Community and Public Health Advisory Committees Meeting

Wednesday, 02\textsuperscript{nd} September 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
02nd September 2015

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

COMMITTEE MEMBERS
Gwen Tepania-Palmer – Committee Chair (WDHB and ADHB board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Deputy Chair
Jo Agnew - ADHB Board member
Peter Atken - 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
Elise Ho - Co-opted member
Rev Featunai Liauana – Co-opted member
Tim Jelleyman - Co-opted member

MANAGEMENT
Dale Bramley - WDHB, Chief Executive
Alisa 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
Peta Molloy - WDHB, Acting Board Secretary

Apologies:

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

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3.25pm 6 GENERAL BUSINESS
## Auckland and Waitemata District Health Boards

### Community and Public Health Committees

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*absent
* attended part of the meeting only
^ leave of absence
# absent on Board business
+ ex-officio member
### Register of Interests

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<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
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</thead>
<tbody>
<tr>
<td>Lester Levy</td>
<td>Chair - Auckland District Health Board, Chairman - Auckland Transport, Independent Chairman - Tonkin &amp; Taylor, Chief Executive - New Zealand Leadership Institute, Professor of Leadership - University of Auckland Business School, Trustee - Well Foundation (ex-officio member), Director - Orion Health Ltd (includes Director – Orion Corporate Trustee Ltd), Member – State Services Commission’s Performance Improvement Framework Review Panel</td>
<td>04/02/15</td>
</tr>
<tr>
<td>Max Abbott</td>
<td>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</td>
<td>19/03/14</td>
</tr>
<tr>
<td>Jo Agnew</td>
<td>Professional Teaching Fellow - School of Nursing, Auckland University, Trustee Starship Foundation, Casual Staff Nurse - ADHB</td>
<td>01/03/14</td>
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<tr>
<td>Peter Aitken</td>
<td>Pharmacist, Shareholder/Director, Consultant - Pharmacy Care Systems Ltd, Shareholder/Director - Pharmacy New Lynn Medical Centre</td>
<td>15/05/13</td>
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<tr>
<td>Judith Bassett</td>
<td>Nil</td>
<td>09/12/10</td>
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<tr>
<td>Chris Chambers</td>
<td>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</td>
<td>20/04/11</td>
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<tr>
<td>Sandra Coney</td>
<td>Elected Member - Chair: Waitakere Ranges Local Board, Auckland Council</td>
<td>12/12/13</td>
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<tr>
<td>Warren Flaunty</td>
<td>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</td>
<td>26/11/14</td>
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<tr>
<td>Lee Mathias</td>
<td>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, Director - IAC IP Ltd, Advisory Chair - Company of Women Ltd</td>
<td>13/07/15</td>
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<tr>
<td>Robyn Northey</td>
<td>Project management, service review, planning etc - Self-employed Contractor, Board member - Hope Foundation Northern Region, Trustee - A+ Charitable Trust</td>
<td>18/07/12</td>
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Register of interests continued...
<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
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| Christine Rankin           | Member - Upper Harbour Local Board, Auckland Council  
                                    Director - The Transformational Leadership Company  
                                    CEO - Conservative Party |
| Allison Roe                 | Member - Devonport-Takapuna Local Board, Auckland Council  
                                    Chairperson - Matakana Coast Trail Trust |
| 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 |
| 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 |
| Rev Featunai Liuana         | 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 |
| 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 |
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

Recommendation:

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

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

Community and Public Health Advisory Committees

Wednesday 22 July 2015

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.01 p.m.

PART I - Items considered in Public Meeting

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Max Abbott (WDHB Board member)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Chris Chambers (ADHB Board member)
Warren Flaunty (Committee Deputy Chair) (WDHB 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)

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)
Tony O’Connor (ADHB, Director of Participation and Experience)
Ruth Bijl (ADHB and WDHB, Funding and Development Manager, Child, Youth and Women’s Health)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Lynda Williams, Auckland Womens Health Council
Tracy McIntyre, Waitakere Health Link
Gaylene Sharman, Te Puna Manana

APOLOGIES:

Resolution (Moved Jo Agnew/Seconded Peter Aitken)

That the apologies from Lester Levy, Sandra Coney, Lee Mathias, Robyn Northey and Dale Bramley 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.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no declarations of interests relating to the open agenda.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 10th June 2015 (agenda pages 7-27)

   Resolution (Moved Allison Roe/Seconded Christine Rankin)

   That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 10th June 2015 be approved.

   Carried

   Matters Arising (agenda page 30)

   With regard to the response from ARPHS regarding impacts of exposure to dust from unsealed roads, Warren Flaunty noted that while the information provided on the work being done nationally to assess impacts from dust was very useful, his question as to whether ARPHS had made any submissions supporting sealing of unsealed roads for health reasons had not been answered. Simon Bowen advised that he would follow up on that.

3 DECISION ITEMS

   There were no decision items.

4. INFORMATION ITEMS

4.1 Mental Health and Addictions Update - 2014/15 Actions (agenda pages 30-35)

   Tim Wood (Deputy Director Funding) presented this report. Matters that he highlighted included:
With support hours implementation (page 31 of the agenda), progress had been slower than anticipated but as of 1 July most NGOs are now on that model. The feedback from the NGOs is that this is a much better model than the previous bed based model.

The Tamaki Locality Project (pages 31-32 of the agenda) has a strong mental health component. The project team is moving forward and they are in the final phase of the EOI process to select a preferred provider for that element of the work plan.

The Social Outcomes Indicators (pages 32-33 of the agenda) confirm the very high percentage of service users who enter and leave the Mental Health Services without any form of employment. There is some potential to work with the Ministry of Social Development on how they might improve the employment situation for these people. An issue is that often they can only start off with very small hours, whereas Work and Income want people placed in substantial employment. There is a policy gap to be worked on.

The Suicide Prevention and Postvention Plan has received feedback from the Ministry of Health and a final plan has been submitted to the Ministry.

NGO Sustainability (page 34 of the agenda) – it had been rather challenging to get agreements in place this year, as there was clearly a difference between the NGOs’ expectations and what is affordable for the DHB. As part of reaching agreement, it had been agreed to look at developing a framework for NGO sustainability. In the Mental Health NGO sector there are a number of niche NGOs that are very small and because of that some are struggling to achieve financial viability. Last year they had needed to work with a couple of these to fold them up. They had made clear to NGOs that the sustainability exercise is about the sustainability of the NGO sector as a whole, not of every individual NGO.

Matters covered in discussion and response to questions included:

- In answer to questions on the Ranui Social Sector Trial (page 33 of the agenda), Tim Wood commented on the concerted effort by the range of agencies involved to deal with the issues. A key to the approach is getting alignment on how issues are dealt with and the collaboration involved to achieve this. It is a small trial and it is too early to tell whether the approach will be sustainable or not, but it is promising. Funding has now been committed for the Ranui Social Sector Trial to go forward. A challenge with it is that Ranui is very much part of a larger metropolitan area; other areas where there had been such trials such as Tokoroa had been well contained communities. Also as a result, it is quite challenging to isolate data specific to Ranui.

- In answer to a question from Tim Jelleyman as to what is being done for children whose parents have mental health issues, Tim Wood advised that there is some activity on that. He would obtain some information on this and provide that.

- With regard to the Suicide Prevention and Postvention Plan, Tim Wood confirmed that “postvention” refers to the response that happens in a community after a suicide. It involves looking at what can be done to support the community so that other young people don’t follow suit, and involves putting in place support mechanisms. This has become a very challenging area with the advent of social media.
• On the Suicide Prevention and Postvention Plan, Tim Wood advised that the major feedback from the Ministry had been the need for more particular emphasis on Pacific communities. He also noted that while the Plan has a five year time frame, Suicide Prevention and Postvention is a continuous process and needs sustained effort over long periods.

• With regard to the size of the waiting list for alcohol and other drug treatment beds (page 34 of the agenda), Tim Wood advised that it is still not clear what the impact on demand will be from the introduction of compulsory addiction and treatment legislation anticipated to be introduced into Parliament in mid-late 2015. CPHAC will be kept updated on this issue.

Tim Wood was thanked for presenting the report.

Resolution (Moved Max Abbott/Seconded Christine Rankin)

That the report be received.

Carried

4.2 Waitemata and Auckland District Health Board Pacific Health Action Plan 2013-2016: Progress Update (agenda pages 36-47)

Lita Foliaki (Manager Pacific Health Gain) introduced the report. Matters that she highlighted included:

• The importance of taking a positive approach when communicating to Pacific people about Pacific health issues; as Rev. Liuaana had commented to the Committee previously, how would you feel to be shown a series of graphs where your ethnic group is always at the bottom?

• Implementing the Pacific Health Action Plan is going relatively well; but the overall story of Pacific health remains an unhappy one, for example Pacific renal patients having dialysis at Middlemore Hospital in their thirties.

• With regard to the Pacific Health Action Plan, they are already thinking about what needs to go into the next plan, as the existing plan is not adequate for addressing the big unhappy overall health picture of Pacific people. The health sector needs to be brought together on this; she sometimes found it easier to work with the community than other parts of the health sector. She needed to engage with the PHOs to connect what they do with the work that is occurring in the community. A major part of her role is to facilitate a better relationship between the PHOs and the Pacific community. In the Pacific way, conversations need to be pleasant if they are to be kept going.

Rev. Liuaana was invited to comment. Points that he made included:

• As someone deeply involved in the design and implementation of the plan, he felt that what Lita Foliaki had said was exactly right. One of the key things from this Plan is that they now know what else needs to be done. They are trying to get everybody on board for that.

• People lose hope when people are failing around them. Positive stories give hope and help people get up. Then it is necessary to make sure they do not fall back down.
• The Pacific Health Action Plan is a very good plan and a lot is being done with it. There is a particularly high level of involvement in the programme aimed at family violence. Training of facilitators for this programme has been especially positive.

Matters covered in discussion and response to questions included:

• Chris Chambers noted that five of the six priorities in the plan involve education and asked if they get help from the education sector on that. Lita Foliaki confirmed that is the case and that the training of facilitators is the key. They require that Pacific people have a degree before they are accepted for this training and feedback provided includes videoing their delivery and feeding it back to them. It is crucial that facilitators are bi-lingual and have lived in a local Pacific community. Those communities will accept critiques when delivered by an insider, including a female insider.

• Rev Liuana commented on the importance of translation into Pacific languages and in a way that people can comprehend fully. Translation to Pacific languages had been a positive feature of the Stanford programme over the last five years.

• With suicide prevention, Lita Foliaki advised that she saw parenting education as the long term response to this issue. In New Zealand Pacific families were faced with multiple conflicting values.

• With regard to the comment on page 46 of the agenda about the two views emerging from health committees in the churches/community groups on expectations on those committees and on funding, Lita Foliaki confirmed that the first view is expressed by older members of the health committees and the second by younger people, as a generalisation. She would like to see the issue discussed honestly over the coming year.

• Rev Liuana advised that the Congregational Christian Church Samoa at Sandringham had set up a Trust and that was contracted by the Ministry of Education to provide various services. This type of approach may also be relevant for the provision of health services.

The Committee Chair thanked Lita Foliaki and her team on behalf of CPHAC and encouraged them to keep up their good work. She noted that the emphasis on bringing hope and building resilience in our communities is a key point. This is demanding because it requires constant connection. It is important when allocating resources to make sure that the Pacific population is able to access what is being provided and that resources are allocated to those populations where there is the highest need – for example with smoke free programmes.

Resolution (Moved Jo Agnew/Seconded Judith Bassett)

That the report be received.

Carried
4.3 **Child, Youth and Women's Health** (agenda pages 48-58)

Ruth Bijl (Funding and Development Manager - Child, Youth and Women's Health), Dr Karen Bartholomew (Public Health Physician) and Dr Alison Leversha (Community Paediatrician) were present for this item.

Ruth Bijl introduced the report. Matters that she highlighted included:

- The slightly different format used in this report.
- There had been a huge effort to try and meet the immunisation at 8 months target. While the 95% target had not been met, Auckland DHB had achieved 94% and Waitemata DHB 93%. This is a very difficult target which only four DHBs had achieved.
- The decline in the rheumatic fever rate for the Auckland region (shown in the graph on page 49 of the agenda).
- A correction to the rate of Before School Checks for Auckland DHB (page 49 of the agenda) the figure for High Deprivation should read 92%, not 91%.

Matters covered in discussion and response to questions included:

- With regard to Children’s Teams (page 50 of the agenda), it was confirmed that they are not required to implement these, but are continuing to think about them.
- The National Child Health Information Platform being implemented in the Midlands Region (page 50 of the agenda) may be a great tool both to understand how child services are performing and being accessed and to assist in locating families missing out on services that they are entitled to. It is hoped that the tool will become available for this region in the future.
- In answer to a question, the Committee was advised that the health promotion campaign planned for September to increase awareness of cervical screening for Asian and Maori women (page 55 of the agenda) would include Asian newspapers as well as development of a face book page.
- In answer to a question, Karen Bartholomew advised that for cervical screening, information can be provided by age and by quintile (not just by ethnicity). Ruth Bijl advised that they target free screening to women never screened or not screened for five years or more.

The Committee Chair thanked the team responsible for this work. She acknowledged the good work that has taken place and commented that every time the Committee receives this report, performance has strengthened. She particularly appreciated the work being done for Maori, Pacific and Asian ethnic groups.

**Resolution** (Moved Warren Flaunty/Seconded Elsie Ho)

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

*Carried*
5. **STANDARD REPORTS**

5.1 **Planning, Funding and Outcomes Update** (agenda pages 59-75)

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

Matters that were highlighted or updated included:

- The 2015/16 Annual Plan had been updated to include some unexpected additional funding that had been received.
- Preparation of the 2014/15 Annual Report is well under way.
- The intention by ARPHS to appeal the Auckland Council’s Provisional Local Alcohol Plan (detailed on pages 69-71 of the agenda).
- The information relating to Psychoactive Substances (pages 71-72 of the agenda).
- The detailed information on services provided to the Western Village Caravan Park in Ranui (pages 72-75 of the agenda).
- The information on POAC (Primary Options for Acute Care (pages 62-68 of the agenda), provided in response to a request from the previous CPHAC meeting.

Clarification was sought on how alternative products to psychoactive substances (referred to on page 72 of the agenda) are investigated and tested. Simon Bowen will check this and advise the Committee.

There was an extensive discussion relating to the Western Village Caravan Park in Ranui and broader issues of homelessness and social deprivation. Matters covered included:

- Simon Bowen confirmed that the services to the Caravan Park have been extended for one year. This is to address the very significant health needs of the large number of families living in the caravan park. There is a hub, owned by the caravan park, leased for the co-ordinator. This is partly funded by a grant from the Ministry of Social Development to provide services on site. There is a steering group with representation from a number of the agencies involved in the initiative. Part of the role of the public health nurse is to co-ordinate the health services that are provided to the residents in the caravan park.
- In answer to a question, Simon Bowen advised that there had recently been an update of the analysis done initially concerning presentations to ED and to secondary health services by residents of the Western Village Caravan Park. It had been established that there were a lot more presentations and admissions than originally found. Some of the residents are phenomenally high users of these services.
- Gaylene Sharman of Te Puna Manana advised that there are between 600 and 700 people living in the Caravan Park.
- In answer to a question, Simon Bowen advised that the 2013 Census defined 10,000 people in the Auckland region as homeless, either living in caravan parks, sleeping in cars or “rough sleepers”. He also advised that the Ministry of Social Development is currently looking at options to improve availability and sustainability of emergency accommodation in Auckland. There is a recognition that current solutions are inadequate and a lot of work is being...
done to look at how to address the issues. With “rough sleepers” in central Auckland, there are currently about 150 and the number appears to be increasing.

- Simon Bowen commented that with the Western Village Caravan Park the thing that he found particularly striking was the poor quality of accommodation and the high cost charged to residents of the caravan park. What they were being charged was a huge amount compared to their income for the people living there.

- Rev Liuaana advised that his church had recently organised a soup kitchen in Auckland and he had been greatly surprised that 30 families had travelled all the way from the Ranui Caravan Park just for that meal.

- In answer to a question Simon Bowen advised that public health nurses are funded and provided by the DHBs. A range of work is underway at a regional level to address the issues of housing and homelessness.

- Ailsa Claire commented that 50% of children in Auckland live in the lower decile areas. While the DHBs can do something, this is a whole of society issue.

- Individual Committee members made a range of suggestions including acting as an advocate on these issues to change national policy, informing the Prime Minister, and lobbying for the Ministry of Social Development to play a major role. Regular reporting on these issues was also requested.

- It was pointed out that housing in Auckland is already a front page issue in the media every week and a significant political issue.

- Dr Julia Peters (Clinical Director, ARPHS) commented that there used to be a healthy housing initiative between the two DHBs and Housing New Zealand but that had been discontinued. She considered that the health sector had contributed a lot in terms of housing research in New Zealand.

- Allison Roe suggested an approach to the Well Foundation to see if it would support a project to raise awareness and funding to help assist with these issues.

- In answer to a question as to whether the number of public health nurses had increased, Simon Bowen advised that he could not advise on that specific question; however there has been an increase in resourcing for the public health nursing in the caravan park. Tim Jelleyman noted that the nature of the services provided is such that they are not dependent on one person.

- Simon Bowen advised that he would follow up the suggestion of an approach to the Well Foundation, and provide updates to the Committee on the Western Caravan Park. A report would be provided for CPHAC on the broader housing issues in Auckland with recommendations about any actions the DHBs could take to help address them.

- Ailsa Claire advised that the Health Needs assessments being prepared for the two DHBs provides detailed information on the relationship between social and economic disadvantage and health inequalities. The DHBs have a significant role as a major employer in the Auckland Region.

- Judith Bassett advised that she would like more information on the work that the public health nurses do generally and whether there are enough of them.

- Rev. Liuaana advised that he was worried about the impact, including health impact, of potential new caravan parks in the Auckland region.

- Max Abbott spoke on the importance of pointing out the health impact of social inequalities and the evidence supporting that link.
In conclusion the Committee Chair noted that when they get more information back, thought will be given to escalating some of these issues up to the respective Boards.

**Resolution** (Moved Chris Chambers/Seconded Peter Aitken)

That the report be received.

Carried

6. **General Business**

No matters were raised.

7. **Resolution to Exclude the Public** (agenda page 76)

**Resolution** (Moved Jo Agnew/Seconded Judith Bassett)

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

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

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

**Obligation of Confidence**
The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence.
[Official Information Act 1982 S.9 (2) (ba)] |

3.30p.m – 4.05p.m – Public Excluded Session
4.05p.m – the meeting resumed in open session.

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

The meeting concluded at 4.05p.m.
<table>
<thead>
<tr>
<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPHAC 04/02/15</td>
<td>4.1</td>
<td>Rheumatic Fever Programme Evaluation/Public Nurse Role in Schools; that the regional evaluation results for the rheumatic fever programme be reported back to the Community and Public Health Advisory Committee when available and that the public/community health nurse role in schools and the appropriate model of care related to that then be reviewed by the Committee.</td>
<td>Ruth Bijl</td>
<td>CPHAC 02/09/15</td>
<td>The RhF team is working with Dr Tom Robinson on an initial evaluation, and expect to present the results of this to the 02/09/15 meeting.</td>
</tr>
<tr>
<td>CPHAC 29/04/15</td>
<td>1.1 - Public Excluded</td>
<td>Maori Health Plans/Pacific Health Action Plan: when the Maori Health Plans have been finalised a presentation to be arrange for CPHAC on them and also covering the Pacific Health Action Plans.</td>
<td>Simon Bowen</td>
<td>Pacific Health was presented 22/07/15. Maori Health to be presented 02/09/15.</td>
<td></td>
</tr>
<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>
<tr>
<td>CPHAC 22/07/15</td>
<td>2.1</td>
<td>Unsealed Roads: to check specifically whether ARPHS has made any submissions supporting sealing of unsealed roads for health reasons – Warren Flaunty to be advised.</td>
<td>Simon Bowen</td>
<td></td>
<td>See note 1 below.</td>
</tr>
<tr>
<td>CPHAC 22/07/15</td>
<td>4.1</td>
<td>Mental Health: information to be obtained and provided on what is being done for children whose parents have mental health issues.</td>
<td>Tim Wood</td>
<td></td>
<td>Information included as part of PFO Update paper on this agenda.</td>
</tr>
<tr>
<td>CPHAC 22/07/15</td>
<td>5.1</td>
<td>Psychoactive Substances: information to be obtained and provided on how alternative products to psychoactive substances are investigated and tested.</td>
<td>Simon Bowen</td>
<td></td>
<td>See note 2 below.</td>
</tr>
</tbody>
</table>
Note 1: Unsealed roads

Between 2012 to the present date, ARPHS has not made any submissions relating to unsealed roads and impacts on health as there have been no submission opportunities.

ARPHS has received some queries regarding impact of exposure to dust from unsealed roads, including by an Auckland Councillor. There have been a number of high profile complaints in Northland, Hawke’s Bay, and Marlborough. The New Zealand Transport Agency has commissioned work by Golder Associates to look at impacts of exposure to dust from unsealed roads, and options for dust control. A report is expected later this year – expected in September or October.

Project objectives include:
- Research NZ and international literature to inform and quantify the impacts of dust exposure from unsealed roads
- Collection of new data to quantify emissions the impacts of dust from unsealed roads
- Determine the cost and effectiveness of available dust mitigation measures
- Development methodology to support decision making about mitigation options.

ARPHS will consider this report when it is released and will forward a summary to CPHAC and Auckland Council.

Note 2: Psychoactive substances – investigation of alternative products

For the purposes of the Psychoactive Substances Act 2013, only specific substances are classified as psychoactive. A psychoactive substance can either be a product that has been approved by the Psychoactive Substances Regulatory Authority (no such products are currently approved) or be a substance specified by the Governor-General (there is currently a list of such substances). The Act also defines substances that are not considered psychoactive, such as controlled drugs, medicines, herbal remedies, dietary supplements, alcohol or tobacco products. Products that are currently marketed and sold as “alternatives” to psychoactive substances may or may not contain psychoactive substances. For example, some of these alternative products have been found to be herbal or tobacco products only.
Public Health Services such as Auckland Regional Public Health Service (ARPHS) are predominantly involved in enforcement and compliance activities related to approved products only. Any testing, investigation and management of unapproved products (i.e. illegal psychoactive substances) or “alternative” products is dealt with by the Police and the Psychoactive Substances Regulatory Authority. Public Health Services may be requested to assist in these investigations.
3.1 Primary Health Care Nursing Strategic Framework for Auckland and Waitemata District Health Board Regions

Recommendation

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.

Prepared by: Jean McQueen (Primary Health Care Nursing Director, Auckland and Waitemata DHBs)
Endorsed by: Simon Bowen (Director Health Outcomes), Dr Debbie Holdsworth (Director Funding), Auckland DHB ELT (09/06/15), Waitemata DHB SMT (20/08/15), Waitemata and Auckland District Alliance ALT (13/08/15)

Glossary

CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
PHC - Primary Health Care
PHO - Primary Health Organisations
Framework - The Primary Health Care Nursing Strategic Framework

1. Purpose

This paper recommends the Community and Public Health Advisory Committee endorse the implementation of a high level strategic framework for Primary Health Care (PHC) Nursing across Auckland and Waitemata District Health Board (DHB) regions (Framework). The Framework outlines a high level collaborative Waitemata and Auckland District Health Board approach to PHC nursing activity, and is attached to this paper as Appendix 1.

2. Background

Demand for services in PHC will exceed the supply in the next two decades (HWNZ, 2010). Therefore there is a need to increase both capability and capacity of the PHC nursing workforce in order to deliver quality care. The knowledge and skills of the PHC nursing workforce is not always currently utilised appropriately to deliver services to contribute to health outcomes for the Auckland and Waitemata DHB populations.

3. Current Situation

The PHC environment is one of rapid change. This means PHC nurses need to be prepared both academically and clinically with the right skills to respond to the health needs of future populations. Currently PHC is facing challenges that impact workforce capacity and capability including:

- increasing public expectations
• rising demand caused by increasing patient complexity and morbidity of long term conditions
• an aging population
• increased demand for acute care
• increased expectations on clinical performance and health targets
• aging nursing workforce
• multiple IT systems that don’t interact
• role development

It is timely to have a plan for PHC nursing across the sector. This approach will address current PHC issues of workforce development, role and leadership development and access to PHC nursing services. A proactive PHC team requires Registered Nurses who are competent and effective to support a sustainable future for healthcare delivery. Processes need to be put in place now to manage future demand for services in PHC and to develop capacity and capability of the PHC nursing workforce.

4. The Framework

The Framework has been developed via a collaborative process between Nurse Leaders across the Auckland and Waitemata districts.

The Nurse Leaders met monthly as the PHC Nursing Reference Group. Members included Primary Healthcare Organisation (PHO) Nurse Leaders and representative Nurse Leaders from Plunket, School Nursing, Community Mental Health, Public Health, District Nursing and Tertiary Nursing Education Institutions. The PHC Nursing Reference Group also had significant input from its consumer representative which was critical in ensuring how nursing is perceived moving forward by the public was considered. Additionally the PHC Nursing Reference Group received input and guidance from the Waitemata and Auckland Maori Health Gain Team regarding opportunities for engagement with high needs populations to achieve equitable health outcomes.

The Framework outlines a high level collaborative Waitemata and Auckland DHB approach to PHC nursing activity, and specifically:

• sets out a strategic purpose for Primary Health Care nursing services to be accessible, capable and proactively respond to current and future community health needs and achieve improved and equitable health outcomes for all
• is built upon nursing professional standards, code of conduct and individual organisational values
• is underpinned by our culture which includes our workforce culture and cultural safety, our compassion as a nursing profession and our drive for equity and for quality
• has two areas of focus:
  o people’s health and independence, this includes nursing services responding to priority population need drawn from policy directives and as defined by the Minister
  o the PHC nursing workforce which includes growth and development of nurses through mentorship, supervision, coaching and professional development.
Has three key strategic priorities to develop into an implementation plan:

- **Influential leadership** achieved by:
  1) strengthening nursing leadership to directly influence decision making to improve nursing contribution to health care delivery systems
  2) proactively engaging in initiatives to grow new nursing leaders for the future
  3) fostering regional and national input into policy and political discussion in order to meet service targets and quality health care measures.

- **Workforce capability** includes sustaining workforce development through:
  1) new graduate recruitment into PHC
  2) retaining nurses at all levels to support role development through mentorship, supervision, coaching and professional development
  3) career pathway progression via education and training support, within a professional development framework
  4) a focus on Maori and Pacific role development
  5) developing, supporting and fostering models of care which include internships for Nurse Practitioner roles.

- **Accessible nursing services** respond to priority population need by:
  1) providing long term condition, prevention and screening services through nurse clinics within the team environment
  2) supporting specialist primary health care and community roles
  3) building business models that orientate nursing services to population priorities, improve health outcomes and address inequities.

The three key priority areas will respond and provide solutions to community health need and the identified population priority work of:

- reducing demand for acute services
- improving health outcomes in child, youth and family/whanau, people with long-term conditions, mental health, older adults and rural health.

### 5. Next Steps

The Framework has been endorsed by the Auckland DHB Executive Leadership Team, Waitemata DHB Senior Management Team and the Waitemata and Auckland District Alliance Leadership Team.

PHOs will use the Framework to inform their strategic plans.

The PHC Nursing Reference Group and the Chief Nursing Officer, Auckland DHB are currently progressing this exciting collaborative. A Framework implementation plan is being developed for PHC nursing activity that can be shared across the Auckland and Waitemata regions. This will include outcome measures relating to nursing activity, including consumer satisfaction feedback on PHC nursing services.
Primary Health Care Nursing Strategic Framework for Auckland and Waitemata

STRATEGIC PURPOSE
Primary health care nursing services that are accessible, capable and proactively respond to current and future community health needs.

Achieve improved and equitable health outcomes for all.

Influential Leadership
1. Strengthen nursing leadership to directly influence decision making to strengthen and improve nursing contribution to health care delivery systems.
2. Proactively engage in initiatives to grow new nursing leaders for the future.
3. Foster regional and national input into policy and political discussion in order to meet service targets and quality health care measures.

A FOCUS ON OUR PROFESSION
Underpin our professional practice with self-care and mindfulness.
Grow nursing through mentorship, supervision, coaching and professional development.

Workforce Capability
Sustain workforce development through:
1. New graduate recruitment
2. Retaining nurses at all levels to support role development
3. Career pathway progression via education and training support, within a professional development framework
4. A focus on Maori and Pacific role development.
5. Developing, supporting and fostering models of care which include internships for Nurse Practitioner roles.

A FOCUS ON PEOPLE
Primary health care nursing services improve people’s health and independence.

Accessible Nursing Services
1. Respond to priority population need through nurse clinics within the team environment.
2. Provide prevention and screening services through nurse clinics.
3. Support specialist primary health care and community roles in response to population need.
4. Build business models that orientate nursing services to population priorities, improve health outcomes and address inequities.

POPULATION PRIORITY WORK
Primary health care nursing services support and provide effective solutions to:
1. Reduce demand for acute services
2. Improve health outcomes in:
   - Child, youth and family /whanau
   - People with long-term conditions
   - Mental health
   - Older adults
   - Rural health

PROFESSIONAL FOUNDATION BLOCKS
CULTURE EQUITY QUALITY COMPASSION
Values and Code of Conduct
The Primary Health Care Nursing Strategic Framework for Auckland and Waitemata was developed by: The Primary Health Care Nursing Reference Group (Auckland and Waitemata Districts)

Members who contributed over 2014/2015:

Jean McQueen – WDHB / ADHB: Primary Health Care Nursing Director
Celeste Gillmer – WDHB: Primary Health Care Nurse Educator / Co-president Auckland School Nurses Group
Rachael Calverley – Waitemata PHO: Director of Nursing & Workforce Development
Carol Ennis – Auckland PHO: Primary Care Nurse Director
Lorraine Hetaraka-Stevens – Procare: Nursing Director
Jessie Naicker – Procare: Associate Chief Nurse/ Knowledge & Innovation Team Manager/Workforce & Funding (until May 2014)
Tania Windelborn – National Hauora Coalition: Support & Performance PHC Clinical Nursing (until December 2014)
Helen Pahau – National Hauora Coalition: Nurse Lead (from April 2015)
Veenita Devi – National Hauora Coalition: Nurse Champion Clinical Performance (from April 2015)
Pauline Sanders-Telfer – Alliance Health Plus: Nurse Leader (from July 2014)
Tepora Peseta – Alliance Health Plus: Nurse Leader (until April 2014)
Margaret O’Sullivan – WDHB: Clinical Nurse Director Community & Specialty Practice / Medicine and Health of Older People
Jane Lees – ADHB: Nurse Director (Adult Community and Long Term Conditions Directorate)
Judy Blakey – Consumer Representative
Kim Ward – Plunket: Clinical Leader
Claire Doole – Auckland University of Technology: Senior Nursing Lecturer
Sue Wilson – WDHB: Clinical Nurse Specialist, Youth Health, Public Health
Sid Cuthbertson – Corrections: Clinical Quality Assurance Advisor / Odyssey House: Clinical Quality Project Manager (until March 2015)
Sue Adams – Massey University: Senior Lecturer, Nursing
Lisa Stewart – University of Auckland: Professional Teaching Fellow, Nursing
Ines Bruins – WDHB: Clinical Nurse Advisor Mental Health (until March 2015)
Frances Ward – Unitec: Programme Leader Practicum, Nursing

Draft PHC NRG 2015 June 4
3.2 A Standardised Approach to Health Literacy across Auckland and Waitemata District Health Boards

Recommendation:

That the Community and Public Health Advisory Committee endorse:

a) A standardised approach to health literacy across the Auckland and Waitemata DHBs.

b) The definition and framework of health literacy.

c) The proposed next steps outlined in this paper.

Prepared by: Tim Wood (Chair Health Literacy Steering Group Auckland and Waitemata DHBs)
Endorsed by: Auckland DHB Senior Leadership Team and Waitemata DHB Executive Leadership Team

Glossary

AMA - American Medical Association
CALD - Culturally and Linguistically Diverse
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
ELT - Executive Leadership Team
HQSC - Health Quality Safety Commission
IOM - Institute of Medicine
SMT - Senior Management Team
WHO - World Health Organisation

1. Executive Summary

The purpose of this paper is to describe the concept of health literacy in a broader sense and explain why health literacy is important.

This paper:

- gives an account of the different ways health literacy has been defined
- makes an argument that in order to improve health literacy its needs to be viewed through a broader lens that captures not just patient’s perspective but that of healthcare professionals, the healthcare organisation and the health system as a whole
- proposes a health literacy framework and the next steps, and makes a set of recommendations

This paper recommends the Community and Public Health Advisory Committee (CPHAC) endorse the implementation of a standardised framework for improving health literacy across both Auckland and Waitemata District Health Boards (DHB). This approach has been endorsed by the Auckland and Waitemata DHB Health Literacy Steering Group, the Auckland DHB Senior Management Team (SMT) and the Waitemata DHB Executive Leadership Team (ELT).
2. Introduction

2.1 Defining Health Literacy

Traditional definitions of health literacy have focused on individual responsibility. Since the 1970’s when health literacy emerged as a concept, there have been different attempts to define health literacy. Many definitions put the weight of responsibility for health literacy on the users of the health system, for example WHO has defined health literacy as:

“the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health”.

While the IOM has defined health literacy as:

“the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”

Recently there has been growing awareness that health literacy is a product of many different factors including:

- the capacity of people accessing health services
- the communication capabilities of health professionals and health services
- the health system itself including policies, programmes, infrastructure and resources.

2.2 Health Literacy and New Zealand

Health literacy is a relatively new concept in New Zealand and there is limited understanding in the health sector as to what the term health literacy encompasses, its implications or how to improve health literacy. The New Zealand definition of health literacy is very similar to that of the IOM set out above. The Ministry of Health defines health literacy as “the ability to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions”.

It is proposed that the Auckland and Waitemata DHBs adopt a broader definition of health literacy, such as that developed by the Victorian Department of Health (Australia):

“Health Literacy means people can obtain, understand and use the health information and services they need to make appropriate health decisions. Healthcare providers and the health system should provide information and improve interaction with individuals, communities and each other to respond to and improve health literacy”.

2.3 Strategic Alignment

Health literacy activities are identified in the Auckland and Waitemata DHBs’ Pacific Health Action Plan 2014. One action area of the Plan is to “Increase health literacy through community based education services”. The Auckland and Waitemata DHB Maori Health Plan 2014 also

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e Centre for Health Communication and Participation on Health Literacy
acknowledges health literacy, providing that “The concept of health equity acknowledges that different types and levels of resources may be required in order for equitable health outcomes to be achieved for different groups. Improving Māori access to health services will be a key DHB contribution towards achieving health equity”. In addition, the joint Waitemata and Auckland DHBs’ Disability Strategy Implementation Plan 2013-16 identifies the need for appropriate communication and resourcing of information for disabled people.

Implementing a health literacy programme across Waitemata and Auckland DHBs will enable both DHBs to deliver on their core organisational values. For Auckland DHB the programme could be aligned with ‘Tuhono’, the importance of working together which acknowledges that the quality of the relationship between a healthcare professional and an individual is a major predictor of outcome. For Waitemata DHB, a health literacy programme can help it realise its core value of ‘Connected’ which provides: “We need to be connected with our community. We need to be connected within our organisation across disciplines and teams.” Health Literacy is also relevant to Waitemata DHB’s value ‘Everyone Matters’: “Every single person matters, whether patients, clients, family members or staff”.

Ngā Painga Hauora has recently been developed for Auckland and Waitemata DHBs. It is a framework for measuring health gains for Māori, especially gains that can be attributed to Māori Health Providers. The framework emphasises the need for Māori Health Providers to build the capability of service users by improving health and wellbeing so that future crises and health-related disorders can be reduced and self-management can become a reality. Building health literacy, for individuals and whanau, is an essential component of this process and as such, is a key performance indicator of the ‘The Promotion of Wellbeing’ outcome goal. Implementing a health literacy framework across Auckland and Waitemata DHB services will support the delivery of Ngā Painga Hauora by working to achieve this in partnership with Maori health providers.

3. Why is Health Literacy Important?

Health literacy is believed to be a stronger predictor of health outcomes than social and economic status, education, gender, and age. Poor health literacy seems to contribute to poorer health regardless of the illness in question.

The research documenting the extensive and far reaching consequences of low health literacy can be broadly categorised as:

- individual health impacts
- community and societal costs
- fiscal costs to healthcare organisations and systems

Some examples include:

- poorer knowledge and understanding of medical conditions, including their preventability and higher likelihood of experiencing a given poor outcome

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1 Nga Painga Hauora, Māori Health Gains: Outcome Indicators For Māori Health Providers, Prepared for Auckland and Waitemata DHBs prepared by Mason Durie May 2015
• lesser use of prevention services, higher likelihood of hospital admissions and readmissions, unnecessary emergency room presentations and higher mortality
• poorer health status and self-reported health and less knowledge of treatment, and medicines, and more medication and treatment errors
• increased risk of developing multiple health problems and less likely to engage with health promotional activities
• lesser likelihood of recognising the first signs of medical problems and waiting until sicker to seek help
• lesser knowledge of disease management and healthy living behaviour and poorer ability to make appropriate health decisions
• lesser ability to communicate with healthcare professionals and take part in decision making

4. A Proposed Framework for Health Literacy

4.1. Underlying principles

The proposed framework is based on an interactive and relational approach to health literacy which recognises that health literacy lies at the centre of the changing and evolving relationship that exists between the health system, the health professionals and the health consumers. It recognises the shortcomings of an approach dominated by a model based on the superior expertise of clinicians (i.e. the expert model). Instead it draws on the Family Partnership model that takes partnership to be the central relational process. The following diagram reflects three interacting factors that jointly influence health literacy. The following model also demonstrates how organisations values can underpin these processes.

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Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 02/09/15
• Health care organisations and systems can be health literate by providing equal and easy access to health care services and health information
• Health care professionals can be health literate by presenting information in ways that improve understanding and ability to act on the information
• An individual can be health literate by using the skills needed to find, evaluate, communicate and use information.

This model was adapted from a health literacy model developed by Workbase 2013, a leader in health literacy policy and practice.

4.2 Proposed Framework

Currently there isn’t an organised and systematic approach to improving health literacy within Auckland and Waitemata DHBs. Literature shows that system-level changes are needed at both health professional and health organisation level if the issue of health literacy is to be addressed effectively.

The Institute of Medicine (2012) recommends a set of ten attributes that identify a ‘Health Literate’ healthcare organisation. The health literacy framework outlined in this paper is based on the IOM principles and consists of ten building blocks. It is recommended that this framework is adopted by both Auckland and Waitemata DHBs to guide further work required to improve health literacy going forward.

These building blocks are:

1. Leadership that makes health literacy integral to its mission, structure, and operations; it is not about just embarking on a few health literacy projects, it’s about making health literacy incorporated into the values and the core business of the organisation.
2. Integration of health literacy into planning, evaluation, patient safety, and quality improvement activities with particular focus on performance in high risk groups to ensure disparities are monitored and quality improvement initiatives are in place. This means health literacy ideally will be deeply and explicitly integrated into all activities and informs strategies and operational planning.
3. Preparation of the workforce to be health literate; to be able to identify groups at risk of poor health literacy, and to communicate culturally appropriately and responsively. Progress in this area should be monitored.
4. Inclusion of consumers/populations served in the design, implementation and evaluation of health information and services. It is especially crucial to involve the populations served who are at high risk of inadequate health literacy.
5. Meeting the needs of all, recognising that individuals have varying ability to process complex and unfamiliar information, and require information delivered in different formats.
6. Effective Communication by using proven health literacy strategies in interpersonal communications.
7. Easy access to health information and services, and navigation assistance available.


8. Design and distribution of collateral i.e. print, audio-visual social media content that is easy to find, understand and act on to make informed decisions for individuals and their families.

9. Targeting those who may find our health system particularly difficult to navigate, such as those in high-risk situations and amongst high-risk groups, such as Culturally and Linguistically Diverse (CALD) individuals and those who have low literacy.

10. Transparency around coverage and costs, clear communication is required about what public health services are provided, eligibility criteria and what individuals who are not eligible will have to pay for services, and where to seek further information.

Healthcare organisation need to prioritise which attributes they need to address first and to what extent depending on their organisational values.

The above building blocks are also aligned to 'The Framework for Health literacy' recently released by the Ministry of Health. The framework outlines an interactive approach to ensuring New Zealanders can make informed decisions about managing their health, or the health of those they care for.

In essence, a health literate healthcare organisation creates an environment that reduces demands on its systems and assists to develop health literacy skills. Their focus is on making it easier for people to navigate, understand and access information and services to take care of their health and to benefit optimally.

5. Suggested Next Steps - Overview

It is proposed that the once the framework is approved in principle the following steps are undertaken to progress this work:

1. Identify a project sponsor/lead project team to drive the development of the detail around the framework and the subsequent implementation planning process. The project will build on existing activity/forums to leverage progress already made, and reduce any duplication of activity.
2. The continuation of a steering group to provide oversight of the project across both DHBs.
3. Ensure that health literacy activities are culturally appropriate, and there are ongoing processes for engaging Māori/Pacific.
4. Identify ways to socialise the framework amongst stakeholders to help develop broader ownership across both organisations e.g. identifying health literacy champions in various services within both DHBs.
5. Ensure the workplan is aligned to the framework for health literacy recently released by the Ministry of Health. This will ensure that our response is consistent with the National approach to building health literacy.
6. Develop an engagement plan, in conjunction with the Community Engagement Forum, to reach consumers, NGOs and primary care.
7. Seek guidance from Workbase/Health Quality Safety Commission (HQSC) as appropriate.
8. Work towards developing evaluation processes.
3.3 School-based Rheumatic Fever Prevention Programme

Recommendation:

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.

Prepared by: 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)

Endorsed by: Aroha Haggie (Maori Health Gain Manager), Lita Foliaki (Pacific Health Gain Manager), Dr Debbie Holdsworth (Director of Funding) and Simon Bowen (Director of Outcomes)

Glossary

ADHB - Auckland DHB
ARF - Acute Rheumatic Fever
BPS - Better Public Service
CHW - Community Health worker
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
GAS - Group A Streptococcus
PHN - Public Health Nurse
RFPP - Rheumatic Fever Prevention Programme
RhF - Rheumatic Fever
WDHB - Waitemata DHB
1. Executive Summary

The focus of this paper is the Auckland and Waitemata District Health Board (DHB) targeted school-based Rheumatic Fever (RhF) (throat swabbing and management) programmes, which are a key component of the wider Rheumatic Fever Prevention Programme (RFPP).

Auckland and Waitemata DHBs have been delivering targeted school-based throat swabbing programme in 21 high needs primary schools since 2013 (16 in Auckland DHB and 5 in Waitemata DHB). The school-based programmes were introduced as part of the two DHBs’ RFPP and are a key component of the strategy to reduce the incidence of RhF by 2017, in line with the Better Public Service (BPS) target.

This paper provides an overview of the school-based programmes, summarises the findings of an initial evaluation and outlines recommendations for future evaluation. The paper recommends that the current school-based programmes are maintained at current levels until at least the end of June 2017 to give sufficient time to obtain more information regarding effectiveness. This requires additional investment from the DHBs, as the Ministry of Health is reducing the additional funding going into the school-based programmes. The Community and Public Health Advisory Committee (CPHAC) is asked to endorse this approach, subject to approvals which will be sought separately from the each DHB’s Audit and Finance Committees.

2. Background

Acute Rheumatic Fever (ARF) is a marker of childhood poverty and disadvantage. ARF is an autoimmune disease which follows throat infection with Group A Streptococcus (GAS) and can lead to serious long term heart disease. ARF is an important public health issue in that it affects children and adolescents, is an important cause of Māori and Pacific health inequalities and occurs in New Zealand fourteen times more commonly than most wealthy countries. The New Zealand incidence of ARF is 4.1:100,000. The rate for the Auckland DHB population is 3.2:100,000 and for the Waitemata DHB population is 2.3:100,000.

ARF particularly affects primary and intermediate-aged children. In the Auckland region between 1998 and 2010, 57% of cases of ARF occurred in 5-12 year olds. The rates for Māori children are 47 times higher and 69 times higher for Pacific children, compared to non-Māori and non-Pacific children. Nationally, rates amongst Māori and Pacific children have continued to rise and disparities increase, as shown in Figure1.1 Between 2008/2009 and 2013/2014 these trends have continued in ADHB, with numbers of ARF cases doubling from 1993. Also, children living in the most socioeconomically deprived areas in the Auckland region (NZDep index 9-10) have a 36 times higher rate of ARF than those children living in the least deprived areas (NZDep index 1-2).2

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2 Jackson, C. and Lennon, D. Rheumatic Fever in the Auckland Region. 2011

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Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 02/09/15
Analysis of data from the Auckland Rheumatic Fever Register has demonstrated that ARF rates are highest in:

- school years 1-8 (children aged 5 – 13 years of age)
- where the school is in the most socioeconomically deprived areas (Ministry of Education decile 1)
- schools that have a high Māori or Pacific Island student enrolment.

Populations with high incidence of ARF also have high rates of other significant childhood conditions such as skin infections, respiratory infections, and dental disease, all of which are potentially addressed through improved access to primary care. Skin sepsis is a common problem among children with almost a third of children in low decile schools reported to have skin conditions such as impetigo, infected eczema, boils or mild cellulitis. School principals report skin infections are the most common health issue affecting children in their schools and are concerned about the resultant absenteeism and reduced learning outcomes. Serious skin sepsis, including cellulitis and abscess, is the third most common reason for children to be admitted to Starship Children’s and Waitakere Hospitals. Pacific children are 4-5 times more likely and Māori 2-3 times more likely to develop cellulitis than their NZ European counterparts.

2.1. What we are trying to achieve in relation to Rheumatic Fever

In June 2012, the Government announced 10 Better Public Service targets, one of which is the reduction of the incidence of RhF by two thirds by 2017. The Auckland DHB’s and Waitemata DHB’s RhF targets were set by the Ministry of Health at 1:1 per 100,000 for Auckland and 0.8:100,000 for Waitemata (based on total populations). These are outlined in Table 1.
Table 1: Rheumatic Fever Better Public Service Target for 2017

<table>
<thead>
<tr>
<th></th>
<th>2009/10–2011/12</th>
<th>2012/13 Target: Remain at baseline level</th>
<th>2013/14 Target: 10% reduction from baseline level</th>
<th>2014/15 Target: 40% reduction from baseline level</th>
<th>2015/16 Target: 55% reduction from baseline level</th>
<th>2016/17 Target: 2/3 reduction from baseline level</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB rate</td>
<td>3.2</td>
<td>3.2</td>
<td>2.9</td>
<td>1.9</td>
<td>1.4</td>
<td>1.1</td>
</tr>
<tr>
<td>ADHB number of cases</td>
<td>15</td>
<td>15</td>
<td>14</td>
<td>9</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>WDHB rate</td>
<td>2.3</td>
<td>2.3</td>
<td>2.0</td>
<td>1.4</td>
<td>1.0</td>
<td>0.8</td>
</tr>
<tr>
<td>WDHB number of cases</td>
<td>12</td>
<td>12</td>
<td>11</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

As Table 1 shows, the number of cases is small in any given year, with a target for 2016/17 set at five cases in ADHB and four cases in WDHB, down from the baseline level of 15 cases in ADHB and 12 cases in WDHB. Such a small number of cases can make it hard to draw conclusions regarding the effectiveness of programme interventions over the short-term.

3. The approach to RhF reduction

The Auckland DHB and the Waitemata DHB RFPP identify the approach and commitment to delivering a range of actions to reduce the incidence of rheumatic fever. The plans take a system wide approach including upstream determinants, community awareness, primary prevention, secondary prevention and disease management. The plans describe:

- the DHBs’ contribution to reducing the effects of overcrowding - through referrals to the Auckland Wide Healthy Homes Initiative (AWHI) and other public health activities including health promotion and health literacy
- primary prevention activities delivered in high need areas through the primary and intermediate school-based sore throat management programme and the Rapid Response service in general practices, pharmacies and secondary schools
- secondary prevention and disease management activities to reduce recurrences of ARF

This paper reports on progress on the school-based RhF prevention component of these plans.

3.1. The school-based Rheumatic Fever sore throat management programme

The school-based RhF sore throat management programme facilitates the early identification and treatment of Group A Streptococcus (GAS). Early identification and treatment of GAS is essential in the prevention of ARF. A systematic review found that school-based programmes reduce new RhF incidence by 60% in schools.³ The school-based model of care is described in the logic diagram in Appendix 1.

Services targeted in areas of high disease burden have proven to be highly feasible and acceptable\(^4\) and are currently being implemented across areas of high RhF prevalence. Auckland and Waitemata DHBs have implemented a school-based programme in 21 specific high-risk primary schools (16 in ADHB and 5 in WDHB). Schools were identified on the basis of scoring system developed by Professor Diana Lennon and Catherine Jackson.\(^5\) This looked at the risk of RF in each school based on a mix of current RF students, % Māori and Pacific enrolled deprivation score and the incidence of RF in the surrounding community. The list of schools covered by the programme is provided in Appendix 2.

The impact of a targeted school-based programme depends on the density of the disease burden. In contrast to Counties Manukau DHB where more than 83% of children who develop RhF attend one of 61 decile 1 schools, Auckland and Waitemata DHBs have a more dispersed disease burden. The school-based programme in the high risk schools is estimated to reach 35% of vulnerable children in ADHB\(^5\) and 19% in WDHB. Despite this restricted reach, a targeted school programme is still a cost-effective way of reducing RhF, and of reducing health disparities for vulnerable populations.

The DHBs are determined to include identification and management of skin conditions in the overall programme response in primary schools due to the burden of disease, community concern regarding its impact on schooling, and to increase the cost-effectiveness of the overall school-based RhF programme. This approach has also been taken in Counties Manukau DHB. This programme aligns with traditional public health nursing (PHN) services.

PHNs primarily provide two types of services to children and young people. These can be broadly categorised as:

- population health services – well-child services such as immunisation and health promotion
- personal health services for individual, usually ‘at risk’ children, young people and their families

The role of the PHN includes:

- promoting and protecting the health of populations, using knowledge from nursing, education, social and public health sciences
- identifying unmet health needs, in individuals, families and communities (especially school communities) and providing early intervention, or referring to other agencies to provide early intervention
- striving to address inequalities in achieving health, particularly where there are access difficulties to healthcare

The school-based RhF programme differs from traditional PHN services in relation to:

- the intensity of the intervention
- the degree of targeting
- the specific focus on reducing RhF through the sore throat swabbing and treatment programme

This intensive school-based programme is delivered by PHNs and Community Health Workers (CHW), supported by a Paediatrician/Medical Officer:

- the programme in the 16 ADHB schools is delivered by:


\(^5\) Jackson, C. and Lennon, D. RhF in the Auckland Region. 2011
9 FTE PHNs
9 FTE CHW
Supported by the Community Paediatrician and a Nurse Practitioner as Clinical Director.

- the programme in the 5 WDHB schools is delivered by:
  - 2.6 FTE PHNs
  - 3.0 FTE CHW
  - 0.4 FTE Medical Officer.

Community health workers (CHWs) are an important component of the project team. They are from diverse cultural backgrounds, appropriate to the schools’ communities and reach out beyond the school gates to the wider community as well as providing appropriate services within schools.

Services provided through the school-based RhF programme include:

- Health Promotion
  - improving health literacy and whānau/family awareness of key health messages
  - involvement in local community events and parent-school partnership evenings
  - hand hygiene education programmes to reduce the transmission of harmful bacteria and communicable disease.

- Sore throat management
  - a three-day-a-week school-based sore throat management programme delivered by PHNs and CHWs working together to the National Heart Foundation Sore Throat Management Guidelines
  - CHWs undertake throat swabbing for children who report a sore throat and PHNs provide treatment for GAS positive throat swabs. Siblings and family members are asked about sore throats and either swabbed or linked with a free sore throat clinic or their family doctor for assessment
  - antibiotic compliance checks are undertaken with follow up at 5 and 10 days post administration of medication. PHNs notify the family GP to ensure continuity of care for children and their families
  - PHNs and CHWs also refer onto other agencies for family support across a range of identified needs, including referrals to the Auckland Wide Healthy Homes.

- Skin infections
  - children with skin infections are identified in two ways. Firstly, CHWs identify children with skin conditions that may require further assessment by the public health nurse. Secondly, the PHN works in partnership with the school administrator and ‘first aider’ to identify children with potential skin concerns
  - following identification, an assessment occurs and, if required, families are supported to obtain treatment from their primary care provider (WDHB). If this is not possible, children are provided treatment by the PHNs under Standing Orders. Parents/whanau of children with skin infections are provided with free education and treatment and information is passed on to their GP.

3.2. Implementation of the programme in Auckland and Waitemata DHBs

The schools have been active partners in the development, delivery and on-going improvement of the programme. Prior to commencing each programme, a meeting was held with each school principal to discuss the rationale of the programme and gain agreement on implementation timeframes. RhF education was provided to school staff, students and school communities at staff
meetings, visits to classrooms, school assemblies, parent-teacher evenings and home-school partnership events.

A phased approach was taken to roll out the school-based sore throat management programme to 16 identified high risk schools in the ADHB area with four schools per term from mid-2013 and five schools in the WDHB area. The programme was fully implemented across both DHBs in time for the winter season of 2014. In ADHB, the 16 high risk primary and intermediate schools in Decile 1 areas are located in three clusters in Glen Innes/Panmure, Otahuhu, and Mount Roskill. For WDHB, the five high risk schools are located in Ranui, Henderson and Onepoto on the North Shore. All schools were selected using the previously described school scoring system.6

4. **Key findings of the evaluation of the implementation of the school-based programmes**

Drs Alison Leversha and Tim Jelleyman led the evaluation of the implementation of the school-based programme with input from Dr Tom Robinson. As yet, it is too early to demonstrate an impact on outcomes with statistical confidence, due to the small number of cases expected in the short timeframe the programme has been running. However, evidence suggests that if these programmes are implemented successfully there will be a demonstrable reduction in ARF over time. The evaluators firstly set out to determine whether the programme had been implemented as planned. The evaluation demonstrated that the programme was implemented as planned and is swabbing a large number of children and treating them in line with the Heart Foundation Guidelines. Key inputs such as high consent rates have been achieved. The programmes have also demonstrated that they are achieving a number of intermediate outcomes including being supported by the school community in which they operate. Comments from school Principals include:

> We have five children being treated for rheumatic fever, and skin problems are prolific at my school. To date we have no new cases of rheumatic fever among children who have been involved in the health clinic checks, and the severity of skin complaint has been reduced as these are being dealt with at a much earlier stage. Terrific! (Principal)

Intermediate outcomes include both quantitative and qualitative data sources.

Key findings include:

- 97% parental consent rates for participation in the school health clinics. A small number of parents choose to access their GP rather than using the school-based service for assessments. The consent rates have been consistently high for all schools over the time since starting the programme
- fall in swabs from children who self-report a sore throat that are GAS positive—rates are higher in the early part of the school year and fall throughout the course of the year (see Figure 2)
- GAS prevalence survey (throat) – GAS rates fell from 14% to 9% based on a cross-sectional survey of all children enrolled in five ADHB schools (~960 children, prior to the school health clinics starting and 12 months after the clinics were introduced) showing a reduced GAS load in the school community
- skin infection prevalence survey - The proportion of children having skin problems fell between the two years. Children presented earlier with skin lesions thus the proportion of

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6 Jackson, C. and Lennon, D. RhF in the Auckland Region. 2011
children needing antibiotics or referral to their GP fell by more than 90%. Most required simple wound care.

- increased health literacy - Surveys of students in both DHBs found increased awareness of RhF; need to have sore throat checked, and; increased understanding of skin hygiene and wound care:
  
  *Tell a grown up and see if you could go to a nurse or doctor. I also would tell them to always take your medicine because rheumatic fever might come your way* (Pupil)
  
  *There has been a positive impact on our students. I think their confidence to self-refer when they have a sore throat or a skin problem has been one of the greatest impacts* (Principal)

- Improved linkage of families with general practices - school staff noted improved access to care and increased trust between families and health services due to the PHN role.

- Strong relationships of staff with the school community allowing other health issues to be raised:
  
  *Our PHN has been very skilled in getting alongside parents and helping them to be involved. This has been a reason for their great success. It's about building relationships* (Principal).

Most importantly, there was also a reported positive impact on broader child health:

*This programme has been extremely successful and has made a huge difference to the health and wellbeing of our students!* (Principal).

**In Auckland DHB:**

Ten school principals were surveyed:

- all were very satisfied with the school health clinics
- 80% reported excellent engagement with students
- 70% reported excellent engagement with school staff
- 70% reported excellent engagement with parents and whanau
- 6/10 reported very positive effects on student’s skin health (the rest was positive)
- 9/10 positive or very positive effect on overall child health and wellbeing
- 8/10 positive/very positive effect on school attendance
- and 6/10 a positive/very positive effect on engagement with learning.

**In Waitemata DHB:**

School staff were surveyed. Almost all (n=39 of 40) rated their assessment of the overall benefit of the Public Health team in the school for students and families as ‘Very good’ or ‘Excellent’ (grade 4 or 5 on scale of 5). Many commented on the way children were assisted to get timely checks and treatment and valued the preventative emphasis of the programme. Real health improvement has been observed. School staff were cognisant of the challenging socioeconomic context for many of their families and commented on the way nurses were assisting these families to access the right care and the related benefit to educational opportunities. There was also a theme of the development of trust with families and health services through effective interactions with the public health nursing and community worker team in the schools – who demonstrate compassion and diligence:

*This has been a vital support service for our school community. Many of our families struggle to get children to doctors because of work commitments and this service has filled that gap. Our community does not always realise how serious a sore throat or skin infection can be and this service has grown this awareness in our school community.* (Teacher)
I would like to see the service continue as a well child is a child that can learn. (Teacher)

Transience of school enrolment was noted by principals as an issue. One school for example had a 30% change from year start to end. This dilutes the benefit of any intervention unless the network of provision covers enough of the schools between which children might be moving. This significant challenge requires further consideration in subsequent evaluation.

4.1. Evaluation findings - GAS positive rates
Overall, there has been a reduction in the proportion of swabbed children who are GAS positive. Rates are higher at the beginning of each year when children return to school, and fall over the course of the year. Note, with each school year a new cohort of students is introduced and the oldest cohort departs.

Figure 2: Percentage of swabs that were GAS positive in ADHB and WDHB, 2013-15

These findings are supported by the throat GAS Prevalence survey. The survey was undertaken as part of a Health Research Council study examining the effectiveness of different school-based models in three DHBs (Lennon D., Leversha A. et al). All children in five schools had throat swabs and examination of their skin for infections prior to the commencement of the clinics, and then repeated after one year. There was a significant drop on the GAS rate across all schools. GAS is the necessary precursor of RhF, thus these findings are considered encouraging and an interim outcome measure.

4.2. Evaluation findings - Skin conditions
Skin conditions are a major cause of concern for principals, staff and PHNs in the low decile schools and are a significant component of the school health clinics. The number and complexity of skin infection cases was greater than anticipated, particularly at the beginning of a programme in a school and at the beginning of each term. In 2014, almost 3,000 children were assessed in Auckland DHB with possible skin infections. Numbers fluctuated month by month over the year.
Skin issues included boils, cellulitis, impetigo, eczema, infected eczema, infected lesions and other non-infected lesions. The distribution varied across schools and geographic areas. The proportion of lesions assessed that were infected varied from 16-44%. The dominant lesions in schools with low infection rates were non-infected skin issues (e.g. simple wound care, and eczema). These schools were typically in the Otahuhu area and had a high proportion of Indian students. The schools with higher rates of infections were in the Tamaki/Glen Innes area and were predominately Pacific students.

Overall, approximately one third of skin lesions were treated (the vast majority with topical cleaning and covering; if antibiotics were needed, fusidic acid (Foban) or, more rarely, Cephalexin or Flucloxicillin were used).

In the cross sectional prevalence study, skin infections reduced significantly. Children identifying with skin lesions reduced from 17% in 2013 to 9.7% to 2014. Very few required intervention in 2014 and if they did, it was simple wound care. 39 children required treatment (topical or oral antibiotics or permethrin for scabies) in 2013 vs. one child in 2014 (~960 examined). Most of the children with chronic eczema were under PHN care which meant the proportion of infected eczema dropped from 18% to 2%. Children were therefore identifying skin issues earlier in the process and milder:

> It is really good having the team in the school regularly several times a week, as health problems are picked up much more quickly. The explicit instructions delivered face to face to parents regarding medication is also an important factor. (Principal)

> While we may not yet be able to have our mid-winter swim activity, we have seen a huge improvement in skin health, so much so that one of our students with a particularly bad case of poor skin health was able to attend a week-long sports camp with confidence. (Principal)

A limited analysis of hospitalisations with serious skin infection was carried out for the children enrolled in the five Waitemata DHB schools. In 2012, prior to the commencement of the programme, there were at least nine children from the rolls of the five schools admitted to hospital with serious skin infections. Over the course of the programme, 2013 and 2014, there were a total of four children hospitalised under the same diagnostic code group. Although these are small numbers, the change was only seen in the schools where the programme was run. In contrast, the number of hospitalisations for school-age children across Waitemata district increased across the three year period. While this is based on small numbers it provides an early indication of a measurable health outcome which may be evaluated through ongoing monitoring.
Table 2: Hospitalisation with serious skin infection for children in the five WDHB schools

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospitalisations, school age</th>
<th>Hospitalisations, enrolled in the five schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>76</td>
<td>9</td>
</tr>
<tr>
<td>2013</td>
<td>77</td>
<td>2</td>
</tr>
<tr>
<td>2014</td>
<td>94</td>
<td>2</td>
</tr>
</tbody>
</table>

4.3. Community engagement and health promotion

The provision of activities to support health promotion and improve health literacy through school communities has been a key component of the programme. This work has been led by the Health Promoting Schools (HPS) team in WDHB and by a combined team in ADHB.

Examples of the activities undertaken include:

- identification of student, family/whanau and school staff sore throat and RhF health literacy
- teaching sessions for all school staff prior to the commencement of the swabbing programme
- development of a ‘chatter box’ RhF game (this has now been introduced regionally)
- information sessions for child on Sore Throats Matter and RhF
- distribution of health promotion resources
- continuation of hygiene and health promotion activities, including hand washing.

The team has also undertaken further health promotion activities across the wider community such as:

- developing a display board for Ranui library
- education sessions in the local community network
- community health days in a number of the schools
- attending parent school partnership evenings
- attending community events (e.g. Glen Innes Community day, Toddler Day Out, Kelston Girls family Day, School sports days)
- Manaiakalani Cluster meeting
- working with the Mount Roskill Campus to run a Fia Fia night focussed on Rheumatic fever prevention.

The Auckland metro DHBs took a regional approach with Health Promoting Schools staff, Public Health Nurses and Community Health Workers developing a consistent strategy and toolbox of resources to engage schools not involved in the RhF school programme and with students from the RhF target population. The aim was to raise awareness with children and their families/whānau on the importance of treating sore throats, preventing RhF and how to access free sore throat treatment through Rapid response clinics. In the Waitemata district this has involved Public Health Nurses undertaking health promotion and Rheumatic Fever prevention work with an additional 13 schools to the five schools involved in the school-based sore throat treatment service.
4.4. Summary of initial evaluation findings

In relation to the school-based programme, the evaluators concluded that the required resources and support are in place in both DHBs to deliver successful school-based programmes. Engagement with the school communities has been excellent with very high rates of parental consent to participate in the programme and good support from children reflected in high presentations for both sore throats and skin infections. A large number of children (and household contacts) requiring treatment are being identified and almost all of these have been effectively treated.

Although information on impact is, at this stage, preliminary, there is evidence of a positive impact on GAS infection rates, reduced skin infections and reports of a wider benefit from school principals.

The evaluators believe that the two DHBs can be confident that the school-based programmes have been implemented in a manner that international evidence suggests should lead to a positive effect on ARF, and that wider benefits are likely. However, it remains too early to establish whether there are indeed reductions in RhF as a result of the school-based and wider programmes. Given the school-based programmes in the two DHBs target a modest proportion of the at risk population (as opposed to Counties Manukau DHB where the school-based programme covers ~83% of the at-risk population), the programmes should be seen in the context of the broader prevention programme. On their own, they have insufficient reach to reduce the rates to the target levels. They are, however, providing timely and free access to primary health care for vulnerable children and families who often have difficulty accessing traditional primary care due to cost, transport, childcare barriers and other factors.

5. Proposed wider outcome evaluation

The evaluators propose conducting a wider evaluation of the school-based programmes for the two DHBs in 2016. At that time the school-based programmes will have been running as a fully implemented programme for two years. The aim of the wider evaluation would be to provide information the DHBs need to determine whether to continue funding these school-based health programmes and, if so, whether there should be any changes made to the programmes to maximise their cost-effectiveness. The evaluation would therefore look at the following questions:

1. Do the Schools Programmes lead to the desired changes in health outcomes?
   • The evaluation will examine whether there have been reductions in first episodes of rheumatic fever and hospitalisations for skin sepsis that are attributable to the school-based programmes.
   • It should be noted that the expected number of new cases of ARF over two years will still be small (17 in the ADHB schools and five in the WDHB schools). This means that very effective programmes may still be difficult to prove to be effective.

2. Are the Programmes optimally designed to achieve the best outcomes (including the best mix of reach and effectiveness) given the particular context of the two DHBs?
   • The evaluation will undertake a more detailed implementation evaluation. This will include comparisons with similar programmes in other DHBs (in particular CMDHB) and understanding which components of the school-based programmes are working well and how they relate to school contextual factors.

3. What are the likely wider benefits and costs of the programmes?
   • This will consider such things as evidence of other health issues being addressed by the PHNs and the opportunity costs of focussing scarce community health resources on a fewer (high needs) schools.
5.1. Outcome evaluation proposed methodology

The proposed outcome evaluation aims to determine whether the programme is leading to a reduction in acute rheumatic fever incidence and hospitalisation for skin sepsis. The evaluators will compare incidence of outcomes for four groups in a difference analysis.

1. children from census area units that are predominantly in the school zones; before the intervention
2. children from census area units that are predominantly in the school zones; during the intervention
3. children from census area units that are outside the school zones; before the intervention
4. children from census area units that are outside the school zones; after the intervention.

The evaluation will be undertaken in the third quarter of 2016 and be available in November 2016. It will be undertaken by Drs Tom Robinson (Public Health Physician), Alison Leversha, Tim Jelleyman (Community Paediatricians) with additional support for the qualitative component.

5.2. Further implementation evaluation

In addition to the proposed outcome evaluation, a further implementation evaluation is proposed and will use a mixture of programme collected data, surveys, and qualitative data (key informant interviews, focus groups etc.) to provide more detail on a number of important areas that provide an overview of what has been delivered, what has worked well, and what could be improved. It will attempt to identify all important positive and negative impacts of the programme and how they are explained by various components of the programme. It will also have a particular focus on possible long term maintenance of the programme, and possible extension to increase reach.

The evaluators consider that it is necessary to undertake this wider evaluation in October 2016, with the findings to be presented to CPHAC in late 2016, to support a decision regarding ongoing funding of a school health based programme.

This paper specifically requests endorsement of ongoing and additional funding during 2016/17. The expected process would then be a request for endorsement from CPHAC (as appropriate and in line with the new evidence) in late 2016 followed by approval by the DHBs’ Audit and Finance Committees for potential continuation of funding to continue and potentially extend the delivery of the school-based programmes in the 2017/18 financial year.
6. **Endorsement of ongoing funding to maintain the school-based programme and for a wider evaluation during 2016/17**

The school-based programmes are delivered by the Child and Youth Teams within the DHBs’ provider arms. The school-based programmes are funded by a mixture of additional funding from the MoH, additional funding from the DHB and redirected DHB resources. Additional DHB contributions have covered the costs of swabs, antibiotics, pharmacy and communications with and through schools. The ADHB funder passed Ministry funding to the provider to increase staffing (PHNs and CHW); the WDHB funder passed Ministry funding to the provider to increase CHW staffing. Existing DHB resources have been re-directed in relation to personnel - public health nurses (PHNs) and community paediatricians/paediatricians / senior medical officers (SMOs). Originally, the MoH contribution to the Auckland and Waitemata school-based sore throat management programme was to cease on 31 December 2015 but funding has now been extended to 30 June 2016. MoH funding has also been confirmed for Rheumatic Fever prevention for 2016/17 and is not tagged to a specific service. It is recommended that a proportion of this funding is used to maintain the school based programme in Auckland and Waitemata throughout 2016/17. Exactly how this funding would be distributed across the entire programme is yet to be agreed but maintaining the school-based programme throughout 2016/17 is considered a priority and will:

- build on the early evidence that the school-based programme has been effective and will ensure there is an ongoing sore throat management service to cover the winter of 2016 where there is an increased Streptococcus A load (the necessary precursor for Rheumatic Fever)
- coincide with the Health Research Council Evaluation, available at the end of 2016, regarding the effectiveness of the different models of the Rheumatic Fever school-based sore throat management programmes in reducing the GAS load and reducing rates of RhF
- give time to undertake the Auckland and Waitemata wider evaluation, after the school-based programmes have been operational for a full two-year period
- provide time for transitional arrangements during the second half of 2016/17, to implement decisions endorsed and or approved by the Boards, as appropriate.

7. **Funding to Extend the School Based Programme and for a Wider Evaluation**

The contributions required from Auckland and Waitemata DHBs to maintain the school-based programmes during 2016/17 and undertake a wider evaluation need to be considered within the context of MoH funding and delivery of the wider programme.

The school based programme is currently funded jointly by the DHBs and the MoH and delivered by the Child and Youth Teams with in the Community Child Health and Disability Services. The funding table below shows:

- the MoH contribution to the School Based and the Rapid Response programme for 2014/15 and 2016/17
- Auckland and Waitemata DHBs contributions to cover the cost of swabs, antibiotics, pharmacy and communications. It does not include the use of existing and /or redeployed resource including public health nurses (PHNs), community health workers, paediatricians and senior medical officers

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7 Auckland DHB Rheumatic Fever Prevention Plan 2013, Waitemata DHB Rheumatic Fever Prevention Plan 2013
- the DHBs contribution for the wider evaluation which cannot be covered by existing DHB resource. The investment of $50,000 will be shared across the two DHBs
- the MoH intention to contribute additional funding for 2016/17 and 2017/18 onwards to support implementation of the Auckland and Waitemata DHBs updated Rheumatic Fever Prevention Plans. Unlike previous MoH funding for Rheumatic Fever prevention, the MoH contribution from 2016/17 onwards is not tagged to specific services.

### Rheumatic Fever Prevention Plan Funding Table 2014/15 Onwards

<table>
<thead>
<tr>
<th></th>
<th>ADHB Revenue MoH 2014/15</th>
<th>ADHB Revenue MoH 2015/16</th>
<th>ADHB Revenue MoH 2016/17</th>
<th>ADHB Revenue MoH 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>School based programme</td>
<td>586,036</td>
<td>602,072</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rapid Response</td>
<td>743,792</td>
<td>743,792</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not tagged</td>
<td>0</td>
<td>0</td>
<td>734,792</td>
<td>240,755</td>
</tr>
<tr>
<td>total</td>
<td>1,329,828</td>
<td>1,345,864</td>
<td>734,792</td>
<td>240,755</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>WDHB Revenue MoH 2014/15</th>
<th>WDHB Revenue MoH 2015/16</th>
<th>WDHB Revenue MoH 2016/17</th>
<th>WDHB Revenue MoH 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>School based programme</td>
<td>100,000</td>
<td>108,963</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rapid Response</td>
<td>783,647</td>
<td>783,647</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not tagged</td>
<td>0</td>
<td>0</td>
<td>550,028</td>
<td>134,567</td>
</tr>
<tr>
<td>total</td>
<td>883,647</td>
<td>892,610</td>
<td>550,028</td>
<td>134,567</td>
</tr>
</tbody>
</table>

### DHB Expenditure on primary school based programmes*

<table>
<thead>
<tr>
<th></th>
<th>ADHB DHB Contribution 2014/15</th>
<th>ADHB DHB Contribution 2015/16</th>
<th>ADHB DHB contribution 2016/17</th>
<th>DHB contribution 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB including swabs, antibiotics etc</td>
<td>232,062</td>
<td>382,000</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>WDHB including swabs, antibiotics etc</td>
<td>90,000</td>
<td>90,000</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td><strong>Evaluation</strong> (shared across both DHBs)</td>
<td></td>
<td>50,000</td>
<td>TBC</td>
<td>TBC</td>
</tr>
</tbody>
</table>

* excluding use of existing and redeployed staff resource

The funding table indicates there is no tagged MoH funding in 2016/17 for the school based programme. However it is likely that a proportion of the MoH funding can be used for this purpose, along with the provision of Rapid Response services which will undoubtedly benefit from the extension of the ‘zero fees’ scheme in primary care for children under 13 years.

The actual funding level is subject to the review and refresh the Rheumatic Fever Prevention Plans to be endorsed by the Minister of Health and effective from January 2016. Whilst it is too early to anticipate the outcome of the review, the maximum potential risk for the DHBs are shown in the table below to fund a six month period for running the school based programme, including the costs of swabs, antibiotics and pharmacy for 2016/17, and a contribution of $50,000 for the evaluation of the programme.
<table>
<thead>
<tr>
<th></th>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Risk for DHB 2016/17 School Based Programme</td>
<td>301,036</td>
<td>54,482</td>
</tr>
<tr>
<td>Antibiotics, Pharmacy</td>
<td>98,883</td>
<td>30,000</td>
</tr>
<tr>
<td>Swabs</td>
<td>45,000</td>
<td>45,000</td>
</tr>
<tr>
<td>Evaluation</td>
<td>25,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Total</td>
<td>469,919</td>
<td>154,482</td>
</tr>
</tbody>
</table>

We will continue discussions with the MoH and in the event there is a gap between what the MoH will fund and expenditure, we will prepare a business case for the respective Audit and Finance Committees to consider.

8. Conclusion

ARF is a significant public health issue as well as a marker of childhood poverty and disadvantage. Identified District Health Boards, including ADHB and WDHB, were required to reduce ARF in line with the Government’s Better Public Service targets. One component of the overall programme is the school-based RhF programme, delivered in 21 primary and intermediate schools (16 in Auckland DHB and 5 in Waitemata DHB). It is too early to determine whether the school-based programme will lead to a decrease in ARF, however, evidence from a systematic review of school based programmes found that school-based programmes reduce new rheumatic fever incidence by 60% in schools.8

An initial evaluation has been under-taken and demonstrates that the programmes have been implemented in line with the programme logic and that intermediate outcomes show some evidence of falling GAS positive rates, and increased health literacy in the target population as well as high programme acceptability. The addition of skin assessment and management as an adjunct to the RhF prevention has been a significant addition. Findings also suggest school health clinics in low decile schools have had other advantages including increased student health and wellbeing, increased health literacy, improved health seeking behaviour, and reduced school absenteeism.

This paper requests CPHAC endorse continuing the school-based programmes throughout the 2016/17 year in order to demonstrate effectiveness through a second evaluation which may demonstrate whether there have been reductions in first episodes of rheumatic fever and hospitalisations for skin sepsis that are attributable to the school-based programmes. This evaluation would also make recommendations regarding service design which would be implemented over the 2017 calendar year. CPHAC is asked to note that additional approvals would be sought from each DHBs’ Audit and Finance Committees in relation to funding implications associated with continued programme delivery in light of decreased MoH contributions.

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Appendix 1: Rheumatic Fever School-based Programme Logic Model

School Based Rheumatic Fever Prevention Project
Appendix 2: Schools covered by the ADHB and WDHB RhF programme

**Auckland DHB**
- Glen Innes Primary
- Glenbrae Primary
- Glen Taylor Primary
- Tamaki Primary
- Point England
- Ruapotaka
- Te Kura Kaupapa Maori O Puau Te Moananui A Kiwa
- Panmure Bridge
- St Pius
- Otahuhu Primary
- Otahuhu Intermediate
- Fairburn School
- St Josephs
- Wesley Primary
- Wesley Intermediate
- St Therese

**Waitemata DHB**
- Ranui Primary
- Birdwood School
- Pomaria Road School
- Nga Kakano Christian Reo Rua Kura
- Onepoto Primary
Appendix 3: Public Health Nursing Scope

The scope of public health nursing care delivery includes:

- Nursing assessment, intervention, follow-up and referral for children, young people and their family/caregivers
- Co-ordinating care across a range of agencies for children with specific health issues (e.g. asthma or allergies)
- Working with families from a range of cultures and ethnicities, including migrant and refugee families
- Identification of health and social needs and on-referral to other agencies
- Promoting the protection of children
- Working with schools and the wider community to provide health initiatives to meet the needs of that particular community
- Working with schools to develop and provide health education and promote a health focus for their community
- Fostering community partnerships and working collaboratively with other agencies
- Maintaining a primary role in disease prevention through immunisation
- Providing education and advice on specific health issues to parents and other agencies
- Responding to national and regional disease outbreaks and assisting with regional initiatives to restore health Providing specialist assessment and/or intervention (e.g. Youth Justice Assessments and Ear Health)
- Providing education and advice on specific health issues to parents and other agencies
- Responding to national and regional disease outbreaks and assisting with regional initiatives to restore health Providing specialist assessment and/or intervention (e.g. Youth Justice Assessments and Ear Health).
- Providing a valuable interface between primary care and inpatient services to ensure best possible outcomes for children and their families
- Accessible and timely service – School, home and community based service provision
- The Public Health Nurse has an important role establishing partnerships and communication strategies with Primary Health Care Organisations and NGOs to improve health outcomes for communities.
- Communicable disease control and primary prevention
- Advocacy
- Supporting health literacy
## Appendix 4: Summary of initial evaluation findings

### Table 3: Description of School Programme Implementation

<table>
<thead>
<tr>
<th></th>
<th>Auckland</th>
<th>Waitemata</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification of schools</td>
<td>16 target schools identified. Programme implemented in all identified schools as planned.</td>
<td>5 target schools identified. Programme implemented in all identified schools as planned.</td>
</tr>
<tr>
<td>School involvement</td>
<td>All Boards and management actively supportive.</td>
<td>All Boards and management actively supportive.</td>
</tr>
<tr>
<td>Resources provided by schools</td>
<td>Varies by school but all provide a private space for swabbing children, and active support of the programme through the schools programmes and access to children</td>
<td>Varies by school but all provide a private space for swabbing children, and active support of the programme through the schools programmes and access to children</td>
</tr>
<tr>
<td>Nurses and CHW available</td>
<td>DHB staffing for intensive visiting programme confirmed. PHN present in the school at least three times a week. CHW visits each school three days a week in term time.</td>
<td>DHB staffing for intensive visiting programme confirmed. PHN present in the school at least three times a week. CHW in the school three days a week.</td>
</tr>
<tr>
<td><strong>Engagement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent process established - Children who have consents to participate signed</td>
<td>4,615 or 97% of potential children consented</td>
<td>1,152 or 90.5% of potential children consented</td>
</tr>
<tr>
<td>Children presenting with skin infections</td>
<td>In 2014 almost 3,000 children presented with possible skin infections (Figure 1)</td>
<td></td>
</tr>
<tr>
<td>Proportion of swabs taken within 5 days of symptoms</td>
<td>95% in 2015</td>
<td>100% in 2015</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients who are GAS positive who are treated</td>
<td>99% (the remainder see their GP for Rx)</td>
<td>99%</td>
</tr>
<tr>
<td>Throat swabs taken from household contacts</td>
<td>205 in 2014 85 in 2015</td>
<td>368 in 2014 219 in 2015</td>
</tr>
<tr>
<td>Proportion of GAS positive household contacts treated</td>
<td>100% in 2015</td>
<td>100% in 2015</td>
</tr>
<tr>
<td>Antibiotic treatment for skin sepsis</td>
<td>Overall, approximately one third of skin presentations required treatment (the vast majority with topical cleaning and covering)</td>
<td></td>
</tr>
<tr>
<td><strong>Intermediate outcomes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Screening swabs that are GAS positive</strong></td>
<td>Rates are higher in early part of the school year and fall throughout the year (Figure 2)</td>
<td></td>
</tr>
<tr>
<td><strong>GAS Prevalence Survey (throat)</strong></td>
<td>GAS fell from 14% to 9% based on surveys of GAS throat carriage conducted in 2013 and 12 months later.</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Skin infection prevalence</strong></td>
<td>The percentage of children having skin problems fell between the two years. The percentage of children needing antibiotics or referral to their GP fell by more than 90%.</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Supportive school community (qualitative comments from schools)</strong></td>
<td>PHNs very skilled in working alongside parents. Programme minimally disruptive to schools. PHN regularly visible in the school building solid and trusting relationship with the community PHN works alongside families, which means better outcomes. Decrease in presentations to office staff for skin conditions, especially complex cases</td>
<td>PHN regularly visible in the school building solid and trusting relationship with the community PHN presence supports parents to feel safe and not targeted (particularly parents who do not normally engage with health services). PHN works alongside families, which means better outcomes. Decrease in presentations to office staff for skin conditions, especially complex cases</td>
</tr>
<tr>
<td><strong>Improved health literacy</strong></td>
<td>Survey of students found increased awareness of RhF; need to have sore throat checked; and increased understanding of skin hygiene and wound care.</td>
<td>Surveys of staff and parents have shown improvements in knowledge and behaviours.</td>
</tr>
<tr>
<td><strong>Reported impact on child health</strong></td>
<td>Ten school principals surveyed: all reported positive effect on student’s skin health, 8/10 positive effect on overall health, 8/10 improvement in school attendance, and 6/10 an improvement in educational engagement</td>
<td>39/40 school staff rated the overall benefit of the programme as very good or higher.</td>
</tr>
<tr>
<td><strong>Improved linkage of families with general practices</strong></td>
<td></td>
<td>School staff noted improved access to care and increased trust between families and health services due to the PHN role.</td>
</tr>
</tbody>
</table>
4.1 Waitemata and Auckland District Health Board 2015/16 Maori Health Plans

Recommendation

That the report be received.

Prepared by: Aroha Haggie (Maori Health Gain Manager)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Simon Bowen (Director Health Outcomes)

Glossary

DHB - District Health Board
EDAT - Ethnicity Data Audit Tool
GP - General Practitioner
Kaumatua - Elderly man or woman
Manawa Ora - Maori Health Gain Advisory Committee
MoU - Memorandum of Understanding
MHGT - Māori Health Gain Team
PHO - Primary Healthcare Organisation

1. Executive Summary

The purpose of this paper is to provide the Community and Public Health Advisory Committee (CPHAC) with a summary of:

- highlights from the 2014/15 Maori Health Plans
- new indicators for 2015/16 Maori Health Plans
- new areas of activity in the 2015/16 Maori Health Plans
- areas of focus for the 2015/16 year

2. Background

District Health Boards (DHBs) are required to improve the health of Māori and reduce health disparities for Māori compared to other population groups in New Zealand. It is currently mandatory that all DHBs have a stand-alone Maori Health Plan to improve the health outcomes of Maori in line with national guidance. The Maori Health Plan provides a summary of our DHBs Māori population and their health needs. The plan also documents and details the interventions and actions the DHB plans to undertake to address health issues in order to achieve national indicator target and local priority areas.

3. 2014/15 Maori Health Plan Highlights

This section of the paper provides a summary of some of the highlights from the 2014/15 Maori Health Plan activities which include:

- Ethnicity Data Audit Tool
- Better help for smokers to quit – primary care
- Kaumatua Action Plan
- Workforce Development Strategy
3.1 Ethnicity Data Audit Tool
The Māori Health Gain Team (MHGT) led the implementation of the Ethnicity Data Audit Tool (EDAT) in general practitioner (GP) practices across both the Auckland and Waitemata District Health Boards. The tool is designed to improve ethnicity data collection in primary care. MHGT is pleased to report that the target of 95% of general practitioner practices implementing EDAT by 30 June 2015 has been exceeded and implementation is currently at 98%. This represents 234 practices. Support by PHOs and GPs has helped to achieve the target.

3.2 Better help for smokers to quit – primary care
The Primary Care Team has continued to support PHOs and GPs to identify smokers who have not been provided with brief advice and support to quit. This sustained effort has seen the maintenance of the ‘better help for smokers to quit’ target of 90% of PHO enrolled patients who smoke being offered help to quit smoking by a health care practitioner across the 2014/15 year. These efforts have complemented the significant increase in performance against this target for the 2013/14 year which saw both DHBs performance increase from approximately 50% to 100% from Q1 to Q4 for Maori. A similar result was also observed for non-Maori.

3.3 Kaumatua Action Plan
Kaumatua health was a local priority identified by Memorandum of Understanding (MoU) partners during the planning consultation process for the 2014/15 Maori Health Plans. One of the key deliverables was to develop a Kaumatua Action Plan. The Plan has been developed in partnership with the Waitemata and Auckland DHB Health of Older People Team and included consultation with kaumatua. The Plan outlines the activities the DHB will undertake to improve kaumatua health over the next three year period. The Plan has been endorsed by Manawa Ora (Maori Health Gain Advisory Committee) and will begin implementation shortly.

3.4 Maori Workforce Development Strategy
Te Runanga o Ngāti Whātua led the development of the Waitemata and Auckland DHBs Maori Workforce Development Strategy on behalf of both DHBs. The Strategy has been endorsed by both the Auckland and Waitemata DHB Boards and implementation has begun.

4. New indicators for 2015/16 Maori Health Plans
The Maori Health Plan has ten indicators that are set nationally. For the 2015/16 year there has been a change in the performance indicator for smoking. The focus of this indicator has moved away from the provision of brief advice and support to quit in both hospital and primary care. The focus is now on pregnant Maori women with the new indicator defined as:

- the percentage of pregnant Maori women who are smokefree at two weeks postnatal
The target for this indicator is 95%.

The Maori Health Plan also allows for the inclusion of local priorities. For the 2015/16 year the local priorities that have been identified in consultation with MoU partners are:

- Obesity
- Cardiovascular disease management
- Workforce development – continued from the 2014/15 Maori Health Plans

5. **New areas of activity for 2015/16**

There are several new areas of activity that both Auckland and Waitemata DHBs are implementing to support improvements in Maori health outcomes and include:

- Smoking cessation
- Oral health
- Obesity
- Cardiovascular disease management

5.1 **Smoking cessation**

The Maori Health Gain Team is leading the development and implementation of an incentives-based programme to support pregnant women to be smokefree during pregnancy and in the initial post-natal period. Women can engage in the programme at any stage of pregnancy, and will receive one-to-one support tailored to their needs throughout pregnancy and for up to two weeks post-natally. The programme involves an initial intensive engagement period to set and achieve a quit date. Women receive a gift pack for engaging in the programme and a gift voucher for every week smokefree thereafter for up to 16 weeks and then again two weeks post-natally. Women will be actively recruited through the Health Babies Healthy Futures programme.

5.2 **Oral Health**

The Planning and Funding Outcomes Team will be working with Auckland Regional Dental Services to improve enrolment and service utilisation. This will occur through the development of a multi-enrolment process, which will enable information sharing at birth from Auckland and Waitemata DHB hospital services. An oral health coordinator has been employed at Auckland DHB to support Oral Health Service enrolment of new-borns on the maternity ward. A similar FTE is already in place in Waitemata DHB.

5.3 **Obesity**

Population and individual strategies are required to address obesity, and we are participating in activities that address both elements. The Planning and Funding Outcomes Team is contributing to the inter-sectorial work through Healthy Auckland Together on the development of an agreed regional obesity approach, and the Healthy Babies Healthy Futures Project. Alongside this longer term development work we will also focus on bariatric surgical services to identify and remedy barriers to Māori being accepted onto the bariatric surgery waiting list.

5.4 **Cardiovascular disease management**

One of the national cardiovascular disease performance indicators is that 90% of eligible Maori will have their cardiovascular disease risk assessed within five years. Whilst Auckland and Waitemata DHB have not quite achieved the target for Maori, performance continues to
improve for both DHBs and it is probable that the target will be achieved shortly. The Maori Health Plan will extend its focus from risk assessment to ensuring that eligible Māori have appropriate management of any cardiovascular risk factors identified, including diabetes.

6. Areas of focus

Some areas require additional focus to support improved performance against national indicators and improved health outcomes for Maori. This section will briefly describe those areas of focus and the activities that will be carried out to improve performance.

6.1 Cervical screening

Improving performance against the cervical screening indicator for Maori has continued to provide challenges for both DHBs. Maori performance has consistently been approximately 20% below non-Maori for both DHBs. There are several activities underway and planned to improve performance against this indicator and include:

- Review of Cervical Screening Strategic Plan with a focus on how to engage with priority women and decrease the inequities that currently exist in coverage rates.
- Improved access to data for PHOs. This data has the potential to be prioritised by the PHOs by ethnicity so practices can be supported to target priority women.
- Training packages are being developed to support clinical and non-clinical staff to improve engagement with Maori women.
- Development of a referral pathway to Independent Service Providers from general practice, an important aspect of the pathway is the feedback to General Practice on the outcome of the referral.
- Continue targeted free smears for Maori women.

6.2 Breast screening

Breast screening is an area that requires additional focus from both DHBs. The following activities are planned to improve performance against this indicator:

- Data-matching at general practice level to support identification of never screened and under-screened Māori women to invite and recall.
- Identification of women not on the breast screening register remains a key strategy to increase Maori coverage rates.

6.3 PHO enrolment

There has been a modest improvement in performance against the PHO enrolment indicator for Maori during the 2014/15 financial year for both DHBs. However, a significant inequity gap of over 10% for both DHBs still remains between Maori and non-Maori enrolment. It is important to note that the EDAT work will assist in determining how much of the equity gap in this indicator is related to misclassification. Initial results suggest the misclassification for Maori is approximately 10% which would suggest that Maori enrolment is similar to non-Maori. The following activities are planned to improve performance against this indicator:

- Further work to support primary and secondary care to improve ethnicity data quality.
- Implement a multi-enrolment process to enable referral and enrolment of new-borns into a range of services, including enrolment with a PHO.
- Analyse the proportion of Māori ASH admissions without a GP recorded and develop an approach to increase enrolment in this group.

Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 02/09/15
4.2 Review of Health Services - Waiheke Island

Recommendation:

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.

Prepared by: Tim Wood (Funding and Development Manager Primary Care, Auckland and Waitemata DHBs)

Glossary

CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
ELT - Executive Leadership Team
NGO - Non-Governmental Organisation
PHO - Primary Healthcare Organisation

1. Executive Summary

The purpose of this paper is to advise the Community and Public Health Advisory Committee (CPHAC) of a public engagement process which will form part of a review of Waiheke Island health services. This engagement process will include a range of external stakeholders:

- Waiheke Island
- NGOs
- Government Departments
- Waiheke residents

This paper sets out:

- background information to identify why a review of Waiheke Island health services is necessary
- findings from an initial internal review process
- a process for external consultation
- further steps for the Waiheke Island health services review
2. Introduction

Auckland District Health Board (DHB) currently contracts a number of healthcare providers to provide a range of services to the residents of Waiheke Island. Many of these agreements are outdated and do not reflect either the current service delivery or the current needs of Waiheke Island residents.

The Auckland DHB provider arm also delivers a number of health services on Waiheke Island.

An internal review of health services available on Waiheke Island has recently been conducted, which focused on examining relevant DHB documentation, and conducting interviews and meetings with DHB internal stakeholders. Waiheke Island demographic data captured during the 2013 census was also considered.

The Funder considers a further consultation process with external stakeholders is necessary to:

- verify findings from the internal review
- identify any service gaps
- ensure health services are configured to optimally meet the current and future needs of Waiheke Island residents

3. Background

3.1 About Waiheke Island

Waiheke Island is the third most populated island of New Zealand, after the North and South Islands, and is the fifth largest in size (approximately 92km²). It is located approximately 17.7km (35min by ferry) from downtown Auckland. At the 2013 Census, 8,238 people were usually resident on Waiheke Island, representing about 2% of the Auckland DHB population. (For the purposes of the New Zealand Census, ‘usually resident’ is defined as “a count of all people who usually live in that area and were present in New Zealand on census night”.)

Waiheke Island is part of the Auckland DHB and has two main health providers delivering services, Piritahi Hau Ora Trust and Waiheke Health Trust. The geographic isolation of Waiheke, coupled with a fluctuating population at weekends and over summer months, poses some unique challenges in delivering care to both residents and visitors.

3.2 Waiheke Island current demographic profile

- The male to female ratio mirrors that of Auckland DHB as a whole with approximately 49% of the population being male. This remains unchanged between 2006 and 2013.
- In 2013 the largest ethnic group on Waiheke Island are European/Other (82.4%), with 11.4% Maori followed by Asian 3.3% and Pacific 2.9%.
- In 2013 6.4% of the population was under 5 years of age, with 17.6% of the population under the age of fifteen, compared to 18.1% in the Auckland DHB population as a whole. 18.6% of the population were over 65 years of age compared to 10.6% in Auckland DHB overall. This differs significantly from 2006 when only 13% of Waiheke residents were over 65 years of age.
- The median income on Waiheke rose 16.3% between 2006 and 2013, from $23,500 to $27,100 per annum. This is a lower median income but a greater rise from the 2006 level than

---

1 Census NZ 2013
Auckland DHB as a whole where the median personal income was $31,500 in 2013 up from $28,100 in 2006 – an increase of 12.1%.

- In 2013, the unemployment rate on Waiheke Island was 6.6 percent for people aged 15 years and over (up from 3.3% in 2006). This compares to 7.9 percent for Auckland DHB overall (5.7% in 2006).

3.3 Review of health services

In July 2009 Auckland DHB, in partnership with Auckland PHO, completed a Health Needs Assessment (HNA) of Waiheke Island. However, subsequently little change took place to deliver improved access, coordination and integration of health care services on Waiheke Island. During the latter part of 2014 an internal stocktake of current health services was initiated, and completed in March 2015. This stocktake also included updating the demographic data provided in the 2009 Health Needs Assessment (HNA) report.

4. Current health services delivered on Waiheke Island

Publically funded primary and community health services are predominantly provided under the umbrella of two organisations, Waiheke Health Trust and Piritahi Hau Ora Trust.

4.1 Primary care

The Waiheke Health Trust owns and operates primary medical care services (traditional General Practice) from Ostend Medical Centre as well as providing a number of contracted health services.

Piritahi Hau Ora Trust has owned and operated a primary medical care services at Piritahi Marae since 1996 in addition to providing a number of other community based health services. It also owns and operates Oneroa Accident and Medical Centre. All General Practice providers on Waiheke Island are members of Auckland PHO.

After-hours services are shared amongst all three General Practice providers. As well as payments for first level services, practices also receive additional Flexible Funding Pool (FFP) funding allocated by Auckland PHO. The three providers also receive additional funding as rural providers, and these payments are paid directly to either the practice or the GPs employed by the practices via the Ministry of Health.

4.2 Community health services

The current approximate combined annual value of Auckland DHB agreements for community health services delivered on Waiheke Island by external providers is $2,539,894 per annum. Note that only an approximate value can be identified as some of the services are uncapped. Services being delivered on Waiheke Island via Planning, Funding and Outcomes agreements include:

- Community health and support services
- Long-term support for chronic health conditions
- Primary nursing services
- Mental health and addiction services
- Mental health community Support Services
- Well Child Tamariki Ora services
- Mental health level 3 residential support
- Delivery of the primary care mental health package
- Aged care residential support and assisted living services.
4.3 Provider arm services delivered on Waiheke Island

There are a range of provider arm out-patient clinics and services delivered at various locations across Waiheke Island including:

- Child health services
- Mental health clinics and services
- Adult, community, and long term health clinics and services
- Older persons health services

It is important to note that poor integration is a common theme of many services provided on Waiheke Island, between primary care and secondary services and between community and primary care providers working on Waiheke Island. However it is evident that Auckland DHB Mental Health Service providers work hard to meet the needs of mental health service users on Waiheke Island. They have a flexible approach, and sometimes work together across service areas to manage acute cases on Waiheke Island. They also report close relationships with community providers on Waiheke Island. One Consultant described their approach to working on Waiheke Island as “rural psychiatry in action”. Although this is an excellent example of collaboration, there is an awareness of the dangers of over-utilising staff that live on Waiheke Island, and the vulnerability of this model if mental health staff re-locate off Waiheke Island.

A more detailed list of the provider arm services delivered directly by Auckland DHB is available in Appendix One.

5. Issues identified during the internal stakeholder process

5.1 Service Delivery

- In the 2009 Waiheke Island Health Needs Analysis it was projected that there would be a continued decline in the relative numbers of over 65 year olds. However this has not occurred. In the 2013 census it was found that the proportion of the Waiheke populations that were over 65 had grown to 18.6% compared to 10.6% in the overall Auckland DHB population. Within the DHB there is an awareness of the growing ageing population on Waiheke Island, and the consequent impact on health services now and in the future. There is no short-stay facility or rest home on Waiheke Island.
- Provider-arm services could be better coordinated on Waiheke Island, for example the Taylor Centre rent a house on Waiheke Island with a spare room while other services report they have no base when they travel to Waiheke Island.
- Reportedly poor relationships between various health providers on Waiheke Island with consequential impacts on service provision such as poor transfer of information
- Current community and primary care providers are delivering non-contracted and non-funded services, for example Waiheke Health Trust is delivering Well Child vision and hearing tests. In other Auckland DHB areas, these services are delivered by the Auckland DHB provider arm. Delivering non-funded services impacts on a community providers ability to fully deliver against their contracted deliverables.
- Contract reporting is not always aligned to current deliverables, and can be onerous and outdated.
- Providers are often unsure about who to approach at Auckland DHB when a service delivery issue occurs, “often they come back to me because they know me, not because I’ve anything to do with the particular issue or query” (Senior DHB staff member).

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• Waiheke Island’s actual population is significantly more than the official resident population, and increases significantly over holiday periods. The 2011 Health Needs Analysis estimated that the average population of Waiheke Island was 48% more than the resident population. Fluctuating demand is difficult to manage, and reportedly puts pressure on primary health care services including after-hours services.

• During the course of the internal consultation process, staff mentioned the poverty experienced by many residents on Waiheke Island, and the visible impacts of this such as families and older people living in poor housing with issues such as poor water quality.

• After-hours services on Waiheke Island are reportedly inconsistent in terms of both location and cost. Waiheke after-hours services have been an ongoing issue, and will now be considered as part of the Auckland Waitemata Rural Alliance.

• There have been issues associated with the sustainability of the Radiology Services provided on Waiheke Island by the Waiheke Health Trust. The Trust’s inability to attract suitably qualified staff has meant even patients representing low to medium risk, from time to time, have been referred to private providers in Auckland City.

5.2 Continuing professional development

DHB providers have raised the difficulty that some service providers on Waiheke Island had attracting staff with the right qualifications and skills. Internal stakeholders agreed that implementing a planned approach to continuing professional development for all health providers on Waiheke Island should be included in future planning. It was acknowledged that DHB outreach services could be compromised if even one staff member chooses to relocate off Waiheke Island.

6. Next steps

The Auckland DHB executive leadership team have endorsed the following next steps:

• An engagement process is undertaken with external stakeholders including health and community services providers, and the public. The objective of this external engagement process is to:
  - verify findings of internal stocktake and consultation,
  - identify any perceived gaps in health services, and
  - gain further insight in how health services could be better configured to meet the Waiheke Island community’s current and future health needs

• After the external engagement process has been completed, a report will be prepared summarising the results of the internal stocktake and engagement processes. This report will be developed in collaboration with the Auckland Waitemata Rural Alliance, including key recommendations, and will be presented to both Auckland DHB ELT and CPHAC for endorsement.
Provider arm services/clinics delivered on Waiheke Island

Child Health Services

- The Child Development Team (CDT) visits the Island regularly, and has an active case load of 7 clients. This service works with children and their families who have or are at risk of suffering a disability. All clients seen by the service on the Island are complex and require the full range of available services.
- School Dental Services are provided by Auckland Regional Dental Service.
- Adolescent Dental Services are provided by a contracted Dentist under the Auckland Combined Dental Agreement (CDA).

Mental Health Services

- Community Adult Mental Health Services: There is a clinic provided on the Island with a caseload of seventy at any one time. The Taylor Centre also provides additional support via visiting staff.
- Older People’s Mental Health Services (MHSOP): Monthly visit by Consultant Psychogeriatrician, and a psycho-geriatric nurse visit 1 day per week. They have a case load of 10 - 15 clients.
- Auckland Opioid Treatment Service (AOTS): The service visits the Island four times per year. Staff make appointments with the seventeen GP clients once per year and the 7 specialist clients four times per year.
- Kari Centre: This service specialises in child and adolescent mental health and holds a full day clinic on the Island every 3 weeks on Island. This clinic is run by a Psychiatrist and a nurse, and usually they see 3 -5 clients a day. Normally at least one of these appointments is a new assessment.

Adult, Community and Long-Term Services

- A Diabetes Clinic is held every 2 months involving a mixed team including SMO, Podiatrist, Nurse and Dietician.

Older Peoples Services

- Every fortnight, two Gerontology Service Co-ordinators travel to Waiheke to see clients in their own homes.
- The average number of complex Gerontology client’s case managed on the Island each month is approximately forty-two.
- Geriatricians and Gerontology Nurse Specialists also travel to Waiheke to visit on an ‘as-needs’ basis. There are currently a total of one hundred and sixty Waiheke clients, one hundred and sixteen of these have non-complex needs and forty-four have complex needs.
5.1 Primary Care Update Quarter 4, 2014/15

Recommendation

That the report be received.

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

Glossary

ALT - Alliance Leadership Team
DAR - Diabetes Annual Review
DSL A - Diabetes Service Level Alliance
DHB - District Health Board
IPIF - Integrated Performance Incentive Network
MoH - Ministry of Health
MOPS - Maintenance of Professional Standards
NHT - National Health Target
POAC - Primary Options for Acute Care
PHO - Primary Health Organisation
SIPP - Safety in Practice Programme

Summary

This report provides an update on specific primary care activities across the Auckland and Waitemata District Health Boards (DHBs) which have shown variance during the fourth quarter (Q4) of the 2014/15 financial year. The report is presented under the following headings:

- Primary Care Highlight (Q4), 2014/15 Annual Plan
- National Health Targets (NHT)
- Integrated Performance Incentive Framework (IPIF)
- Progress against the 2014/15 Annual Plan deliverables

1. Primary Care Highlight (Q4), 2014/15 Annual Plan

1.1 The Safety in Practice Programme

The aim of the Safety in Practice Programme (SIPP) is to enhance the quality improvement capability of general practices. SIPP has a specific focus on patient safety thereby reducing the number of events which could cause avoidable harm from healthcare delivered in the primary care setting. Auckland DHB, Counties Manukau DHB and Waitemata DHB are supporting the programme and working closely with PHOs to implement.
SIPP is an adaptation of the Scottish Patient Safety Programme in Primary Care. SIPP uses a range of tools and resources alongside coaching from improvement and clinical experts to support general practice teams to bring about a patient safety culture within practices.

Improvement Advisors from the DHBs are working with PHO staff within practices to provide quality improvement support and facilitation to assist with:

- up-skilling teams in improvement methodology
- identification of current systems, processes and behaviours
- data analysis
- re-design of practice systems and processes
- Plan, Do, Study, Act testing of small-scale change and familiarity with the Safety in Practice care bundle audit tools
- introduction of a primary care trigger tool and climate safety survey.

Practice-based meetings allow reflection on data collected and identification of areas of change to be tested within the practice. Four learning sessions scheduled throughout the year bring all the practice teams together. These provide an opportunity to provide additional coaching and to share what has been learned in terms of what has and has not worked. Most significantly, as a result of participation in the learning sessions practices are now collaborating, outside the structured sessions, to share and learn from each other.

SIPP is now into its second year and has expanded. In the first year general practices could choose one of three key safety areas: (i) laboratory results handling, (ii) medication reconciliation or (iii) prescribing and monitoring of warfarin. In the second year a fourth area has been added - opioid management. Year 2 has seen ten practices from the Auckland DHB and eight practices from the Waitemata DHB areas involved.

The NZ Health Quality & Safety Commission has co-funded an evaluation of the first year. Although it was not possible to use quantitative measures to evaluate Year 1, it was generally viewed as a success. Some of the key findings were:

- the design and implementation of SIPP is a very important step in expanding the focus on continuous improvement to drive patient safety throughout the end-to-end health system
- results from the interventions and from anecdotal feedback received from participants highlighted that Year 1 of SIPP:
  - was mostly viewed as a success against each of the evaluation questions by the programme team, key stakeholders and programme participants
  - partially met each of the stated programme objectives.

There is anecdotal feedback that improvements made have reduced risk and improved health outcomes. However, there was no reliable data or reporting generated in the programme regarding health outcomes and the patient experience. Feedback suggested that the lack of data was expected, mirroring the Scottish experience.

The collaborative approach was regarded as positive by all participants and stakeholders, with many practices highlighting the benefits of sharing and learning with other practices, both within their own bundle and across the wider SIPP. Participants have all responded favourably, advising that their knowledge of improvement tools has increased. There is anecdotal evidence that the changes made by practices have reduced risk to patients and in some cases reduced harm. However, there is no
conclusive evidence of the impact of SIPP on patient safety outcomes. There was also valuable feedback about how SIPP support and approach can be improved.

The Royal New Zealand College of General Practitioners are supportive of SIPP and have endorsed the accreditation of Maintenance of Professional Standards points for medical staff attending SIPP learning sessions.

In summary, SIPP is focused on supporting general practice teams to look at their systems and to identify and test improvements that enable improved patient safety. The first year has been focused on SIPP running successfully. The second year is intended to consolidate the learning from Year 1 and to inform if SIPP should be expanded. It is noted that in Scotland safety in practice is now a mandatory programme for general practices.

1.2 Free Under 13s Scheme

Nationally, 96% of general practices with enrolled children aged between 6 years and 12 years have opted in to providing free medical consultations during the day for those under 13 years of age (Free U13s). In Auckland DHB, currently 90% of general practices have opted in with an additional 7% offering free visits for those under 6 years only. In Waitemata DHB, currently 93% of general practices have opted in with an additional 5% offering free visits for those under 6 years only. From 1st September 2015, two additional general practices will be opting in, which will increase the free U13 figure to 95% for Waitemata DHB.

2. National Health Targets

The Primary Care Scorecard (Figure 1) is a standardised tool that is used by both Auckland and Waitemata DHBs to internally review and track performance against a range of measures including the NHT.

The Scorecard shows for each measure the actual performance of both DHBs during Q4 2014/15, against the NHT.
### Auckland and Waitemata DHB Primary Health Care Scorecard

#### Health Targets - Auckland DHB

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<th>Indicator Title</th>
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<th>Target</th>
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<td>Better help for smokers to quit (primary care)</td>
<td>97%</td>
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#### Health Targets - Waitemata DHB

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<td>90%</td>
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<tr>
<td>More Heart and Diabetes Checks - Total</td>
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#### Improving population health (diabetes) - Auckland DHB

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#### Improving population health (diabetes) - Waitemata DHB

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#### Service Delivery - Auckland DHB

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#### Service Delivery - Waitemata DHB

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<tr>
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**How to read**

- **Improvement against previous result**
- **Actual DHB performance achieving or above the target will display as a solid green line.**
- **Target DHB performance achieving or above the target will display as a solid green line.**

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Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 02/09/15
2. 1 Better Help for Smokers to Quit

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

The ‘Better Help for Smokers to Quit’ result is reported both as a NHT and at PHO level within the IPIF (see Section 3). Overall, the PHOs have done well to maintain achievement of the target for the previous four quarters. The NHT results for Q4 are shown in the Primary Care Scorecard and in Figure 2 below:

- Auckland DHB 97%, ↑1% from Q3
- Waitemata DHB 94%, ↓5% from Q3.

Although Waitemata DHB is still meeting the 90% health target, as shown by the red line in Figure 2, performance is on a downward trend since its peak in Q4 (2013/14). The most recent decrease of five percentage points from the previous quarter is due to a large cohort of people being given brief advice to stop smoking in Q4 (2013/14), which ended after 12 months (Q4, 2014/15) and needs to be provided again. Waitemata PHO and ProCare set a very high original benchmark in 2014 and even taking into account this decrease, Waitemata DHB is still exceeding the NHT.

**Figure 2: Auckland & Waitemata DHBs ‘Better Help for Smokers to Quit’ Trend Data**
2.1.2 More Heart and Diabetes Checks

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

The ‘More Heart and Diabetes Checks’ result is reported by the MoH as a NHT and is also part of the IPIF reporting. Both Auckland and Waitemata DHBs met the More Heart and Diabetes Checks – National Health Target in Q4 2014/15. The results from the MoH shows Auckland DHB achieved 92.4% whilst Waitemata DHB achieved 90.5%. Both DHBs have consistently met this target through the 2014/15 year (see Figure 3).

**Figure 3** Auckland & Waitemata DHBs ‘More Heart and Diabetes Checks’ Trend Data

2.1.3 Improving Population Health - Diabetes Annual Reviews

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

The percentages of registered diabetics who have had a Diabetes Annual Review (DAR) in the last 12 months was 97% and 70% for Auckland and Waitemata DHBs respectively. However, the percentages of diabetics who have had a DAR in the last 12 months and had good diabetes management were 70% (Auckland DHB) and 73% (Waitemata DHB), which falls slightly short of the NHT. As Figures 4 and 5 show, both DHBs are showing slight improvement in the NHT from Q2 through to Q4, when the whole population is taken into account. However, when the data is broken down by ethnicity it is evident that the good management data for both Maori and Pacific populations have worsened through the year for both DHBs.

There has been a substantial drop between Q3 and Q4 in the Maori population with good diabetes management (a reduction of 3% and 6% for Auckland and Waitemata DHBs respectively). Whilst for
the Pacific population with good diabetes management, there has been a gradual drop of 2% throughout the year for both DHBs.

Action Plan: The Alliance Leadership Team (ALT) has identified diabetes as a key strategic priority and ratified the establishment of the Diabetes Service Level Alliance (DSLA), to lead and oversee a suite of work targeted to improve diabetes-related health outcomes across both DHBs. Reporting to ALT, the DSLA members represent a range of stakeholders (i.e. primary care, specialist diabetes teams, Treaty partners, planning and funding, and consumer representation), and the first DSLA meeting was held in August 2015. A stocktake and gap analysis of the current diabetes services provided across both DHBs has been completed. Based on the findings, the DSLA will develop a work programme and prioritise areas of work to be undertaken by various working groups under its leadership, particularly focusing on improving outcomes in Maori and Pacific populations.

The DHB is working towards finalising a work plan to maximise the delivery of diabetes services in the community setting (e.g. retinal screening and podiatry) with the DSLA, by the end of September 2015 (Q1). A further update will be provided in the next report.

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

The following tables show the trend data for individual PHO performance on five IPIF indicators (IPIF target vs. actual results), for the last four quarters (Q1-Q4, 2014/15). Note that the data for Increased Immunisation (2 year olds) and Cervical Screening were not released by the Ministry of Health before the CPHAC reporting deadline.

**Auckland PHO**

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<th>Q1 Target</th>
<th>Q1 Result</th>
<th>Q2 Target</th>
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<th>Q3 Target</th>
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<td>94.6%</td>
<td>97%</td>
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<td>Cervical Screening</td>
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<td>81.1%</td>
<td>80.0%</td>
<td>81%</td>
<td>80.0%</td>
<td>82%</td>
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### ProCare Limited

<table>
<thead>
<tr>
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<th>Q1 Target</th>
<th>Q1 Result</th>
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<th>Q2 Result</th>
<th>Q3 Target</th>
<th>Q3 Result</th>
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<td>91.8%</td>
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<tr>
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<td>93.4%</td>
<td>94.9%</td>
<td>94%</td>
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<td>-</td>
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### Waitemata PHO

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<th>Q2 Target</th>
<th>Q2 Result</th>
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<th>Q3 Result</th>
<th>Q4 Result</th>
<th>Quarterly National IPIF Target Achieved (Q4 Target)</th>
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<tbody>
<tr>
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<td>80.1%</td>
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<td>83.4%</td>
<td>89%</td>
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<td>90%</td>
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<tr>
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<td>94%</td>
<td>90%</td>
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<tr>
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<td>93.8%</td>
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<td>92%</td>
<td>94%</td>
<td>No (95%)</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
<td>93.6%</td>
<td>91.0%</td>
<td>94.1%</td>
<td>91%</td>
<td>94.5%</td>
<td>92%</td>
<td>-</td>
<td>Yes / No (95%)</td>
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<tr>
<td>Cervical Screening</td>
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### Alliance Health Plus (hosted by Counties Maukau DHB)

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<th>Q2 Result</th>
<th>Q3 Target</th>
<th>Q3 Result</th>
<th>Q4 Result</th>
<th>Quarterly National IPIF Target Achieved (Q4 Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
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<td>87.1%</td>
<td>90%</td>
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<td>90%</td>
<td>91%</td>
<td>Yes (90%)</td>
</tr>
<tr>
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<td>86.0%</td>
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<td>Increased Immunisation – 8 Month Olds</td>
<td>92.5%</td>
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<td>93.3%</td>
<td>96%</td>
<td>94.2%</td>
<td>93%</td>
<td>94%</td>
<td>No (95%)</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
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<td>94.9%</td>
<td>95.0%</td>
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<td>94.6%</td>
<td>-</td>
<td>Yes / No (95%)</td>
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<tr>
<td>Cervical Screening</td>
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<td>73%</td>
<td>78.0%</td>
<td>74%</td>
<td>-</td>
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### National Hauora Coalition (hosted by Counties Maukau DHB)

<table>
<thead>
<tr>
<th>IPIF Indicator</th>
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<th>Q1 Result</th>
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<th>Q2 Result</th>
<th>Q3 Target</th>
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<th>Q4 Result</th>
<th>Quarterly National IPIF Target Achieved (Q4 Target)</th>
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<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>83.8%</td>
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<td>85.9%</td>
<td>90%</td>
<td>87.9%</td>
<td>89%</td>
<td>91%</td>
<td>Yes (90%)</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
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<td>85.4%</td>
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<td>87.7%</td>
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<td>Increased Immunisation – 8 Month Olds</td>
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<td>95.0%</td>
<td>90.9%</td>
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<td>93.0%</td>
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</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
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<td>93.8%</td>
<td>95%</td>
<td>-</td>
<td>Yes / No (95%)</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>73.6%</td>
<td>72.1%</td>
<td>75.7%</td>
<td>72%</td>
<td>77.9%</td>
<td>73%</td>
<td>-</td>
<td>Yes / No (80%)</td>
</tr>
</tbody>
</table>

Note that the narrative on the IPIF results for immunisation and cervical screening were provided in the Women, Children and Youth Update to CPHAC on 22nd July 2015.
4. Progress against the 2014/15 Annual Plan Deliverables

4.1 Regional Primary Options for Acute Care Services

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

The Primary Options for Acute Care (POAC) service provides responsive coordinated acute care in the community, and is funded by the three Auckland DHBs. Clinical pathways and policies support consistent practice and drive greater safety and quality of care. The total number of Auckland Metro POAC referrals in Q4 were 16% below the target (see table below). Auckland DHB is 22% below target and Counties Manukau DHB is 36% below target, whilst Waitemata DHB is 26% above target volumes for the quarter. Overall, the total number of POAC referrals received increased by 11%, compared with the same period in the previous year (Auckland DHB >23%; Counties Manukau DHB >13%; Waitemata DHB >4%).

Total referrals year-to-date (July 2014 – June 2015):
- Auckland DHB: 4,597
- Counties Manukau DHB: 8,248
- Waitemata DHB: 8,445

The average cost per referral remains lower across the whole region compared with the same time last year. This in part can be attributed to changes in clinical policies and revised provider agreements. In Auckland DHB, 87% of patients were safely managed in the community and avoided hospital presentation with 86% in Counties Manukau and 88% in Waitemata DHB.

<table>
<thead>
<tr>
<th>Quarter 4</th>
<th>Waitemata DHB</th>
<th>Auckland DHB</th>
<th>Counties Manukau DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual number of POAC referrals (target number of referrals)</td>
<td>2,055 (1,630)</td>
<td>1,180 (1,510)</td>
<td>1,966 (3,080)</td>
</tr>
<tr>
<td>Average cost per referral (excl. GST), budget $200</td>
<td>$146.89</td>
<td>$151.63</td>
<td>$174.72</td>
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</table>

Referrals by ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Waitemata DHB</th>
<th>Auckland DHB</th>
<th>Counties Manukau DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>73%</td>
<td>55%</td>
<td>51%</td>
</tr>
<tr>
<td>Maori</td>
<td>8%</td>
<td>9%</td>
<td>15%</td>
</tr>
<tr>
<td>Pacific</td>
<td>6%</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td>Asian</td>
<td>7%</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>5%</td>
<td>8%</td>
<td>5%</td>
</tr>
</tbody>
</table>

4.2 Access to Diagnostics - Radiology

A service budget is notionally allocated per Auckland DHB general practice to manage radiology referrals for diagnostic purposes. Only 61% of the total budget was spent in 2014/15 (i.e. $305,025 against the allocated budget of $500,000), leaving an underspend of $194,975. Positive steps are being put in place to resolve this issue.

The Auckland Metro DHBs are due to commence an evidence-based review of POAC and Access to Diagnostics which is a key deliverable in the 2015/16 Annual Plan. The review will provide more...
detailed advice regarding utilisation, clinical outcomes aligned to clinical case review, reduced admissions to hospital, current investment and what future investment and service configuration should be in place, to address future funding allocation and service provision across the three DHBs. It will also provide recommendations regarding an overarching quality framework.
5.2 Planning, Funding and Outcomes Update

Recommendation

That the report be received.

Prepared by: Wendy Bennett (Manager - Planning and Health Intelligence), Kate Sladden (Funding and Development Manager - Health of Older People), Aroha Haggie (Manager - Maori Health Gain) and 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 DHBs’ planning and funding activities and areas of priority, since the last CPHAC meeting on 22 July 2015. It is limited to matters not already dealt with by other Board committees or elsewhere on this CPHAC meeting agenda.

1. Planning

1.1 Annual Reports

Drafts of the Auckland DHB and Waitemata DHB Annual Reports have been considered by the respective Executive Leadership team, who have endorsed the new format of the reports. The reports have been submitted respectively to each DHBs Audit and Finance Committee.

1.2 Scorecards and HAC report

A new scorecard model, with revised traffic lights and trend indicators, will be piloted for the CEO Scorecard presented at the Waitemata DHB September Board meeting. If the new model is endorsed by the Board, it will be used for other scorecards covering both DHBs.

1.3 Health Needs Assessment

Development of the Health Needs Assessment continues, specifically in the areas of Asian, West Auckland and disease specific profiles.
1.4 Engagement

The consultation on transgender services was very well received by participants and an observer from the MoH commended it as a good model for community engagement. Work is under way for stakeholder engagement in September for the Waitemata DHB Health Services Plan; and planning is underway in partnership with the Health Links for a consumer representative forum later this year to review the model of support and evaluation for consumer representative involvement in DHB work.

2. Health of Older People

2.1 Home Based Support Services

The Home Based Support Services (HBSS) contracts for Auckland and Waitemata DHBs have been rolled over for 2015/16. During this time a request for proposals for this service will be undertaken. A series of meetings have been held with the Health of Older People clinical directors from both DHBs. The patient journey and proposed key elements of a new HBSS model are aligned across both DHBs, however, there are differences in interaction with the two DHB provider arms due to the configuration and existing systems in place at each DHB so at an operational level alignment is more difficult. A paper outlining the options for a tender process is being prepared.

There has been a steady increase in the proportion of Waitemata DHB HBSS clients with an interRAI assessment (standardised clinical assessment) during 2014/15, as shown below (reported one quarter in arrears):

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>95.7%</td>
<td>94.6%</td>
<td>95.0%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>57.9%</td>
<td>67.7%</td>
<td>75.6%</td>
<td>79.6%</td>
</tr>
</tbody>
</table>

2.2 Aged Residential Care

Certification periods are a reflection of ARRC performance in audits; four years is the maximum certification period. However, new facilities will only be certified for one year initially. All facilities will have a surveillance audit (unannounced) mid-way through their certification period. The table below shows the certification periods for ARRC facilities in Auckland and Waitemata DHBs for 2014/15.

<table>
<thead>
<tr>
<th>Certification Period</th>
<th>Auckland DHB % (n)</th>
<th>Waitemata DHB % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months</td>
<td>0</td>
<td>9.7% (6)</td>
</tr>
<tr>
<td>24 months</td>
<td>7.2% (5)</td>
<td>13.0% (8)</td>
</tr>
<tr>
<td>36 months</td>
<td>66.7% (46)</td>
<td>61.3% (38)</td>
</tr>
<tr>
<td>48 months</td>
<td>26.1% (18)</td>
<td>16.0% (10)</td>
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</table>

An analysis of corrective actions from audits of ARRC facilities during 2014/15 has been undertaken. The three areas receiving the highest number of corrective actions across the two DHBs were:

- medication management
- human resource management
- quality risk management and systems

These will be areas of focus for the two DHB Quality and Monitoring Managers.
The forum for Asian owned and operated ARRC facilities is now well established. The aim of the forum is to better understand the issues faced by these providers so appropriate support can be offered and to increase their engagement in DHB ARRC programmes e.g. cluster groups, education sessions, study days and the like. Areas that have been covered to date include Needs Assessment and Coordination (NASC) processes, the national ARRC Agreement and audits and monitoring corrective actions.

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. There have been several key achievements since the beginning of the financial year which include:

- funding proposal that promotes quitting to pregnant women and their whānau has been developed
- communications plan that promotes quitting to pregnant women and their whānau has been developed
- resources for the programme have been developed

3.2 Kaumatua Action Plan
The Kaumatua Action plan was presented to Manawa Ora in July 2015. The Plan outlines the activities that the Auckland and Waitemata DHBs will undertake over the next three years to improve health outcomes for Maori aged 65 years and over. Manawa Ora endorsed the Plan under the proviso that changes were made based on their feedback. The Plan has been updated and will be presented to both the Auckland and Waitemata DHB Boards for feedback and endorsement.

3.3 Maori Health Plan
The 2015/16 Maori Health Plans have been approved by the Ministry of Health and have been uploaded onto the Auckland and Waitemata DHB websites as well as the Ministry of Health’s website.

4. Mental Health and Addictions

In response to an action from the Community and Public Health Advisory Committee (CPHAC) meeting of 22 July 2015, this section of the Update summarises the range of services Waitemata and Auckland DHB provide to address the needs of children who have parents experiencing mental illness and/or addiction (COPMIA).

4.1 Services for Children
A number of initiatives are in place for COPMIA:

- Auckland DHB operates the Tu Tangata Tonu service.
- Two Non-Government Organisations (NGO), Emerge Aotearoa and Equip, are currently piloting COPMIA programmes within their existing funding for family/whanau services.
- There are also a number of child focussed contracts across both Auckland and Waitemata DHBs including:
- **Supporting Families in Mental Illness** Auckland have 2 FTE in Waitemata DHB and 3 FTE in Auckland DHB. These positions are used in part to implement COPMIA type initiatives including two day workshops for COPMIA, which operate during school holidays or when there is sufficient demand.

- **Connect Supporting Recovery** are contracted in Auckland DHB to provide COPMIA Whanau support hours to children, adolescents and families with a mental health disorder.

- **Daysprings Trust** is a mental health funded NGO specializing in working with mothers with mental illness. The Trust currently provide a range of services primarily designed to meet the needs of mothers with babies/young children including counselling services, mental health community support work service, supported landlord service, parenting and recovery programmes including Early Years Toolbox Parenting Course and the Circle of Security Parenting program. These activities while not strictly for COPMIA do provide significant support for children including childcare and support of children via one-to-one counselling as required by a child psychotherapist.

- **Te Whanau O Waipareira Trust** operates a Family Whanau Support Education and Advocacy Service.

- **Emerge Aotearoa** has a contract to provide infant, child adolescent and Youth Crisis Respite and Day Services along with an infant child and adolescent package of care service.

DHB services are actively trying to:

- identify the number of clients within the service who have children currently living with them
- increase clinicians’ awareness of risk factors for COPMIA
- consider implications for clinical responsiveness

As well as services aimed specifically at COPMIA, there are a number of other initiatives designed to support parents experiencing mental illness and addiction, which in turn improves developmental and health outcomes for children. These are set out below.

### 4.2 Auckland Metro Mother and Baby Acute Continuum Mental Health Services

Auckland Metro Mother and Baby Acute Continuum Mental Health Services are specifically for pregnant women and mothers and infants where the mother is experiencing an acute deterioration in her mental health from the period of the 2nd trimester (13 weeks+) of pregnancy through to 12 months post birth.

The services include:

- Enhancing secondary service maternal mental health capacity to provide extended hours acute responsiveness (recruitment partially complete and on-going)

- Community NGO Crisis Respite Beds and Clinical and Non-Clinical Support Hours, a joint Auckland and Waitemata DHB service opened officially on 26 June by Minister Coleman. Operated by WALSH Trust, the residential respite service is based in Te Atatu in a rented property while the purpose built facility is under construction
- Regional three mother and baby inpatient beds at the Child and Family Unit, Auckland City Hospital

4.3 Pregnancy and Parental Service Community Alcohol and Drugs Service

Pregnancy and Parental Service Community Alcohol and Drugs Service is a support and information service for pregnant women and parents of children under the age of 3 years which works to minimize substance related harm in pregnant women and new mothers. The Service provides education on the effects of alcohol and other drug use during pregnancy and in relation to parenting; helps women to access antenatal care, parenting support and community and health services and; to coordinate services to work together to best meet the needs of these families. This is a multidisciplinary team made up of full time nurses, a part time psychiatrist, psychologist and peer support worker. There has been a recent enhancement provided to this service and recruitment is under way to increase staffing levels. The service works collaboratively with obstetric services, child welfare agencies, maternal mental health services and community agencies across the Auckland region.

CADS Counselling and Opiate Treatment services work with women of child bearing age and provide education around risks of substance use to the unborn child and provide AOD treatment to minimize harm in this area.

4.4 Odyssey House Intensive Alcohol and Drug Services with Accommodation

Odyssey House operates a family programme which enables children to be with their parents during their recovery journey. Children attend early childhood education and school and Odyssey House is also in the process of implementing the Triple P parenting programme.

4.5 Parenting Programmes

There are also a range of parenting programmes aimed at supporting and educating parents to better manage conduct problems and to establish healthy relationships and attachments to the children. Waitemata DHB is one of the pilot sites for MOH initiatives, relating to the government Drivers of Crime strategy (conduct and behavioural problems work stream). There are two key components:

- **Incredible Years**  Specialist Interagency Response to Children and young People’s Conduct Disorders provides specialist Incredible years programs through Child and Adolescent Mental Health Services (CAMHS) for parents with children whose parenting and behavioural problems are at the more severe end of the spectrum.

- **Triple P Positive Parenting Programme**  Primary Care Triple P is a less intensive programme designed for delivery in primary care/community settings. Triple P parenting courses are currently being rolled out in Waitemata DHB by Te Whanau O Waipareira Trust who are contracted to deliver the programme and to support and coordinate up to 40 practitioners per year to undertake the training, supported by the Werry Centre. These programmes are being implemented as with one-on-one consultations accessed through primary care or in discussion groups.
5. Auckland Regional Public Health Service

5.1 Submissions

ARPHS has completed and submitted four submissions during July and August 2015.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 July</td>
<td>Property Maintenance and Nuisance By-Law</td>
<td>• The proposed bylaw provides for a new registration and monitoring regime for industrial cooling towers (that currently fall outside Building Act requirements). This was a collaborative piece of work between ARPHS staff and Council officers and was a direct response to the 2012 outbreak.</td>
</tr>
</tbody>
</table>
| 23 July 2015 | Draft General Transitional Facilities (TFs) for Uncleared Risk Goods – standard guidance documents | • Noting the need for better access to TFs after hours and contact information.  
• Guidance on improved pest management control measures, particularly in regard to managing breeding habitats in and around TFs. |
| 31 July 2015 | Guidelines for Legionella Control; in the operation and maintenance of drinking water distribution systems in health and aged care facilities | • ARPHS provided several detailed wording amendments to provide further specific information, such as the bactericidal value of copper pipes, and soil as a possible Legionella source within facilities. |
| 17 August  | Future Land Supply Strategy – 30 year strategy discussing the sequencing and logistics of having land ready for development | • An integrated planning approach and incorporate health impact assessments into large projects to maximise health outcomes will strengthen the strategy. |

5.2 Proposed Auckland Unitary Plan

ARPHS continues to be engaged in the Unitary Plan process. ARPHS’ full submission on the Proposed Auckland Unitary Plan is in three parts and available [here](http://www.arphs.govt.nz/about/submissions). Throughout July and August, 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>02 July</td>
<td>058 Public Open Spaces</td>
<td>Hearing</td>
</tr>
<tr>
<td>08 July</td>
<td>043 &amp; 044 Transport Objectives, Policies, Rules and Other</td>
<td>Hearing</td>
</tr>
<tr>
<td>20 July</td>
<td>061 Retirement and Housing Affordability</td>
<td>Hearing</td>
</tr>
<tr>
<td>23 July</td>
<td>046 Water Quality and Quantity</td>
<td>Hearing</td>
</tr>
<tr>
<td>14 August</td>
<td>049 Stormwater Discharges &amp; Wastewater</td>
<td>Hearing</td>
</tr>
<tr>
<td>19 August</td>
<td>076 Major Recreation Zones and Precincts</td>
<td>Hearing</td>
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</tbody>
</table>

In general, our presentations have been well received by the Independent Hearing Panel on each of the specific topics. Key examples include:
061 - Retirement and Housing Affordability
Focus was on housing affordability and our key messages included:

- Unaffordable housing has public health costs and wider implications.
- Relying on market forces to resolve issues or negate these wider implications will not address the need.
- Intervention is required through the housing affordability policies (Inclusionary Zoning) contained in the Proposed Auckland Unitary Plan.

ARPoS’s strong recommendation was:

- The level of the contribution be increased from 10% to 15% for greenfields development; with the contribution levels to be negotiated with 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.

049 - Stormwater Discharges & Wastewater
ARPoS supported the general onsite wastewater provisions in the Proposed Unitary Plan and suggested minor amendments, which would ensure:

- Poor performing wastewater systems contribute to elevated levels of nutrients and pathogens entering water bodies, creating environments unsafe for swimming and other contact recreational activities.
- Owners of onsite wastewater systems comply with inspection and maintenance requirements in the permitted activity control 2.1.1.3.
- Council should adopt an onsite wastewater inspection and certification programme, which would include Council holding a register of all onsite wastewater.

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

<table>
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<tr>
<th>Date</th>
<th>Topic</th>
<th>Hearing or Mediation</th>
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<tr>
<td>1 September</td>
<td>Sustainable Design</td>
<td>Hearing</td>
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<tr>
<td>7 September</td>
<td>Centre Zones, Business Parks, Activities &amp; Controls</td>
<td>Hearing</td>
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5.3 HunuaRanges 1080 aerial pest control operation is under way
ARPoS received Auckland Council’s Vertebrate Toxic Agents (VTA) Application to undertake aerial 1080 pest control in the HunuaRanges on 12 June. The Environmental Protection Agency has delegated ARPHS HSNO warranted officers to a statutory role under the Hazardous Substances and New Organisms Act 1996, to review and approve VTA applications, including 1080. Our Medical Officer of Health has now granted the permit with conditions to ensure protection of the public and Council’s aerial operation commenced on 30 July.

This will be the first aerial 1080 drop in Auckland in 20 years. Council believes that application by helicopter is the only practical distribution method in the challenging terrain. The ranges also contain Auckland’s four largest water reservoirs, which supply nearly 60% of the city’s water. The operation will be completed in two parts with two water reservoirs off-line at a time. Aerial application of 1080 is used extensively in other parts of New Zealand, including around water sources. No contamination of public water supplies with 1080 has been recorded to date. The risk to public health from drinking reticulated water has been independently assessed by Landcare
Research, on behalf of Auckland Council, as very low. The main public health risk is unintentional direct contact with the bait, especially to small children.

The Council and WaterCare Services are implementing the following safety measures:

- closure of the park during the operation
- ‘no-fly zones’ over the reservoirs
- no loading of bait in the reservoir catchment areas
- a buffer zone of 50-80m around the reservoirs where no bait will be applied and a 200m buffer zone around the water intake valve towers in the reservoirs
- helicopters will be equipped with specialised GPS equipment and ‘trickles buckets’ will be used to apply the bait around the perimeter of reservoirs, both designed to provide accurate application of the bait
- track clearances after each drop
- comprehensive communications and signage to visitors and neighbouring properties (some of which are included in the operation)
- extensive sampling, monitoring and auditing of operations.

For more information, see the Council’s website or ARPHS’ website.