Region as SPARX registration only asks residing location by region. There are 7 levels that can be completed. Completing level 4 or higher is considered to have a therapeutic effect. In total 12 young people completed level 4 in Q2 and 5 completed level 7. A technical limitation preventing users accessing SPARX via Google Chrome is currently being addressed. Promotional activities direct to youth are being limited while an upgrade resolving this issue is being tested. This may explain low user numbers.

SPARX - is a self-help initiative, provided by the University of Auckland

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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 14/10/15
F. Workforce Development

Outcome: To grow and develop the workforce so it reflects the diversity of our population and so we have the right people with the right skills in the right places.

Opportunities: There is a workforce that has the skills mix and diversity that is sustainable into the future. It is confident to work fluidly across organisational boundaries and with virtual tools.

The lived experience of children, young people and families / whanau is a valued contributor to personal resilience and recovery, peer support and other forms of help and treatment.

6.1: Workforce Competency
Rationale: aspirational
Target: Status:
Definition:
Data Source:
Analysis Comments
Currently we do not have data to provide a baseline.

6.2: Workforce Diversity
Rationale: A diverse workforce that reflects the population it services will be well placed to deliver services appropriate and responsive to that population.
Target: tbc Status:
Definition: Workforce as a % of population and clients
Data Source: Werry Centre Workforce Survey on Child and Adolescent Mental Health / AOD Services 2014
Analysis Comments
ADHB 0-19 year Workforce compared to proportions of clients and population

<table>
<thead>
<tr>
<th>% workforce 2014</th>
<th>% clients 2013</th>
<th>% population 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Workforce compared to clients and population show a considerable disparity. This will need to be addressed in the regional workforce development plan. LGBTI data to be added when available.

Total data will be added
### 6.3: Number of youth and peer support advisors

**Rationale:** The lived experience of children, young people and families/whanau is a valued contributor to personal resilience and recovery.

**Target:** Growth in peer support roles

**Definition:** See comment below on the definition of Peer support

**Data Source:** Werry Centre two yearly workforce survey

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>One source of data is the Performance Monitoring returns – Affinity, Mind and Body, Provider Arm.</td>
<td>Work needs to be done on defining what roles Peer Support include so they can be counted and a baseline established – the current data is collected as “Other Non-Clinical Support for Clients”. In the DHB they are called Peer Support and in Non Government Organisations (NGOs) Youth Workers, Youth Consumer Advisors or Advocacy/Peer Support Whanau roles. The numbers being too small to separate out. The additional question is the number in Adult MH&amp;A services available for 18-24 year old. The total number in Adult services is 15 (2014 data as reported by Te Pou).</td>
</tr>
</tbody>
</table>

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 14/10/15
G. Working better together

Outcome: To achieve integrated processes and access to appropriate services across our partner agencies and organisations

Opportunity: The whole system works together to improve process and access for children, young people and their family / whanau to the appropriate services at the right time

7.1: Discharge transition plans signed off

<table>
<thead>
<tr>
<th>Rationale:</th>
<th>Formal discharge transition plans include referral and support to Primary Care as well as other agencies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: The MOH target is 95%.</td>
<td>Status:</td>
</tr>
<tr>
<td>Definition: % of discharges where a transition discharge plan is in place on discharge from the Kari Centre.</td>
<td></td>
</tr>
</tbody>
</table>

Data Source: ADHB data

Analysis

<table>
<thead>
<tr>
<th>Kari Centre transition discharge plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>100.0%</td>
</tr>
<tr>
<td>90.0%</td>
</tr>
<tr>
<td>80.0%</td>
</tr>
<tr>
<td>70.0%</td>
</tr>
<tr>
<td>60.0%</td>
</tr>
<tr>
<td>50.0%</td>
</tr>
<tr>
<td>40.0%</td>
</tr>
<tr>
<td>30.0%</td>
</tr>
<tr>
<td>20.0%</td>
</tr>
<tr>
<td>10.0%</td>
</tr>
<tr>
<td>0.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2014/15 Q1</th>
<th>2014/15 Q2</th>
<th>2014/15 Q3</th>
<th>2014/15 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge transition plans</td>
<td>22.9%</td>
<td>82.9%</td>
<td>84.9%</td>
</tr>
</tbody>
</table>

Comments

Transition planning ensures that:
- service provision is matched as closely as possible to the needs of the young person and delivered by the most appropriate service/s to meet those needs
- the young person and their family/whānau are the key decision-makers regarding the services they receive
- care is delivered across a dynamic continuum of specialist and primary level services with decisions based on the needs and wishes of the young person and their family/whānau and not service boundaries
- processes are in place to identify and respond early should the young person experience a re-emergence of any mental health or AOD concern.
<table>
<thead>
<tr>
<th><strong>7.2: Proportion of TRC relocation assessments that have a health assessment</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale:</strong> Tamaki Redevelopment Company are taking a holistic approach to the redevelopment project – health is a key part of this needs map</td>
<td></td>
</tr>
<tr>
<td><strong>Target:</strong></td>
<td><strong>Status:</strong></td>
</tr>
<tr>
<td><strong>Definition:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Analysis</strong>&lt;br&gt;Data and its source yet to be determined.</td>
<td><strong>Comments</strong>&lt;br&gt;It has been proposed that a health assessment be included in the socioeconomic assessment that each family will participate in before they are moved. This will reflect a true partnership with our agency partners in looking at the holistic needs of a family/individual.</td>
</tr>
</tbody>
</table>
4.2 Mental Health and Addictions Update - 2014/15 Actions

Recommendation

That the report be received.

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

Endorsed by: Tim Wood (Acting Funding and Development Manager, Mental Health and Addictions)

Glossary

AOD - Alcohol and Other Drug
CADS - Community Alcohol and Drug Service
CEO - Chief Executive Officer
COO - Chief Operating Officer
CPHAC - Community Public Health and Advisory Committee
DAP - District Annual Plan
DHB - District Health Board
Funder - Term used to describe the joint Auckland DHB/Waitemata DHB funding team established in July 2013
GM - General Manager
KPI - Key performance Indicator
NASC - Needs Assessment and Co-ordination
Navigate - Peak body for Northern Region Mental Health NGOs
NGO - Non-Government Organisation
PEG - Provider Executive Group
PHO - Primary Healthcare Organisation
SNAP - Support Needs and Assessment Plan
WSN - Waitemata Stakeholder Network

Executive Summary

This report provides an update to the Community Public Health and Advisory Committee (CPHAC) on sector-wide collaborative approaches in Waitemata and Auckland DHBs for mental health and addictions. These collaborative approaches are designed to build infrastructure for integration and the use of current resources more effectively. These are two key priority areas identified in Rising to the Challenge/Mental Health and Addictions Service Development Plan, 2012 – 2017. This report identifies how activities within these collaborative approaches link to DHB annual planning cycles and also highlights several current projects.
1. Sector-wide collaborative structures

1.1 Waitemata DHB

Waitemata DHB has a longstanding and productive set of collaborative forums across mental health and addictions NGOs, Provider Arm services, PHOs and funders.

Waitemata Stakeholder Network (WSN)
The Waitemata Stakeholder Network (WSN) is the overarching group, which other forums (including Provider Executive Group and Waitemata DHB Provider Forum) report to. The sponsor group for WSN comprises the Chair, the General Manager and the Clinical Director for DHB services, and representatives from Planning, Funding and Outcomes.

This group is currently chaired by an NGO Chief Operating Officer (COO). The membership of the network is:

- Provider Arm General Manager and Clinical Director, Consumer Advisor, Family Advisor, and the Service Managers for Child and Youth, Adults, Older Adults, Addictions, Asian, Pacific and Maori Mental Health
- Representative Mental Health and Addictions NGO CEOs
- Chairs of Shared Visions North-Shore, Rodney and West Auckland
- NGO Consumer Advisory organisation
- NGO co-chair of PEG
- Family/whanau representation
- Representative for Primary Care
- Mental Health and Addictions Funding and Planning team members.

The WSN plan is developed every five years through extensive consultation with broad community and stakeholder representation. The WSN work plan covers the areas of child and youth, adult, older adults, Asian, Maori, and Pacific.

Outcomes from the WSN process include:

- A shared Awhina training calendar – delivering an integrated sector-wide training approach
- Cultural competence training provision (e-learning) for Primary, NGO and provider arm services
- Development of a scorecard for social outcome indicators and other key performance indicators across the NGO and provider arm (15/16 Annual Plan action)
- Sector wide health promotion focusing on Smoke free services, environments and service users

The NGO chair of WSN also participates in the DHB Annual Planning process, which ensures alignment of WSN activities with the annual planning process.

Provider Executive Group (PEG)
The Provider Executive Group (PEG) is co-chaired by an NGO CEO and the DHB Service Manager for Adult Mental Health. The group comprises senior DHB clinicians, managers and mental health NASC, CEOs (or delegates) of all mental health and addictions NGOs, mental health representatives from the two PHOs, and Planning, Funding and Outcomes team members.

PEG essentially forms the adult work stream for WSN. There are identified PEG working groups who report back to PEG and also through to WSN. Currently the workgroups are:

- Navigation tool for service-users/families, communities and referrers (15/16 Annual Plan action)
- Housing solutions
• Employment (15/16 Annual Plan action)
• Continued NGO/DHB integration
• Mental health medication information available online.

The NGO chair of PEG also participates in the DHB Annual Planning process, which ensures alignment of PEG activities with the annual planning process.

**WDHB Provider Forum**

The provider group is an operational group of NGO and DHB team leaders, the mental health NASC co-ordinators, and the funder. This is co-chaired by an NGO representative and the DHB Clinical Team Manager for the Mental Health NASC. This group works collaboratively to make the best use of resources, work in a coordinated way across the continuum, develop tools for collaborative use, and implement new models of working and new service specifications. This group reports to PEG and final sign off is through PEG.

Outcomes from the Provider Forum include:

• Development and implementation of the Support Needs and Assessment Plan (SNAP) a collaborative needs assessment and support plan, used by service coordinators, NGOs and clinical teams
• Development and implementation of a generic referral form to access support options
• Implementation and ongoing review of the support hours model
• Improved access to services

**1.2 Auckland DHB**

**Innovate**

In December 2014 and February 2015 two meetings were held to develop an Auckland DHB provider executive group for senior Provider Arm, NGO managers, PHOs and the Funder. The primary objectives of Innovate are:

• Identify solutions that can create measurable improvement in outcomes for Auckland DHB service users and their families
• Provide opportunities for providers and planning and funding to work together in a ‘whole of sector’ and ‘integrated systems’ framework
• Network, share information, and identify opportunities for collaboration and improved service delivery for service users and their families
• Develop a shared strategy and projects for the development and support of the sector in mental health and addictions

To achieve these objectives Innovate has provider arm and NGO Co-Chairs and meets on a monthly basis. Currently there are four work-streams:

• Addictions – Development of a gaps analysis, service navigation and information resource
• Health and Safety – Review and respond to the Work Safe NZ consultation document
• Housing – Report and advocate for mental health and addictions service users in the current housing crisis
• Primary care – Development of a shared referral form and triage system. This initiative links into the Tamaki mental health and well-being initiative.

**ADHB Provider Forum**

This group is similar in structure and purpose, to the Waitemata DHB Provider forum. The stated purpose of the forum is to support and maximize the potential of service users in their recovery by:
• Supporting the movement of service users through the recovery support continuum
• Working collaboratively to strengthen effective working relationships between NGOs, ADHB Service Co-ordination and ADHB Clinical Services.
• Continually reviewing and improving service access and delivery systems
• Enhancing communication, sharing experiences, information and learning amongst the group
• Identifying service gaps and potential solutions
• Identifying and agreeing areas for project work
• The ADHB group is actively working on projects which include Promoting Healthy Lifestyles and improving the interface between the Taylor Centre, a DHB community mental health service, and NGOs.

2. Auckland DHB and Waitemata DHB Employment Workgroup Strategy

The Auckland DHB and Waitemata DHB Employment Work Group Strategy (attached as Appendix 1 to this paper) is an example of the work generated by the groups described above and is provided for information only. It is also an example of collaborative activity across both DHBs. Sponsorship has been provided by both NGO and provider arm leaders across both DHBs.

Employment is a central part of recovery for people with mental health problems and is generally good for mental health. The evidence on how best to support people with mental illness into employment is well established. Te Pou, the New Zealand Centre of Mental Health Research, report that people with mental health conditions:

• Fall out of work at twice the rate than people with other health conditions following the onset of symptoms
• Are less likely to be employed - less than 20% of people with a severe mental illness are employed
• Make up 40% of new and existing beneficiaries and;
• Once a person has been out of work for more than six months, the risk of developing a mental health condition increases

Rising to the Challenge identifies better access to employment support as a priority area of action. Both Auckland DHB and Waitemata DHB annual plans have actions related to improving access to these services.

The mental health and employment strategy for the Waitemata and Auckland DHB populations, “Everyone’s Business”, has been completed (Appendix I). The objectives of the “Vision 2020” strategy is that by 2020 anybody in the region with a mental health or addiction issue will be able to access employment support, at the right level of intensity. The aim is that at least 50% of people exiting from specialist mental health and addiction services will be in employment.

The action plan focuses on three areas:

• Understanding the employment status of people in contact with secondary mental health and addiction services
• Increasing access to employment support service provision across mental health, addiction and primary care services
• That all health services apply the practices of work focused health care to support people return to and stay at work.
Currently, Everyone’s Business is in draft and undergoing ratification by members of Innovate, the Waitemata Stakeholders Network (WSN) and the Waitemata DHB Provider Executive Group (PEG). It will then go through a formal endorsement process. The plan assumes all the actions can be undertaken within existing resources. If additional resources are required then this would be subject to a duly developed and approved proposal.

3. Support Hours

The development and implementation of the Support Hours model was an Auckland and Waitemata DHB collaboration with NGOs, which commenced in 2012. The model was achieved by reconfiguring 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 at any point in time. The outcome was the introduction of a new Support Hours contract service specification and reporting template.

Following the implementation the Waitemata Provider Forum has focussed on operationalising the new service specification. The Provider Executive Group have regularly reviewed and refined the model and the service specification. As a result of this, a new service specification was agreed at PEG in 2014. When the Auckland DHB forum (Innovate) began, this presented another opportunity for the Funder to consult with the Auckland NGO providers on the new service specification as agreed in Waitemata. The group accepted these, and consequently from when all mental health and addictions contracts were renewed, as of 1 July 2015, all support hours providers across both DHBs now have the same specifications.

The Support Hours and Social Outcomes Indicators reporting template has been implemented across both DHBs. The collection of the social indicator data meets national KPI collection requirements.

The achievement of reliable Support Hours and Social Outcomes Indicators reporting has taken effort particularly from the NGOs. Data quality and reliability is now such that benchmarking “Everyone’s Business” is now possible.

A current 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.

4. Next Steps

These collaborative approaches, and the outcomes generated through these forums are positive evidence of building infrastructure for integration and using current resources more effectively.

A number of NGO providers work across both DHBs, as do the funders and the DHB Clinical Team Manager for the Mental Health NASC. In the future, it may be possible to amalgamate forums so a common approach across both DHBs is possible. In the meantime, it is intended to combine some of the working groups that sit under PEG and Innovate.
“Healthcare professionals must adapt the advice they give to patients to reflect the importance of remaining in or returning to work wherever possible. Government must lay the foundation for long-term change through the piloting of a new approach to early intervention and a renewed commitment to make the public sector an exemplar”.

Dame Carol Black, Working for a Healthier Tomorrow, 2008.
This strategy document is supported by the following organisations who have agreed to be part of ‘Everyone’s Business’. They are committed to Vision 2020 outlined in this strategy and will take action to make it become a reality.

Organisations committed toEveryone's Business:

If your organisation would like to be displayed on this strategy as a partner in Everyone’s Business, contact Rob Warriner (rwarriner@walsh.org.nz) or Warren Elwin (warren.elwin@workwise.org.nz)
“When I become unwell why is it the first thing I am told is I that need to think about giving up my job? My job is my hope for the future”.

Person with lived experience

The quotes used throughout this strategy document are illustrations of the types of comments and views raised through the stakeholder meetings.

The vignettes have been developed from the experiences and stories which were told throughout the conversations with stakeholders. Their inclusion is to assist in the articulation of a shared vision for how things could look and feel in 2020.
1. VISION 2020

The vision for 2020 is that anybody in the region with a mental health or addiction issue can access employment support at the right level of intensity.

One indication of achieving this vision is that by 2020 at least 50% of people exiting from specialist mental health and addictions services will be in employment.

Definitions

Employment is used throughout this strategy and refers to open, competitive employment of at least 5 hours or more a week, paid at minimum wage or above. This includes part-time and full-time employment as well as self-employment.

Employment support services is the phrase used throughout this strategy to refer to services that support people to get and to maintain Employment as defined above. These services will vary in the types of support services they offer and are provided through a mix of government (i.e. Work and Income) and non-government agencies.

Specialist mental health and addiction services are those which offer dedicated clinical and support services for people referred from primary and community services as well as from in-patient services. They include those services provided by government agencies (DHBs) and non-government agencies.

“I think employment has to be everyone’s business. By 2020 everyone across health services will want to know: ‘Do you have a job?’ If not, they will want to know: ‘Do you want a job and how can we help’?

NGO provider
Setting a specific target of a 50 per cent employment rate for people exiting specialist services is not to exclude the importance of employment support for people who experience these issues and are receiving treatment from primary care services. The importance of increased access to individualised employment support across the whole health system is part of VISION 2020. However it is people who are in contact with specialist mental health and addiction services, who currently have the lowest employment rates, only limited access to employment supports, and therefore are currently most excluded from realising the benefits (in terms of their recovery and well-being) and opportunities that access to employment can bring.

Agreeing the shared vision

During the meetings with stakeholders during 2014 and 2015, VISION 2020 was outlined and discussed. People were overwhelmingly supportive of this vision. The only concern raised was that with the 50 per cent target we also should monitor for unintended consequences arising from people solely focused on meeting the target i.e. supporting people into any job prior to leaving services. That said, people agreed that they liked the 50 per cent goal, as it was a stretch and would really focus the whole system on working together and making employment support an integral part of mental health and addiction services.

“It’s not just about how many people are in work, it is also about who is getting work and the quality of that work”

DHB provider
2. Principles

The following principles underlie this strategy and action plan, along with relevant research and government policy and should be used to guide its implementation.

I. We acknowledge Te Tiriti o Waitangi as the founding document of Aotearoa / New Zealand and the rights of all New Zealanders to reach their full potential.

II. We believe that everyone who experiences a mental health or addiction issue should have access to the intensity of employment support suited to their individual aspirations and goals.

III. We believe that all stakeholders have an obligation to identify how they can contribute to bringing about this change and commit to working collaboratively to achieve VISION 2020.

IV. We commit to supporting people into the right jobs, not just any job.

V. We endorse and support the right for everyone to access the employment opportunities they choose, with the option of support where requested.

Research has shown that for most people being in employment improves mental health whilst being out of work negatively impacts on both physical and mental health (Waddell and Burton, 2006). New Zealand research has found that most people who experience mental illness enjoy working and view it as part of their recovery (Duncan and Peterson, 2007). The mental health and addictions service development plan, Rising to the Challenge, sets out the need for better access to employment support as one of the priority areas of action for both government and non-government organisations (Ministry of Health, 2012) and both the Waitemata and Auckland DHB annual plans (2014/15) stipulate the need to improve access to employment services. Everyone’s Business is supported by the 2015/16 annual plans which are currently being drafted.

“Access to employment support services is really patchy at the moment, we need to get consistency of coverage and make sure everyone is clear how to access them”

Everyone’s Business steering group members.
2020 Vignette One

I work full-time and have been a service user of the DHB mental health services for six years. Every three months I have a meeting with my care manager and every six months I see one of the consultant psychiatrists together with my care manager and employment advisor to review how I am doing. My work status including my hours of work is on the front of my medical notes. This means that anyone who is arranging an appointment knows to schedule it out of these working hours wherever possible. They always manage this, as now the mental health team work in the evening and weekends as do the people who administer my medication, not just for crisis calls but for anyone using mental health services.

It is not just the timing of the meetings which have changed, the content has too. We focus on my symptoms and medication, but always through the lens of how it is affecting me in my home and working life. It feels like everyone involved in my healthcare is committed to supporting me to maintain my job.

“I want to see the provider arms of mental health and addiction services working closely alongside employment support services. We need to keep employment visible”.

DHB provider.
3. Background to the strategy

Waitemata and Auckland DHBs, with support from the Waitemata Stakeholder Network, funded a three phase project to develop this regional mental health and employment strategy.

<table>
<thead>
<tr>
<th>Everyone’s business - the three phases to develop the strategy</th>
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<tbody>
<tr>
<td><strong>Phase 1:</strong> Setting the vision and initial stakeholder engagement (Nov 2014 – Feb 2015)</td>
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<tr>
<td>Discuss and explore, and develop the first draft of the ‘employment support for all’ strategy</td>
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<tr>
<td><strong>Phase 2:</strong> Refinement of the strategy and gaining stakeholder agreement (Feb – Aug 2015)</td>
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<tr>
<td>Gather feedback, gain agreement and finalise strategy. Establish cross-agency governance group, and identify champions. The strategy will include action points, responsibilities, and delivery dates.</td>
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<tr>
<td><strong>Phase 3:</strong> Assembling ready for implementation</td>
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<tr>
<td>Launch the strategy and begin its implementation utilising stakeholder input and resources.</td>
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Building on existing resources

In 2013 the Ministry of Social Development contracted providers to deliver employment support services to people who experience mental health issues and are long term unemployed (referred to as Mental Health Employment Service contracts). These are additional contracts to the MSD disability supported employment contracts. In some parts of the country, DHBs also purchase employment support services for people who experience mental health issues.

Waitemata and Auckland DHBs, in partnership with the NGO sector, wish to maximise the employment support available in the regions as these are highly valued and there is energy to extend the opportunities these services create. Throughout 2014 a series of meetings were held between NGOs and DHB representatives to consider the best way to do this and there was agreement that a regional mental health and employment strategy was needed.
Research on employment and mental health

There is considerable research on the positive health impacts of employment and conversely the negative effects on being out of work (Waddell & Burton, 2006). Many people who experience mental health issues enjoy working and see employment as a key part of their recovery (Duncan & Peterson, 2007). Employment has an impact on improved self-esteem, self-respect and confidence as well as improving social integration (Gordon & Peterson, 2015).

Yet people who experience mental health issues have very low employment rates especially when compared to people across all disability groups and to the general population (Statistics New Zealand, 2014). Employment rates are lower for all people who experience mental health issues but are lowest for people with severe mental illness of whom less than 20 per cent are in employment (Welsh, 2010; Harvey et al., 2009).

In response to the interests and aspirations of people who experience mental health issues and in recognition of this inequality, researchers and practitioners have focused on how to improve employment rates. In the past 20 years research on effective ways to support people to get and keep jobs has advanced significantly. This includes more than 20 randomised controlled trials globally (Drake & Bond, 2014) along with many more observational studies published of real world services.

As a result there is much literature available now showing the way to design and deliver effective employment support services. This includes focusing on the provision of individually tailored support, working in partnership with clinical teams, and proactively engaging with local employers (Marshall et al., 2014; Kinoshita et al., 2013). There is strong evidence that the provision of healthcare services alone does not support a return to work (Waddell et al., 2008); and that employment services and health services should be integrated at policy, funding and delivery levels (OECD, 2015).

So people who experience mental health conditions would like to work, there is rigorous evidence on how best to support people. A key barrier therefore that needs to be address is ensuring better access to high quality, effective, employment support services (Lockett & Bensemann, 2013; Ministry of Health, 2012).
2020 Vignette Two

I manage 12 engineers as part of a medium sized private business operating across Auckland and the Waikato. One of my team has been regularly working really late, missing deadlines and consistently talks about feeling tired because he is not sleeping well.

I had recently been on a management course on mental health and well-being. This taught me what to be aware of and how to be an effective manager in these situations. This is a mandatory course for all managers as part of the new WorkSafe health and safety at work regulations. During the course I had been surprised to learn just how common mental health conditions are and instantly realised that I had been slow to pick up these issues in many staff I had previously managed and even when I had, I had been unsure of my role.

The course was really helpful, and using what I had learnt along with my previous experiences, I found time to talk to my team member in a private, informal environment. I focused on how much we value him, I outlined my recent concerns about his change in behaviour and in particular his lack of sleeping. I encouraged him to talk to his GP and also to mention to the GP that him and I had spoken, so that the GP would be aware of the support available from his employer. Over the next day or so, I checked in with him to see if he had made an appointment yet. The following week he came to me and we discussed his consultation. They had talked about his symptoms and the GP had also discussed his working life identifying both the supportive as well as the challenging aspects of his job and how that might be affecting his health. The GP considered that on balance being at work with some adjustments and flexibility would be better than being off work.

Together with the GP we developed a ‘working wellness plan’, this plan is standard practice in our workplace for both physical and mental health issues and is developed for pre-existing conditions as well as new ones. The focus is on what each of us, the individual, the GP and the employer (particularly the line manager) can do to support the person to stay at work.
4. The people involved

This strategy has been developed following discussions and presentations with the following individuals, organisations and stakeholder groups. Thanks are extended to everyone for their contribution to the strategy and action plan.

Steering Group members:

Warren Elwin, Ian McKenzie, Lee Reygate, Rob Warriner, Ruth Williams, Maria West.

Project Manager:

Helen Lockett

Organisations and stakeholder groups:


“What about all the people who don’t need to use specialist mental health services? They are often supported by their GP or an NGO – or both. Where do they get appropriate employment support services from when they need it?”

DHB provider
When I arrived at the addictions team I was rock bottom, no self-esteem or self-worth, the things I had done, I was pretty embarrassed by some of them. I wanted to change but when you don’t think your life has any value it’s hard. During my assessment my key worker asked about the usual stuff but then asked me; “...what kind of work do you do?” She went on to ask about my aspirations for the future, including whether I wanted support to go to work. When they said that I knew then that they thought I could actually beat this thing and weren’t just saying that I could do it because they were paid too. It hasn’t been plain sailing and I’ve had relapses but work gave me a reason to get sober and try to stay that way without it I’m not sure I’d have bothered. It’s also given me structure, routine, money and makes me feel valued as an individual but perhaps most importantly it has given me a whole new social circle so I now have friends who aren’t using. My clinical team have focussed my whole care around work, they meet me outside of my working hours and they talk about maintaining wellness and identifying possible triggers at work. We met every six months with the employment consultant, case worker and psychiatrist to talk things through, I’ve been doing so well that my GP is coming to the next one as they’re taking over my care.

“If we are serious about recovery oriented care, then conversations about employment should be an important part of clinical conversations.... from the inpatient unit to meeting my NGO support worker”.

*Person with lived experience*
5. Everyone’s Business Champions

To support the oversight and implementation of this strategy, a number of champions have been identified. They are people with a particular commitment to and energy for bringing about the needed changes and come from across the stakeholder groups. They will do this in their day to day working roles and for some through their participation in the Everyone’s Business Implementation Group (EBIG).

Q1: Should this be a new group made up of some of the suggested people below or could the oversight of this strategy lie within an existing multi-agency forum? If so, how can we make sure wider stakeholders, like primary care and employers, are involved?

Helen to contact individuals and ask if they would like to be an Everyone’s Business champion. Q2: Is there anyone else people feel should be asked?

Rob Warriner (Walsh Trust)
Warren Elwin (Workwise)
Lee Reygate (DHB Planning and Funding)
Leigh Murray (Family/Whānau)
Magdel Hammond (Consumer Advisor)
Ian McKenzie and Maria West (ADHB and WDHB) (co-chairs)
Ruth Williams (ConnectSR)
Johnny O’Connell (Procare PHO)
Lynne Edmonds (ADHB)
Don Mackinven (WDHB)
Andrew Blackburn (Consumer Advisor, WDHB)
MSD

If you want to get more involved in Everyone’s Business or you want to know how implementation of the action plan is progressing then talk to one of these champions.

“One size doesn’t fit all, we need a range of support services”.

DHB provider.
6. The Action Plan

One of the most important things about this action plan is that all the stakeholders who are identified as taking a lead for action areas have agreed to them and have also agreed to providing feedback on a regular basis to the Everyone’s Business Implementation Group. This is crucial as the actions in one area have an impact on other areas and progress therefore needs to be monitored on a regular basis.

The action plan sets stretching but realistic objectives. In the most part these are obtainable within existing financial and human resources and where not, there will be a need to identify additional resource.

“We want to be operating as a whole system with multiple doors to increase access to employment support services”

NGO employment support providers.
### The Action Plan (to be reviewed and updated annually by the Everyone’s Business Implementation Group)

<table>
<thead>
<tr>
<th>Where we want to be in 2020</th>
<th>Where we are in 2015</th>
<th>Accountability</th>
<th>Who else needs to be involved?</th>
<th>Achieved by</th>
<th>Deliverables (what success will look like)</th>
</tr>
</thead>
</table>

#### A. Understand the employment status of people in contact with secondary mental health and addiction services

| Reliable data on employment status captured on first contact with specialist MH&A services | Some basic information but data is missing or incomplete | DHB MH&A provider arm, DHB MH&A planning and funding | DHB provider arms and NGO providers | June 2016 | Data on employment status is available for at least 90% of people accessing MH&A services. |

#### B. Increase access to employment support service provision across the mental health, addiction and primary care services

<table>
<thead>
<tr>
<th>Greater availability and access to ESS</th>
<th>ESS is patchy – available for some groups and not for others</th>
<th>NGOs, DHB MH&amp;A provider arm, DHB MH&amp;A Planning and Funding</th>
<th>PHOs</th>
<th>Incremental increase each year to achieve full coverage in 2020</th>
<th>Service mapping across the regions is completed annually; gaps for populations identified. A year on year increase in availability and access to employment support services (as measured by the service mapping). There is an increase in the number of NGO providers of non-clinical support hours including Employment Specialists within these teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joined up commissioning: health and welfare</td>
<td>Single contracting by each individual government agency</td>
<td>MSD, DHB MH&amp;A Planning and Funding</td>
<td>PHOs, MoH, ACC</td>
<td>December 2016</td>
<td>At least one single integrated contract has been drawn up and service delivery is underway.</td>
</tr>
<tr>
<td>Good awareness and understanding of ESS across all parts of the sector including individuals and family / whanau, peer workforce, clinical services, NGO and community providers and MSD</td>
<td>It is hard to know who delivers services to whom where</td>
<td>NGOs, DHB MH&amp;A provider arm, DHB MH&amp;A Planning and Funding, Regional Work &amp; Income</td>
<td></td>
<td>December 2016</td>
<td>Service mapping is completed and information is hosted on the relevant health information web portals/sites. Annual service user and service provider questionnaires include questions about knowledge of local employment support services. A year on year increase in knowledge is reported.</td>
</tr>
</tbody>
</table>
### C. All health services apply the practices of work focused health care to support people to return to and stay at work

<table>
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<td>C. All health services apply the practices of work focused health care to support people to return to and stay at work</td>
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</tr>
<tr>
<td>Everyone working across mental health and addictions services is committed to employment support as an integral part of recovery focused services</td>
<td>Although there are pockets of good practice it is not something that is routinely part of health services</td>
<td>NGOs, DHB MH&amp;A provider arm</td>
<td>DHB MH&amp;A Planning and Funding</td>
<td>December 2016</td>
<td>Annual staff surveys to include questions on employment and mental health. A year on year improvement in knowledge, attitudes and practice is reported. Increased referrals to employment support services are reported.</td>
</tr>
<tr>
<td>Policies and processes within organisations reflect work focused health care, including treatment and care planning</td>
<td>Absence of work-focused healthcare across most parts of the system</td>
<td>NGOs, DHB MH&amp;A provider arm</td>
<td></td>
<td>December 2016</td>
<td>All providers of MH&amp;A services in the region have reviewed and updated their policies and processes to reflect the principles and vision of Everyone’s Business. Annual service user surveys or real time feedback include questions on whether people would like support to return to work and whether they have received support with returning to work. A year on year increase in vocational aspirations and % receiving support is reported. All MH&amp;A services include training on employment and mental health as part of continuing professional education.</td>
</tr>
</tbody>
</table>

ESS – Employment support services; MH&A – mental health and addiction services
References


4.3 Child, Youth and Women’s Health

Recommendation

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

Prepared by: Ruth Bijl (Funding and Development Manager - Child, Youth and Women’s Health), Natalie Desmond (Senior Programme Manager - Child Health), Pam Hewlett (Programme Manager - Women’s Health), Dr Karen Bartholomew (Public Health Physician), Dr Tim Jelleyman (WDHB Community Paediatrician) and Dr Alison Leversha (ADHB Community Paediatrician)

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

Glossary

ARDS - Auckland Regional Dental Service  
BPS - Better Public Service  
CHIP - Child Health Improvement Plan  
CPHAC - Community and Public Health Advisory Committee  
CYF - Child, Youth and Family  
DHB - District Health Board  
DHW - Design for Health and Wellbeing (DHW) Lab  
EEG - Early Engagement in Pregnancy Care Group  
HEEADSSS - Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety  
HPV - Human Papilloma Virus  
IPIF - Integrated Performance Incentive Framework  
ISP - Independent Service Providers for cervical and breast screening  
LMC - Lead Maternity Carer  
MACSAG - Metropolitan Auckland Cervical Screening Advisory Group  
MQSP - Maternity Quality and Safety Programme  
NIR - National Immunisation Register  
NMMG - National Maternity Monitoring Group  
NSU - National Screening Unit  
OIS - Outreach Immunisation Service  
PHO - Primary Health Organisation  
PMS - Practice Management System  
RhF - Rheumatic Fever  
SALT - Service Alliance Leadership Team  
SBHS - School Based Health Service  
WCTO - Well Child Tamariki Ora

1. Summary

This report presents information on significant health outcomes for children, youth and women. The report is in the form of a scorecard. The indicators cover the life-course of maternity, child and youth health, as well as women’s health. All indicators are presented as a Total with breakdowns by Maori, Pacific and Asian ethnicity. The narrative presents highlights, key issues and discussion in relation to items that are not on track.
### Auckland and Waitemata DHBs Child, Youth and Women’s Health Scorecard

#### October 2015

<table>
<thead>
<tr>
<th>Priority 1: Health Targets - Auckland DHB</th>
<th>Priority 1: Health Targets - Waitemata DHB</th>
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<tbody>
<tr>
<td><strong>Fully immunised by 8 months</strong></td>
<td>Actual</td>
</tr>
<tr>
<td>Auckland DHB</td>
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</tr>
<tr>
<td>Auckland DHB</td>
<td>95%</td>
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<tr>
<td>Waitemata DHB</td>
<td>95%</td>
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</table>

| **Rheumatic Fever rate** | Actual | Target | Period |
| Auckland DHB | 1.60 | ✔️ | 2014/15 |
| Waitemata DHB | 1.30 | ✔️ | 2014/15 |

### Children

#### Fully immunised by 8 months

- Auckland DHB: 95%
- Waitemata DHB: 95%

#### Fully immunised by 2 years

- Auckland DHB: 95%
- Waitemata DHB: 95%

### Breastfeeding - % exclusive or fully breastfed at discharge from LMC

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<tr>
<td>Total</td>
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<tr>
<td>Other</td>
<td>76%</td>
<td>✔️</td>
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### % of women smokefree at delivery

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<td>Total</td>
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<tr>
<td>Other</td>
<td>98%</td>
<td>✔️</td>
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### Oral health - % babies enrolled with a PHO by 18 months

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<td>Q4 2014/15</td>
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### Oral health - % utilisation by 1 year

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<td>Other</td>
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### Before School Check coverage rates

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Youth
HPV immunisation coverage (dose 3)
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Oral health: Adolescent utilisation rates

HEAADS coverage in DHB funded school health services
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<td>80%</td>
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<td>Other</td>
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HPV immunisation coverage (dose 3)
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<td>65%</td>
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Oral health: Adolescent utilisation rates

HEAADS coverage in DHB funded school health services
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Oral health: Adolescent utilisation rates

HEAADS coverage in DHB funded school health services
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<th>100%</th>
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<td>95%</td>
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<td>Other</td>
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Women
Cervical screening rate (25-69 years: 3 year coverage)
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<th>100%</th>
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<td>Total</td>
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<td>Jun-15</td>
</tr>
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<td>56%</td>
<td>80%</td>
<td>Jun-15</td>
</tr>
<tr>
<td>Pacific</td>
<td>81%</td>
<td>80%</td>
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<td>Other</td>
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Cervical screening rate (25-69 years: 3 year coverage)
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<tr>
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<tr>
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<tr>
<td>Pacific</td>
<td>72%</td>
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Cervical screening rate (25-69 years: 3 year coverage)
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Cervical screening rate (25-69 years: 3 year coverage)
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<th>Ethnicity</th>
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<td>80%</td>
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<tr>
<td>Other</td>
<td>68%</td>
<td>80%</td>
<td>Jun-15</td>
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</tbody>
</table>

Indicators Title
85% | 100% | Improvement against previous result
Actual Performance Target

How to read
"Other" represents all ethnicities not otherwise specified. Generally this means NZE and all non-Māori, Pacific and Asian ethnicities (depending on level of data available).

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 14/10/15
2. **Highlights and key issues for Children, Youth and Women**

- The confirmed first quarter results for the immunisation health target will be provided verbally to the Committee. We anticipate that ADHB will achieve the 95% target but that WDHB will not. Data as of 26 September 2015 shows that 93% of all 8 months old infants were fully immunised in WDHB. As previously seen, the 95% target is being achieved in both DHBs for Pacific and Asian infants but not yet being achieved for Maori infants.

- We provided a full report on Rheumatic Fever (RhF) to the Committee in September. We are working on the re-freshed RhF plans which are due to the Ministry this month. We have identified that, while most elements are meeting expectations, we need further improvements in Rapid Response services. We will continue to work with PHOs to better embed a rapid response in primary care. ADHB did not achieve the 2014/15 target and WDHB partially achieved the target. However, as previously noted small number variations makes this difficult to assess.

- The smoking cessation incentive programme for pregnant women has started.

- As previously communicated, the B4 School Check programme achieved targets (90%) for all groups.

- We cannot yet report Youth Health assessments by ethnicity, but data is now being reported by ethnicity.

- We have met with Auckland Girls Grammar School leadership who are very positive about working with the DHB to establish an Enhanced School Based Health Service for their students.

- While only very minor improvements in cervical coverage can be seen so far, PHOs are working very collaboratively and are fully engaged in discussions regarding how to increase coverage. The Ministry of Health has recently launched a consultation document which may signal changes to be made to the screening pathway including use of HPV testing and a potential change to the screening interval.

3. **Activity in detail**

3.1 **Immunisation**

The 8 months immunisation health target (to complete three immunisations due at six weeks, three months and five months to protect against diphtheria, tetanus, pertussis, polio, hepatitis B, haemophilus and pneumococcal diseases) is 95%. The target is reported quarterly, against all infants who turn 8 months in that quarter as recorded by the NIR. As of 26 September 2015, Auckland DHB achieved 95% (1% increase) and Waitemata DHB achieved 93% (no change). We expect ADHB to achieve the end of quarter coverage target and will report the confirmed end of quarter results to the Committee verbally.

As previously reported, delayed availability of influenza vaccine this year added to workforce pressure for primary care and other immunisation services to achieve rapid rollout of vaccinations prior to influenza season.

One PHO did not achieve the end of year target. Auckland PHO is working against a plan to achieve the target.
A communications campaign promoting on-time immunisation is underway. The Ministry of Health has identified Waitemata DHB as one of four DHBs nationally for an additional targeted campaign that includes social media promotions as well as postcard mail-outs.

There appears to be a positive shift in coverage at five years of age, with a particularly notable increase of six percentage points to 81% for Maori children in ADHB and three percentage points to 77% for WDHB children. Pacific rates have increased six percentage points to 83% in ADHB and by one percentage point to 81% in WDHB.

3.2 Rheumatic Fever
The refreshed RhF Prevention Plan (RFPP) is being prepared. Changes include enhancements in governance, Rapid Response and health literacy/community engagement in particular.

The DHB is required to submit the Plans to the Ministry on 20 October. The process then involves feedback from the Ministry and potentially revision by the DHB, before the Plans are submitted to the Minister of Health to approve.

As ADHB did not achieve the target, we are also required to submit a resolution plan to the Ministry. This will be in line with the refreshed plans.

3.3 Early Pregnancy Care Engagement
The early pregnancy care indicator is the percentage of women who register with a Lead Maternity Carer (LMC) in the first trimester of their pregnancy. The target has been set at 80%. The latest data from the Ministry (2014) shows WDHB slightly ahead of the national average at 69% and ADHB slightly behind the national average on 67.5% both around 2 percentage points above last year. We do not yet have the ethnicity breakdown information from the Ministry.

As previously reported, activities to improve engagement with an LMC within the first trimester are coordinated under the regional Early Engagement in Pregnancy Care Group (EEG). The focus of the group is to ensure all women receive quality early pregnancy care, particularly priority women. This goes beyond LMC registration and includes care provided by GPs and the relationship between GPs and LMCs. One strand of EEG work includes a survey of GP current practice (service delivery, models of care and funding). The survey is currently in the field. Another key strand is the completion of the first trimester clinical pathway for GPs. This is currently out for further consultation. Narratives demonstrating examples of successful GP/LMC relationships will also be promoted via Healthpoint.

3.4 Maternal Smokefree
The current focus of activity is on strategies for Māori women (as noted in the scorecard the percentage of Māori women smoke free at delivery is much lower than for the total population at 66% for Auckland compared to 95% and 73% for Waitemata compared to 93%). The smokefree coordinator now sits in the Māori Health Gain Team and is focusing on the project to incentivise pregnant women to quit smoking. The incentives programme will begin in October. The providers are Auckland DHB Pregnancy Services, ARPHS – Pacific Quit Smoking Service and Waitemata PHO. Anyone can refer to the programme including friends.

3.5 Breastfeeding
Exclusive breastfeeding is recommended up to 6 months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond. Focus groups have been undertaken with young pregnant women/new mothers as well as with Maori and Pacific mothers.
The general theme from all focus groups is that mothers who give up breastfeeding before 12 weeks often do so due to lack of support from professionals and family members. To enhance breastfeeding rates additional support is required both in terms of practical help with household chores and professional advice on breastfeeding technique. Combined midwifery and Well Child nurse education/training will be implemented to ensure women receive consistent evidence based breastfeeding information. Additional breastfeeding support is being provided in the Auckland DHB region through the implementation of community breastfeeding clinics. The clinics will be collocated with Well Child and maternity and will target priority women. Waitemata DHB provides breastfeeding support through DHB located clinics.

3.6 PHO enrolment

Enrolment of babies with a general practice and PHO is measured at three months of age. Work is underway to increase enrolments in a number of areas including with PHOs. We are working towards an electronic solution, but at this time remain reliant on somewhat manual processes. We have developed an information form informing new mothers that their contact details will be shared with a range of providers in order that the service can offer them services for which their baby is eligible. No health information will be shared through this process. Testing of the information brochure is underway. Each service will still need to contact, engage and enrol infants.

3.7 Oral health

Last report, we were unable to report against the oral health enrolment indicator due to data integrity problems. This issue has been resolved, however enrolment and utilisation measured at the first year is low. While appointments are routinely made for children at or before one year, the DNA rate for this cohort is very high and the service is currently investigating alternative ways to see these children at a time when teeth are just emerging. The main purpose of engagement at this age is to provide education to parents to establish good oral health habits and prevent the development of caries.

We note that the target set is DHB specified and the Ministry target is for pre-school enrolment. However, statistics show decay sets in early, suggesting the need for engagement and preventive action also needs to start earlier, hence the DHB measures of enrolment and utilisation at one year of age. Graph 1 shows decay free by children at ages up to five years for Maori, Pacific and Other in WDHB. The decline in decay free teeth shows a similar pattern in ADHB children (Graph 2). Note, the percentage is children seen and the number of children seen is very low in the first two years, with Maori and Pacific children seen less commonly than other groups of children.
Auckland Regional Dental Service (ARDS) has recently implemented an enrolment strategy that was partially effective in WDHB within ADHB of a maternity ward enrolment approach. Other initiatives include:

- Matching of birth list data.
- Inclusion of Oral Health in the WDHB/ADHB Multi enrolment information sheet.
• Enhancing consistency of messages to parents regarding value of under two years of age dental checks.
• Referral using Well Child Tamariki Ora – My Health Book by well child providers at five months
• First dental appointment around first birthday, noting the MoH target is by two years of age.
• Children with high decayed, missing and filled teeth scores identified and targeted for preventive care.
• Working with the Ministry to provide tooth brushes and paste to targeted families and children with high dental needs. May need additional resource to cover all children, replacements, family focus and reduce sharing of tooth brushes.

Auckland Regional Dental Service, with funding from the Ministry of Health, has also been running a pilot programme providing oral health care to pregnant women from deprived communities. In addition to the health benefits to the pregnant woman, they expected to increase enrolments of infants of these women. ARDS will be preparing a paper for the Audit and Finance Committee regarding continuation of this programme for high needs pregnant women and extending the service to pregnant women in ADHB.

3.8 Youth

HPV immunisation coverage for Year 8 young women, oral health utilisation and the number of HEEADSS assessments as a proportion of Year 9 students in the DHB funded enhanced school based health service programme are reported as the Youth indicators in the scorecard.

HPV immunisation results are essentially the same as those reported in the last scorecard. ADHB has achieved the coverage target for all ethnicities. This is an outstanding achievement. WDHB has achieved the target for Pacific but no other groups. They have however made significant improvements over time and are getting closer to achieving the 65 percent dose three coverage target. The Ministry of Health has recently signalled their intent to refresh this immunisation programme.

Neither DHB is achieving the oral health target of 80 percent of young people being seen, with ADHB at 76% and WDHB at 66%. Regionally, the governance of oral health is being reviewed with a view to separating out operational business and strategic direction. In ADHB there has been a 13% increase in the adolescent population with an increase in utilisation but a decrease in percentage utilisation from 85% in 2014 to 76% in 2015. In WDHB the total population has reduced slightly while the utilisation rate has increased slightly from 65% in 2014 to 67% in 2015. An analysis of geographic areas is due to be undertaken. This will indicate where utilisation rates are low and further initiatives will target these areas. Currently all low decile schools and all other schools which have agreed to have mobiles, have a mobile service in place.

We hope to be able to bring the Committee end of term three data on HEEADSS assessment coverage during the meeting. The scorecard presents data on activity for the first two terms of the calendar year. Progress is in line with expectations, with ADHB ahead of WDHB as the WDHB service is still developing capacity. We are also pleased to inform the Committee that a new enhanced school based health service will be established in Auckland Girls Grammar.

3.9 Cervical screening

While there is little change in cervical screening coverage since our last report, we have seen a 1% increase for Maori, Pacific and Asian women in both DHBs. PHOs are engaged and working cooperatively to increase uptake of cervical screening especially for priority women. Initiatives
include further detailed understanding and leveraging of data plus consideration of employing more nurse smear takers. Procare is also supporting screening through church led initiatives that will also be available for non Procare enrolled women. Other PHOs are moving away from campaigns/projects to looking at a systems improvement approach. This includes having dedicated rooms in clinics for opportunistic screening, training for non-clinical staff on invitation and recall and weekly targets.

The Ministry of Health has recently initiated a consultation on HPV testing as part of the screening pathway. This would also potentially see changes to the screening interval (from three years for most women to five years). The five year coverage rates are provided below. These show that overall coverage is relatively high 94% in ADHB and 88% in WDHB compared with 91% nationally, but both Maori and Asian women are less likely to be screened. This reinforces the ongoing need to focus strategies around Maori women in particular. Note that as we don’t have a population database, these rates are at best an estimate of coverage and that an adjustor is made to the denominator to attempt to reflect hysterectomy rates.

**Graph 3: NCSP 5 year coverage rates by ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>72%</td>
<td>69%</td>
</tr>
<tr>
<td>Pacific</td>
<td>103%</td>
<td>87%</td>
</tr>
<tr>
<td>Asian</td>
<td>78%</td>
<td>72%</td>
</tr>
<tr>
<td>European/Other</td>
<td>105%</td>
<td>96%</td>
</tr>
<tr>
<td>Total</td>
<td>94%</td>
<td>88%</td>
</tr>
</tbody>
</table>

### 3.10 Breast screening (50-69 years: 2 year coverage)

Q4 coverage has remained stable for Māori and Pacific women in the Auckland DHB region. Maori coverage is 62% down 1% and Pacific coverage whilst continuing to meet the 70% target is down 1% to 75%. In the Waitemata region coverage is lower for Maori women dropping 1% to 59%. For Pacific women the rates are unchanged at 77%. Extra activity is required to engage with Māori women especially in the Waitemata region. A key strategy to identify unscreened and under screened women is through Lead Provider/PHO data matching; an agreed pathway is being developed by the PHOs.

**Number of Māori women required to reach 2 year coverage target for breast screening (at June 2015), by DHB**

<table>
<thead>
<tr>
<th>DHB</th>
<th>Eligible women</th>
<th>2 year coverage 50-69 years %</th>
<th>2 year coverage actual number of women</th>
<th>Number of women needed to reach 70% target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>3,290</td>
<td>62.4%</td>
<td>2,054</td>
<td>259</td>
</tr>
<tr>
<td>Waitemata</td>
<td>4,220</td>
<td>58.8%</td>
<td>2,482</td>
<td>472</td>
</tr>
</tbody>
</table>

Source: National Screening Unit (NSU)
4.4 Proposed Building (Pools) Amendment Bill 2015

Recommendation

That the Community and Public Health Advisory Committee:

a) Receive this report.

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

Prepared by: Jane McEntee (General Manager, Auckland Regional Public Health Service)
Endorsed by: Simon Bowe (Director Health Outcomes)

Glossary

- ARPHS - Auckland Regional Public Health Service
- Bill - Building (Pools) Amendment Bill 2015
- DHB - District Health Board
- FoSP Act - Fencing of Swimming Pools Act 1987
- CPHAC - Community and Public Health Advisory Committee
- MBIE - Ministry for Business, Innovation and Employment

1. Executive Summary

This paper provides the Community and Public Health Advisory Committee (CPHAC) with:

- a description of the proposals in the Building (Pools) Amendment Bill;
- an update of the Bill through the Parliamentary process; and
- commentary from Auckland Regional Public Health Service (ARPHS).

2. Background

In March 2013, the Ministry for Business, Innovation and Employment (MBIE) published a consultation document, Making Pool Safety Easier, containing proposals to reduce compliance costs associated with the Fencing of Swimming Pools Act 1987 (FoSP Act) while maintaining child safety.

In the foreword to the consultation paper the then Minister for Building and Construction, Hon Maurice Williamson, stated:

"It's time to review (the FoSP Act) to see if we can still achieve reduced drownings but also reduce some of the dreadful compliance costs... This review is not about exposing young children to more risk of drowning, but is our chance to get more workable rules that are supported by pool owners, councils, and water safety groups... Please ask yourself whether MBIE's proposals strike an acceptable balance between protecting young children from drowning and the practicality of the rules of pool owners and councils... Remember there will always be a risk of drowning as long as we have swimming pools".

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 14/10/15
The consultation paper had outlined a number of issues with the FoSP Act, including:

- The term ‘swimming pool’ is unclear and councils are required to decide – based on the circumstances – whether it includes a garden pond, irrigation pond or stormwater retention lake.
- The requirements for restricting access to the pool are confusing and inflexible.
- It is difficult to determine where the fence must be located, and the location is sometimes impractical (for example, for properties with very small outdoor areas).
- Children have a higher risk of drowning when a door opens from the house to the pool.
- Many owners are unaware of (or neglect) basic maintenance needed to keep their fence childproof.
- There is no national consistency in the way councils check pools to ensure they continue to comply with the FoSP Act.
- Councils have few enforcement options other than prosecuting uncooperative owners.

MBIE also noted that these issues are exacerbated by social and technological changes since 1987, when the Act was passed: traditional quarter-acre sections are being replaced by denser urban living, technologies for restricting access have evolved, and spa pools and other portable pools have become more affordable.

Examples include:

- childproof spa pools, which are simple to make childproof to industry standards. Some councils exempt such pools via a costly exemption process, while other councils require the owner to fence them
- portable pools deeper than 400mm, such as deep inflatable pools: people often put up such pools without installing a fence, and councils find it difficult to locate them and enforce the fencing requirement.

In 2013 ARPHS provided a submission to the consultation process emphasising the points made by the Paediatric Society in that drownings have reduced from 10 to 3 since the inception of the FoSP Act, thereby underlining its importance and effectiveness.

3. Building (Pools) Amendment Bill

The Building (Pools) Amendment Bill (Bill) will amend the Building Act 2004 and repeal the Fencing of Swimming Pools Act 1987 to reduce the compliance burden currently imposed on pool owners and territorial authorities in relation to residential pools while maintaining child safety.

This Bill aims to remove these aspects from pool safety legislation and increase child safety by:

- deeming child-resistant covers on spa pools and hot tubs to be an adequate means of restricting access, without requiring spa pools or hot tubs to have an additional means of restricting access
- clarifying that councils should inspect swimming pools 5-yearly to ensure that owners maintain the means of restricting access to their pools
- replacing the current offence provisions involving court prosecutions with a more cost-effective graduated enforcement regime that includes prosecutable offences

- relying on performance-based standards in the Building Code to specify the requirements for restricting access to pools, rather than the current duplicate and inconsistent requirements

- requiring retailers and manufacturers to inform buyers about their obligations under the Act when they buy spa pools, hot tubs, and portable pools, so as to encourage voluntary compliance underpinned by the new enforcement regime, rather than relying on councils to locate and inspect all spa pools, hot tubs, and portable pools.

It is estimated that the changes in this Bill will result in a $17 million (net present value) reduction in compliance costs, mainly because spa pools and hot tubs with child-resistant covers will no longer need another means (for example, a fence) to restrict access, and the possible avoidance of a further 6 drownings every 10 years through the periodic inspection regime.

4. The Bill’s progress to date

The Bill was introduced to the House of Representatives on 9 September 2015. The first reading was on 16 September 2015 and has been allocated to the Local Government and Environment Select Committee with instructions to report back to the House 16 March 2016.

The Select Committee have requested submissions from the public due 5 November 2015.

5. General and initial commentary from ARPHS

Our preliminary areas of focus of the draft Bill are:

- Ensure the objective to reduce compliance costs does not erode child safety.

- The Ministry of Business, Innovation and Employment state there is considerable uncertainty surrounding the estimates used in its options analysis. We would therefore clarify the cost-benefit analysis, its underlying assumptions and data surrounding the estimated number of lives saved (or relative risk) as a result of compliance cost reduction.

- We understand that the existing Act is applied inconsistently across different Councils and can be interpreted in different ways. This confusion is to be addressed in the proposed Bill. ARPHS would support consistent application of legislation, rules and regulations across the country.

6. Comment on any management implications for DHB Pools from Facilities

The Group Manager Facilities and Development has confirmed that WDHB and ADHB pools (for example at the Mason Clinic) meet the requirements of the existing legislation. The proposed new legislation would not impact on how the DHBs control them from a safety perspective.

7. Conclusion

The Building (Pools) Amendment Bill is currently at the Local Government and Environment Select Committee stage. The Select Committee has requested submissions due by 5 November 2015, with a report back to Parliament required by 16 March 2016.
ARPHS will continue to consider the wider implications of this Bill and engage with other organisations such as WaterSafe Auckland, Safekids New Zealand and the Paediatric Society.
5.1 Planning, Funding and Outcomes Update

Recommendation

That the report be received.

Prepared by: Wendy Bennett (Manager - Planning and Health Intelligence), Tim Wood (Funding & Development Manager – Primary Care; Acting Funding & Development Manager – Mental Health & Addictions), Ruth Bijl (Funding & Development Manager – Women, Children & Youth), Kate Sladden (Funding and Development Manager - Health of Older People), Aroha Haggie (Manager - Maori Health Gain), Lita Foliaki (Manager – Pacific Health Gain), Samantha Bennett (Manager – Asian, Migrant & Refugee Health Gain), Jane McEntee (General Manager - Auckland Regional Public Health Service)
Endorsed by: Dr Debbie Holdsworth (Director Funding), Simon Bowen (Director Health Outcomes)

Glossary

ARPHS - Auckland Regional Public Health Service
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
HBSS - Home Based Support Services
MoH - Ministry of Health
NASC - Needs Assessment and Coordination
RFP - Request for Proposals
TF - Transitional Facilities
VTA - Vertebrate Toxic Agents

Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata District Health Boards’ (DHB) planning and funding activities and areas of priority, since the last meeting on 2 September 2015. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting’s agenda.

1. Planning

1.1 Annual Plans

Both the Auckland DHB and Waitemata DHB Annual Plans for 2015/16 have been signed and will be published shortly.

1.2 Annual Reports

The Auckland and Waitemata DHB 2014/15 annual reports are nearing completion. Final drafts are being presented to the respective Audit and Finance committees for approval in early October.

1.3 Health Needs Assessment

Development of the Health Needs Assessment continues, with demographic profiles close to finalisation and a disease-specific summary for cardiovascular disease under way.
1.4 Engagement

A stakeholder engagement event took place to gain feedback on draft content of the Waitemata DHB Health Services Plan. Over 60 stakeholders attended the event which included representation from PHOs, a range of NGOs, other agencies such as ministries of Social Development and Education, ACC and the police plus consumer representation both through health links and through DISAC and CPHAC representatives. Feedback from the event is being considered alongside internal feedback as the development of the Waitemata DHB Health Services Plan continues.

A consumer representative forum is being organised in partnership with Health Links to take place on 5 November. The purpose of the forum is to ensure we have the right support and training in place for consumer representatives; provide them with an opportunity to meet each other; and for them to share their experiences of working with the DHB to hear what we could be doing better and how we could make best use of consumers’ insights and time.

2. Health of Older People

2.1 Home and Community Support Services (HCSS)

The Joint Auckland and Waitemata Working Group on HCSS has agreed overarching principles for HCSS, a redesigned patient pathway and a single set of performance measures. However, due to different configurations and systems in each respective provider arm, completed alignment has not been achieved and it has been proposed that different procurement processes are used at each DHB.

Recommendations from the Director General’s Report on HCSS are expected in the next few weeks and could have some bearing on the design of the HCSS models and the procurement processes.

2.2 Aged Related Residential Care (ARRC)

The annual review of the ARRC Agreements is underway and DHBs have until the end of October to identify issues, which will then be prioritised by the Review Group. The review will concentrate on those issues linked to the strategic priorities areas – palliative and end of life care, integration of services for ARRC residents (primary care, community pharmacy and ambulance services) and technology.

3. Maori Health Gain

3.1 Smoking cessation

The Maori Health Gain Team is leading the development and implementation of an evidence based incentives programme to support pregnant mothers to become and stay smokefree. The programme offers pregnant mothers who smoke an incentive to quit smoking followed by further incentives to stay smokefree. The 20-week programme consists of two weeks focusing on initial engagement, 16 weeks focusing on key milestones to quit smoking during pregnancy and a further two weeks post-partum. The Programme was endorsed by Waitemata DHB Board and will be launched in October 2015.

3.2 Kaumatua Action Plan

The Kaumatua Action Plan outlines the activities Auckland and Waitemata DHBs will undertake over the next three years to improve health outcomes for Maori 65 years and over. The Plan was
presented to both Auckland and Waitemata DHB Board’s and received endorsement. We are in the process of implementing year one actions.

3.3 Cardiovascular rehabilitation

The Maori Health Gain Team is leading the development of a framework for phase two cardiac rehabilitation in the community. The framework has been drafted and is being reviewed by the Northern Regional Alliance Rehabilitation Network.

4. Pacific Health Gain

The implementation of Pacific Health Action Plan (PHAP) is on target for Priorities 1 – 5.

4.1 PHAP Priority 1 – Children are safe and well and families are free of violence

Two Incredible Years parenting programmes will be implemented in Q2, in a Samoan and a Tongan church on the North Shore. Training of facilitators to run Living Without Violence programmes in churches / communities took place. The first programme is being implemented in a Samoan church in Auckland central. A Working Group is developing the programme in the Tongan language and the first Tongan language programme will be implemented in a church in Ranui in Q2.

The Healthy Babies Healthy Futures (HBHF) contracts for 2015-16 has been agreed with providers. The service consists of a six module programme with a focus on practical skills and interactive learning.

4.2 PHAP Priority 2 – Pacific People are smoke-free

The WERO group smoke free competition is now provided by HealthWest. HealthWest has met with Enua Ola health committees in West Auckland. They are in a position to provide more practical support to groups who will join the competition.

4.3 Priority 3 – Pacific people are active and eat healthy

The annual weight loss competition for the Enua Ola programme has just completed and data is being analysed. The HVAZ Aiga Challenge started in the third week of September. Data from both programmes will be analysed for the three years that the competition has taken place. The data will be used to assess the success (or not) of the competition over the three period.

A meeting between the NZ Institute of Sport, HVAZ and Enua Ola programme manager and co-ordinators took place resulting in the Institute of Sport offering support for the training of physical activity instructors in the HVAZ/Enua Ola programme.

A meeting with the Active Families Co-ordinator from Sport Auckland also took place. The Active Families programme works with children aged between 5 yrs to 12 years and their families to increase levels of physical activity and improve nutrition. The programme is starting in Glen Innes. The Team is facilitating meetings between the co-ordinator and Pacific providers in the area and will also inform the HVAZ churches in the area.

4.4 PHAP Priority 4– People seek medical and other help early

The Parish Community Nursing service is progressing well. The number of people that the nurses have identified as having high blood pressure is concerning. They provide individualised education to
people and encourage that they see their GP. One person was taken to ED because her blood pressure was very high and she was admitted.

4.5 PHAP Priority 5 - Pacific people use hospital services when needed

A project to understand Pacific patient’s experience of hospital services has been initiated by the General Manager for Pacific Hospital Services. The Pacific Planning and Funding Team is involved and will focus specifically on the interface between hospital services and primary care/community services.

4.6 PHAP Priority 6 – Families live in houses that are warm and adequate

No further action has occurred with respect to this priority but the Ministry of Business, Innovation and Employment runs workshops on addressing the housing needs of Pacific people and the DHB Pacific Team participates in the workshops and will keep the Enua Ola and HVAZ networks informed.

4.7 General Comments

A review of the Enua Ola and HVAZ programmes is being undertaken. A Review Working Group, consisting of six community people from HVAZ and the Enua Ola programmes as well as Pacific providers has been established. Health committees will be consulted. The Enua Ola and HVAZ programmes were initially established to address increase physical levels and improve nutrition but other programmes have been added over the years. The health committees that organise the implementation of the programmes within the churches / community groups are voluntary. One of the key issues that will be explored by/through the review is the on-going viability of the programme based on volunteer work.

5. Asian, Migrant and Refugee Health Gain

The Asian & Middle Eastern, Latin American and African (MELAA) Health Governance Group agreed that the portfolio’s key goal is to increase health gain in targeted Asian, migrant and/or refugee populations where health inequalities impact on their health status in the Auckland and Waitemata District Health Boards (DHB). Key priorities for 2015-16 are set out below.

5.1 Increase the DHBs’ capability and capacity to deliver responsive systems and strategies to targeted Asian, migrant and refugee populations

Asian International Benchmarking Report - As part of the Health Needs Assessment (HNA) cycle, a benchmarking report is underway comparing health outcomes for Asian subpopulations around the world, in order to identify potential emerging areas that may impact on the health of specific Asian groups in Waitemata DHB and Auckland DHB catchments. The analysis will aim to cover health outcomes, important risk factors, health service use, and policy framework.

5.2 Increase Access and Utilisation to Health Services

Indicator: Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 80% (ADHB) and 84% (WDHB) targets by 30 June 2016 (current rates 78% (ADHB) and 82% (WDHB) as at 30 June, 2015)

- Asian PHO enrolment targets for 2014-15 were not met. In WDHB, there was a 1% increase from 81% to 82% which equates to 6,974 new enrolments with 7,200 new Asian migrants settling in WDHB.
• The Auckland Regional Asian and MELAA Primary Care Governance Group has agreed to increase the target by 2% from 82% to 84% for WDHB in 2015-16.

**Indicator:** Reduce admissions to the Emergency Department (ED) at Auckland City Hospital (ACH) for identified recent migrant and/or student populations

• A scoping paper has been developed to explore ‘Utilisation of ED at ACH and primary care services for recent migrants and students (international and domestic) in the Auckland district’. Concurrently, a survey to students has been rolled out to identify their ‘Awareness of health services and health information in the Auckland district’ to guide better understanding of attitudes and behaviours to health service access for students. The survey is available online across the three Auckland University of Technology (AUT) campuses, and online and via hardcopies (Chinese and Korean languages) at the two New Zealand Management Academies (NZMA) campuses. The survey will be made available across other university and training platforms shortly. The findings for this Project will guide the development of targeted interventions to these identified groups, particularly those living in the central business district (CBD) and inner city suburbs on appropriate pathways to primary and acute care.

**Indicator:** Increase opportunities for participation of eligible refugees enrolled in participating general practices as part of the Refugee Primary Care Wrap Around Service funding

• The Refugee Primary Care Wrap Around Service Agreements with PHOs are rolling out with identified general practices participating in the programme to offer subsidised culturally appropriate services to enrolled refugees within the practices. The Programme Manager - Asian, Migrant and Refugee (WDHB-ADHB) will provide onsite support to practices where necessary to address barriers to uptake of services experienced by the refugee populations or primary health workforce. An Operational Group for participating PHOs has been established to provide support and act as a platform for shared learnings and group discussion. Professional development opportunities were provided to frontline staff and primary health staff to upskill them on the soft skills and cultural competencies required to support refugee families at the practice level. They included:
  o Two receptionists training to frontline staff delivered in March and June 2015 (25 pax attended)
  o Three refugee health network forums on Women’s Health, Men’s Health and Youth Health delivered in May, August and November 2015 (120 pax attended)

**Indicator:** Increase the number of Indians who have a heart and diabetes check through targeted engagement

• Intent is to engage with partners reaching out to Indian communities in Auckland and West Auckland to raise awareness about heart and diabetes checks, and healthy lifestyle messaging via partner platforms in Q2/Q3.
6. **Auckland Regional Public Health Service**

6.1 **Submissions**

ARPHS has provided two submissions during September 2015.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 September</td>
<td><strong>Northern Corridor Improvement Project</strong></td>
<td>Public health issues include endorsing proposals for cycling and walking tracks</td>
</tr>
<tr>
<td>18 September</td>
<td><strong>Northern Interceptor Project</strong></td>
<td>Inputting into a resource consent project supplying quality water to the North West Auckland – benefits will be felt region wide</td>
</tr>
</tbody>
</table>

6.2 **Proposed Auckland Unitary Plan**

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

Throughout September, ARPHS has been involved in the following topics:

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Hearing or Mediation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 September</td>
<td>077 Sustainable Design</td>
<td>Hearing</td>
</tr>
<tr>
<td>7 September</td>
<td>051,052,053 and 054 Centre Zones, Business Parks, Activities &amp; Controls</td>
<td>Hearing</td>
</tr>
</tbody>
</table>

6.3 **Public Open Spaces**

At its meeting of 2 September 2015, CPHAC requested further detail regarding public open spaces. A copy of the one page ARPHS Public Open Spaces evidence statement is provided in the 058 – Hrg document, attached to this report as Appendix 1.

In the evidence statement, ARPHS supported explicit provisions for community gardens in public open spaces. ARPHS supports the inclusion of community gardens as a Permitted Activity in the Activity Table for all Public Open Space Zones.

ARPHS has submitted that this is beneficial for Auckland’s liveability due to:

- Developing community connection and resilience
- Developing skills in local food production and food preparation
- Improving nutrition and physical activity
- Contributing to local sustainable development
- Reduction of economic hardship
- Supporting community wellbeing programmes such as food banks, mental health and disability support services
Hearing for 051-054 Centre Zones, Business Parks, Activities and Controls

On 09 September, ARPHS team presented to the Hearing Panel on Centre Zones, Business Parks, Activities and Controls. This was the topic where we sought to protect social wellbeing through integrated control over alcohol and fast food retailing, as envisaged by the Auckland Plan.

Key points (high level legal points)

- Our evidence statements highlighted the importance of controlling the density and location of alcohol and fast food outlets in proximity to sensitive activities, particularly in areas of high social deprivation or need
- Urban planning is very much about density and location, and so our concern is within the scope of the Resource Management Act
- Social wellbeing is not yet addressed under the Proposed Auckland Unitary Plan, as envisaged by the Auckland Plan
- The Panel has an opportunity to recommend to Auckland Council rectify this omission

Comment

ARPHS evidence statements and responses to questions were generally well received by the Panel as it is unlikely to have extensively considered these types of issues (impacts on social wellbeing). The Panel is to report back with their findings to Council in July 2016.

In October, ARPHS will be involved in the following topics:

- Residential Zones, Policies, Activities, Development Controls
- Subdivisions
- Definitions

6.4 Housing Affordability

ARPHS’ original submission to the Unitary Plan (February 2014) discussed concerns about housing affordability. The evidence statement provided to the Hearing Panel in June emphasised the following:

- Links between affordable housing and health are well established. When housing becomes unaffordable, households make compromises in terms of size, quality or location. Unaffordable housing has public health costs. Overcrowding, damp and cold homes increases the risk of spreading infectious disease and has a high psychosocial toll. High housing cost leaves less residual income for other necessities, including heating, food, clothing and essential services.
- Relying on releasing new tracts of land with the expectation that the market will provide housing at an affordable price point will not solve the problem – this approach has not worked so far. Without any requirement or encouragement for affordable housing development, there will continue to be a mismatch between the houses that are being built (larger more expensively designed houses) and housing need (houses at an affordable price point). We agree with Council evidence on this.
- ARPHS supports the inclusionary zoning policies as contained in the Proposed Auckland Unitary Plan as one tool among a suite of tools, which could improve affordable housing
supply. We note that inclusionary zoning can be very successful at delivering affordable housing, as found in the United Kingdom through their Section 106 provisions.  

- ARPHS views the affordable housing policy as contained in the Proposed Auckland Unitary Plan (PAUP) as a pragmatic mix using both mandatory and voluntary tools. However, we strongly recommend that:
  - the level of the contribution be increased from 10% to 15% for greenfields development; with this contribution to be negotiated with developers for brownfields developments
  - the number of “affordable” units be rounded up rather than down
  - all dwellings that result as part of the policy be subject to a retention clause or covenant to preserve their affordability into the future.

ARPHS also referred the panel to the earlier submission from Professor Phillipa Howden-Chapman’s evidence to Topic 013: RPS Urban Growth provided on behalf of Housing New Zealand Corporation. That submission provides further evidence and analysis of the links between housing and health.

6.5 Council Adopts the Property Maintenance and Nuisance Bylaw

On Thursday 24 September, the Auckland Council Governing Body reviewed and accepted the report from the Hearing Panel on the Property Maintenance and Nuisance bylaw, thereby adopting the bylaw with ARPHS’ main submission points included. The result is a significant achievement for ARPHS, as this piece of work has been developed to address a significant failing in processes for Council regarding identification and shock treatment of industrial water cooling systems.

ARPHS submitted its support for:

- the proposed maintenance and registration regime for industrial water cooling towers,
- the adoption (where practicable) of the recommendations of the Christchurch Coroner’s report into legionella, and
- the inclusion of asbestos as a listed item in the interpretation section of materials and things within the bylaw.

During a 2012 Legionella outbreak, 17 people contracted the disease – with two fatalities. Processes to shock treat water cooling towers with suitable biocide became complicated due to the Council’s inability to locate water cooling towers across the region. This proved extremely sub-optimal and identified a gap in the Building Act 2004, where industrial water cooling towers fall out of scope for maintenance requirements as well.

A joint interagency working group had identified a bylaw as being an appropriate mechanism to put in place while work continues at central government level to remedy inefficiencies within the Building Act.

The new Property Maintenance and Nuisance bylaw now provides the powers for compulsory maintenance and registration of industrial water cooling towers in the Auckland region. This will enable Auckland Council (and ARPHS) to track down and shock treat suspected water cooling towers in the event of an outbreak of legionella, as well as ensuring water cooling tower systems are maintained and monitored. These changes will lead to protecting more lives effectively and efficiently.

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Non-occupational exposure to Asbestos is rare\textsuperscript{2} – however in anticipation of increased building and housing demolition, asbestos when freed from its inert state through demolition (professional or amateur) has the potential to expose those in close proximity to a building site. Having specific references to asbestos as a listed material or thing within the bylaw also allowed for more operational efficiencies for Council and ARPHS enforcement officers in carrying out duties.

The new bylaw will provide a regionally consistent approach to addressing maintenance and registration of water cooling towers, and other nuisance issues.

These are examples of positive early engagement within the policy development process between ARPHS and Auckland Council resulting in a bylaw which will have positive implications for the Auckland Region.

**6.6 Aerial 1080 operation in the Hunua Ranges Update**

This operation has been completed in two stages by Auckland Council to reduce levels of pest species, specifically possums, rats and stoats, to allow native birds and flora to flourish. Both stages have been successfully completed and water reservoirs are now back on-line. Both 1080 drops were followed by water monitoring, track clearing, and audit programmes.

All water reservoir monitoring results have returned non-detectable levels of 1080. For the next month, monitoring of the reservoirs will also occur after any heavy rainfall.

There has been ongoing, low-level anti-1080 activity in the Auckland region as a result of this operation, but it has been insufficient to interfere with the operation or attract any significant media interest.

ARPHS has a regulatory role under the Hazardous Substances and New Organisms Act for 1080 and other VTA (vertebrate toxic agent) operations. ARPHS is also the regulator in the region ensuring that drinking water quality standards are maintained by the drinking water supplier (Watercare in this instance) since four water supply dams are located within the Hunua Ranges. ARPHS’ role was to review, approve and audit the 1080 operation as well as to require any conditions to protect the public.

ARPHS has audited all signage and security for the operation, bait loading, aerial flight paths, track clearance operations, and reservoir water testing.

**6.7 Emergency Management Update**

On Friday 18th September, ARPHS facilitated an interagency meeting to endorse changes to the 2014 ‘Auckland maritime public health emergency framework’.

The document describes at a high level the roles and responsibilities of agencies for any potential public health emergency response. It is aligned with the International Health Regulations 2005 as part of public health core capacity requirements for international border points of entry into New Zealand, with other regional ports and airports having equivalent interagency plans in place.

The meeting was well-attended, with around 45 management representatives from 19 agencies. The focus of the meeting was to refresh agencies on the scope of public health emergency risk

\textsuperscript{2} Asbestos is a material that was used within the NZ building industry until the mid-1980s. In a stable form (e.g. bound within a cement matrix in good condition) it is inert. However, if asbestos is broken up or disturbed and fibres are released in the air, it becomes a significant health risk.
assessment and response. Another key topic was to discuss the implications of recent port facility changes on logistical planning, in particular interagency coordination for passenger screening off a large vessel. The attendees endorsed the revised document in principle at the close of the meeting.

6.8 Healthy Auckland Together

Healthy Auckland Together was initiated in response to increasing concern by Auckland DHBs about the increasing and inequitable community burden of obesity and chronic disease. They asked Auckland Regional Public Health Service (ARPHS) to coordinate a long term, strategic and collaborative region-wide plan to address the environmental determinants of health in settings where Aucklanders live, learn, work and play.

We are now into phase two of Healthy Auckland Together in which we begin implementation of the 5-year Plan. During this financial year we will build on the interagency support for a long term, regional, intersectoral approach to improving overall health gain and reducing health inequity by reducing and preventing obesity, improving nutrition and increasing physical activity.

In the first year, 21 agencies collaborated on the establishment of the Healthy Auckland Together coalition, agreeing a vision, aims, and approaches. The primary focus is on regional activities within the direct control of partner agencies, along with a collective voice to influence national and regional level policies that would benefit the Auckland region overall.

Chief Executives from partner organisations have given their formal commitment to the coalition. 65 projects in the Healthy Auckland Together Plan 2015-2020 reflect the agreed priorities over the next five years and contribute to our vision of ‘a social and physical environment that supports people living in Auckland to eat well, live physically active lives and maintain a healthy body weight within their communities’.

In addition to providing backbone support to the coalition, ARPHS will be implementing 31 of the 65 projects.
Auckland Unitary Plan Hearings

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1. The Auckland Regional Public Health Service staff attended mediation sessions on this topic. We are generally supportive of the amended versions of plan provisions following mediation.

2. We wish to reiterate our support (from the RPS hearings) for Council keeping a high priority for public open space in areas which are under pressure for housing and other development. These are important for the liveability of the city.

3. ARPHS’ submission supported explicit provisions for community gardens in public open spaces. We support the inclusion of community gardens as a Permitted Activity in the Activity Table for all Public Opens Space Zones (I2.1) as outlined in Mr Reidy’s evidence (Para 13.6).

4. There are now over 50 community gardens around Auckland (some on public land, others in church land and other community spaces) plus a large number of “edible gardens” in schools, as well as local horticulture programmes for groups such as people with mental health disabilities and people in the justice/corrections services.

5. We see these as beneficial for the liveability of Auckland by:
   - Developing community connection and resilience
   - Developing skills in local food production and food preparation
   - Improving nutrition and physical activity
   - Contributing to local sustainable development
   - Reduction of economic hardship
   - Supporting community wellbeing programmes such as food banks, mental health and disability support services

6. Location of community gardens will need to consider matters such as land contamination, access and safety. There have been successful community gardens on closed landfill sites, such as one on a 4 hectare site in East Brunswick, Melbourne which hosts a range of environmental programmes.