Community and Public Health Advisory Committees Meeting

Wednesday, 08\textsuperscript{th} June 2016

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 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.
AGENDA

KARAKIA

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

Items to be considered in public meeting

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

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES

2.05pm 2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 27/04/16........................................................................................................................................ 7 Matters Arising from Previous Meeting .............................................................................................................................................. 16

3 DECISION ITEMS

4 INFORMATION ITEMS

5 STANDARD REPORTS

2.10pm 5.1 Primary Care Update .......................................................................................................................................................... 17

2.30pm 5.2 Planning, Funding and Outcomes Update .................................................................................................................................... 31

2.50pm 6 GENERAL BUSINESS

2.55pm 7 RESOLUTION TO EXCLUDE THE PUBLIC ....................................................................................................................................... 48

Apologies: Lee Mathias
### Auckland and Waitemata District Health Boards
#### Community and Public Health Committees

**Member Attendance Schedule 2016**

<table>
<thead>
<tr>
<th>NAME</th>
<th>FEB</th>
<th>MAR</th>
<th>APRIL</th>
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✓ attended  
* 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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<tbody>
<tr>
<td>Lester Levy</td>
<td>Chair – Auckland District Health Board Chairman – Auckland Transport Chairman – Health Research Council 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) Lead Reviewer - State Services Commission, Performance Improvement Framework</td>
<td>03/02/16</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>
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<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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<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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<td>Sandra Coney</td>
<td>Elected Member - Chair: Waitakere Ranges Local Board, Auckland Council</td>
<td>12/12/13</td>
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<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 Owner – Life Pharmacy North West Director - Westgate Pharmacy Ltd Chair - Three Harbours Health Foundation Director - Trusts Community Foundation Ltd</td>
<td>25/11/15</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</td>
<td>03/02/16</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...

| **Christine Rankin** | Member - Upper Harbour Local Board, Auckland Council  
Director - The Transformational Leadership Company | 15/07/15 |
|----------------------|-------------------------------------------------------------------------------------------------|---------|
| **Allison Roe**      | Member - Devonport-Takapuna Local Board, Auckland Council  
Chairperson - Matakana Coast Trail Trust | 02/07/14 |
| **Gwen Tepania-Palmer** | Chairperson - Ngatihine Health Trust, Bay of Islands  
Life Member - National Council Maori Nurses  
Alumni - Massey University MBA  
Director - Manaia Health PHO, Whangarei  
Board Member - Auckland District Health Board  
Committee Member - Lottery Northland Community Committee | 10/04/13 |

| **Co-opted Members** | Associate Professor - School of Population Health, University of Auckland  
Member - Waitemata DHB Asian Mental Health and Addiction Governance Group  
Member - Problem Gambling Foundation of New Zealand Advisory Board  
Trustee – New Zealand Chinese Youth Trust | 03/09/14 |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| **Elsie Ho**         | Chairperson – Congregational Christian Church Samoa Sandringham Trust Board  
Trustee – Congregational Christian Church Samoa Trust  
Chairperson – Mothers and Daughters Health – HVAZ and Alliance Health Plus  
Committee Member – Working Group for Pacific Health Action Plan (ADHB and WDHB)  
Deputy Chairperson – Working Group Pacific Family Violence (ADHB and WDHB)  
Member – MIT Pasifika Students Forum  
Secretary - Negotiation Committee – EFKSNZ Trust  
Secretary – EFKSNZ Trust | 29/04/15 |
| **Rev Featunai Liuaana** | Clinical Chair - Child Health Network, Northern Regional Health Plan  
Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland  
President elect – Paediatric Society of New Zealand  
Member-Board of Kaipara Medical Centre  
Community Paediatrician, Waitakere Hospital  
Member – ASMS | 18/01/16 |
2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 27\textsuperscript{th} April 2016

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 27\textsuperscript{th} April 2016 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB Community and Public Health Advisory Committees

**Wednesday 27 April 2016**

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

**Part I - Items considered in Public Meeting**

**COMMITTEE MEMBERS PRESENT:**

- Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
- Jo Agnew (ADHB Board member)
- Judith Bassett (ADHB Board member)
- Chris Chambers (ADHB Board member)
- Sandra Coney (WDHB Board member)
- Warren Flaunty (Committee Deputy Chair) (WDHB Board member)
- Lee Mathias (ADHB Deputy Chair)
- Robyn Northey (ADHB Board member) (present from 2.15p.m)
- Christine Rankin (WDHB Board member)
- Tim Jelleyman (Co-opted member)
- Rev Featunai Liuaana (Co-opted member)

**ALSO PRESENT:**

- Debbie Holdsworth (ADHB and WDHB, Director Funding)
- Simon Bowen (ADHB and WDHB, Director Health Outcomes)
- Tim Wood (ADHB and WDHB, Funding and Development Manager, Primary Care)
- Paul Garbett (WDHB, Board Secretary)

(Staff members who attended for a particular item are named at the start of the minute for that item)

**PUBLIC AND MEDIA REPRESENTATIVES:**

- Lynda Williams, Auckland Womens Health Council
- Tracy McIntyre, Waitakere Health Link
- Wiki Shepherd-Sinclair, Health Link North
- Lorelle George, Comprehensive Care/Waitemata PHO
- Brian O’Shea, ProCare
- Gaylene Sharman, Healthwest
- Ngaire Harris, Waipareira Trust
- Lorraine Symons, Waipareira Trust

**PRAYER:**

At the invitation of the Committee Chair, Rev. Featunai Liuaana provided an opening prayer.

**WELCOME:**

The Committee Chair gave a warm welcome to all those present. She gave recognition to, and expressed appreciation of, the contributions of Pio and Kiri Jacobs to the health sector over very many years. A special
event to recognise and celebrate their contributions was to be held at the United Marae on 28 April from 10.30a.m to 12.30p.m and anyone who would like to attend would be welcome.

APOLOGIES: Resolution (Moved Jo Agnew/Seconded Sandra Coney)

That the apologies from Lester Levy, Max Abbott, Peter Aitken, Allison Roe, Elsie Ho, Dale Bramley, Ailsa Claire and Naida Glavish be received and accepted.

Carried

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no declarations of interests relating to the agenda.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 16th March 2016 (agenda pages 7-17)

Resolution (Moved Lee Mathias/Seconded Featunai Liuaana)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 16th March 2016 be approved.

Carried

Matters Arising

The question was raised of whether the Hon. Peseta Sam Lotu-liga, Associate Minister of Health, Minister of Local Government and Minister of Pacific Peoples had been given a copy of the Pacific Health Update to the March CPHAC meeting. Debbie Holdsworth advised that she would follow up to see if that had already been done, and if not that will be arranged.

3 DECISION ITEMS

There were no decision items.
4. INFORMATION ITEMS

4.1 Mental Health and Addictions - Quarterly Update (agenda pages 19-24)

Tim Wood (Acting Funding and Development Manager, Mental Health and Addictions) presented this item. Matters that he highlighted included:

- The Substance Addiction (Compulsory Assessment and Treatment Bill) summarised on page 20 of the agenda. A substantive submission had been prepared on this which all three metropolitan DHBs had provided input to. The submission suggested how the Bill could be improved and also discussed issues with implementation.
- Section 3 of the report on High and Complex Needs and progress with developing the service. They are finding the community setting being provided very beneficial to patients.
- With the Tamaki Mental Health and Wellbeing Initiative (page 24 of the agenda) the co-decision making approach is leading to piloting of services based on self-referral. Preliminary reporting indicates very favourable feedback from clients. They are now in the process of looking at how to expand that approach and document learnings from the pilot.

Matters considered in discussion and response to questions included:

- With regard to the SACAT Bill, Warren Flaunty advised that from his experience there is a problem that funding does not appear to follow patients back into the community setting. For example patients receiving methadone treatment whose condition stabilises are referred back to their GPs and faced with co-payments that it is hard for them to pay. In response Tim Wood advised that there appears to be a lot of inconsistency around the country on this. The Ministry of Health has done a stock take on it, but the results have not been released yet. Some information in the media is not correct from his perspective. Generally GPs should be managing high needs patients in a similar way. The stock take will help provide a picture of the situation and direction for what might be needed.
- Sandra Coney advised of a meeting that she had attended at Glen Eden, which had included community policing representatives and had focussed on what was seen to be an upsurge in that area of rough sleeping and the number of people generally “down and out”. She had raised the issue that Mental Health services had not been invited to the meeting. She asked the question of how best to interface with the Police or anyone else when a concern arises that rough sleepers may have mental health problems. In response Tim Wood advised that if such cases come to the attention of the Police, there are protocols and relationships in place with Mental Health Services to handle that.
- Simon Bowen noted that Auckland DHB has a community outreach service that works directly with a range of clients including rough sleepers, but would only work with clients that would meet their threshold for intervention. His understanding is that the incidence of rough sleeping is increasing; while there are some programmes and actions aimed at addressing the problem, they clearly have not succeeded in reducing the number of rough sleepers. There has been some investigation of a Canadian model “Housing First”, looking at addressing the more chronic end of the rough sleeping issue.
• With regard to suicide prevention and postvention (page 22 of the agenda), Tim Wood confirmed that they are looking at how to address the requests coming out of the workshops for additional training for practice nurses.
• It was noted that Table 1 on page 22 of the agenda needs correcting for future reports.

Tim Wood and the team involved in this report were thanked.

Resolution (Moved Lee Mathias/Seconded Christine Rankin)
That the report be received.

Carried

4.2 Child, Youth and Women’s Health (agenda pages 25-35)
Ruth Bijl (Funding and Development Manager - Child, Youth and Women’s Health), Natalie Desmond (Senior Programme Manager - Child Health), Pam Hewlett (Senior Programme Manager - Women’s Health), Dr Alison Leversha (ADHB Community Paediatrician) and Dr Karen Bartholomew (Public Health Physician) were present for this item.

Ruth Bijl introduced the report. Matters that she highlighted included:
• The unlikelihood of achieving the immunisation health target for the quarter.
• The refreshed rheumatic fever plans (pages 28-29) of the agenda and the reduced funding, particularly for Auckland DHB, where a Board decision has been to meet the additional cost to maintain the service for 2016/17.
• The recent review of the national Integrated Performance Indicator Framework (IPIF) measures, which will be reflected in future reporting.

Matters covered in discussion and response to questions included:
• In answer to a question as to when the Government’s announced decision of the shift of responsibility to DHBs for deciding on whether a particular area’s water supply will be fluoridated or not will take effect, Lee Mathias advised that is not yet known, but it is expected that it may take effect from the date of the October 2016 elections. Simon Bowen noted that ARPHS had to date led the response to the issue of fluoridation on behalf of the region’s DHBs and he assumed would continue to advise on it. Lee Mathias advised that Counties Manukau DHB had asked Julia Peters and her team at ARPHS to develop a position statement that could be used region wide.
• Robyn Northey commented that women continue to die from breast cancer not detected until they are 70 years and older and it seemed wrong that breast screening ceased at 65 years. Karen Bartholomew advised that there are papers on this subject and she could report back to CPHAC on it.
• The low percentage rates of children enrolled in dental services by the time they are one year old was highlighted. This had been worked on for two years with little progress to date. A number of process system issues need resolving. More automatic flow of information across providers is being
looked at. Debbie Holdsworth noted that the approach introduced by Midlands DHB looked promising, with single enrolements for multiple purposes.

- With regard to cervical screening coverage (page 33 of the agenda), Karen Bartholomew commented on the substantial work that had been done to get incorrect ethnicity data updated.
- On the question of trialling free screening, the meeting was advised that there had been a recent free screening session at Manurewa, with 66 women screened in a four hour period. There had been “pop up” sessions offering screening for unscreened or under-screened women around the region. Rev. Liuaana advised that up until about three years previously, this service had been made available at his church; however they had not been able to get further visits since then. Saturdays provided an excellent opportunity to get women together for this type of purpose.
- Rev. Liuaana commented on the widely varying costs that can be charged for immunisation for such illnesses as whooping cough. Another issue is the lack of information and fear in the community. There needs to be clarity on who should be informing pregnant women and mothers on immunisation. Ruth Bijl commented that one of the challenges is that there may be five different health professionals that mothers have contact with in the early years of a baby’s life. Trying to get them all saying something consistent about immunisation is a challenge, but they are working on it and will continue to do so. Natalie Desmond outlined the range of activities undertaken to try to promote awareness of the need to vaccinate and to reassure the public about safety. She also advised that adults are entitled to a free whooping cough vaccination at age 45 and age 65.

The Committee Chair thanked the team involved in presenting this report.

Resolution (Moved Lee Mathias/Seconded Christine Rankin)

That the report be received.

Carried

5. STANDARD REPORTS

5.1 Planning, Funding and Outcomes Update (agenda pages 36-44)

Simon Bowen, Debbie Holdsworth, Tim Wood, and Aroha Haggie (Manager Maori Health Gain, ADHB and WDHB) presented this report.

Simon Bowen highlighted:

- Progress towards finalising the Auckland and Waitemata DHBs’ Annual Plans (pages 36-37 of the agenda – drafts of the Annual Plan provided separately with the agenda).
- The first draft of the Waitemata DHB’s Community Services Plan is expected to be ready to come to the May Board meeting.
- In the ARPHS update, the issue with BCG vaccine unavailability (page 41 of the agenda).
The Auckland measles outbreak has ended.

The update on the Zika virus (page 42 of the agenda).

The Healthy Auckland Together (HAT) update (page 42 of the agenda), particularly their submission on the children’s code of advertising and also their first baseline monitoring report of indicators of healthy behaviours.

On the issue of healthy food, research is taking place on the percentage of healthy food outlets in different areas. They are finding that in deprived areas there is a tenfold difference in the ratio of unhealthy food outlets to healthy food outlets, compared to areas with lowest level of deprivation.

Matters covered in discussion and response to questions included:

- In answer to a question, Simon Bowen advised that the HAT baseline monitoring report draws together diverse information from a range of different sources.
- Lee Mathias advised that she had recently heard of a healthy food truck sponsored by the Tairawhiti DHB, which goes to community events, sports events and the like, providing wraps and salads and giving out recipes for healthy food. This has been going for 18 months and she had heard that it is thought to be starting to make a difference. Brian O’Shea advised that ProCare funds a truck that includes a gym and focuses on healthy activity and healthy diets. This had started the previous week. ProCare would be happy to expand the scope of this initiative but would need more financial support for that if it were to do so. The truck is funded from the flexible funding pool. Sandra Coney commented that looking more into this type of approach seemed like an excellent idea. The Auckland Council ran a number of events aimed at children and really struggled to get vendors who provided healthy foods. At the moment it is very hard to provide healthy alternatives.
- Simon Bowen commented that the issues with unhealthy food are massive. The amount of work that would be required to make an impact sufficient to compete with the advertising by some of the fast food companies is phenomenal. They are keen to support the work going on in the Council concerning its Healthy Eating Programme.
- Lee Mathias suggested part of the way forward is to be able to have a system where there are approved providers of healthy food. Then a list of those providers can be given to event organisers.
- In summary on the healthy food issue, the Committee Chair commented that there are some committees and some community groups working on this issue. There are partnerships going on and good progress has been made in some areas. For example some of the maraes had changed dramatically over the last 20-25 years, using a common kitchen to produce healthy food that everyone will be eating on the day. To get healthy food there does not necessarily need to be appropriate vendors; communities can take charge. Communities that take the right approach for their events also need to be acknowledged for that.
- Tim Jelleyman suggested thinking about how best to share success stories and do that more broadly. Part of the focus of HAT is to find examples of better practice and challenge others to follow those examples.
- In answer to questions with regard to the number of closures and reconfigurations of Aged Related Residential Care (ARRC) facilities (page 38 of the agenda), Debbie Holdsworth advised that the general pattern is for a
reduction in rest home beds, but an increase in dementia and hospital beds. The total number of beds is not reducing. Small standalone ARRC facilities are not proving economic and are closing. Also more people are being helped to stay in their own homes. There had been a presentation to the Disability Support Advisory Committee covering the situation.

Aroha Haggie and Karen Bartholomew presented the Maori Health Gain section of the report (pages 38-39 of the agenda). Matters that they highlighted included:

- The HPV Self-Sampling Project which starts in August.
- The Collective Impact section of the report, this referring to the commitment of a group of Whanau Ora partners from different sectors (known as the Whanau Ora Partnership) to support a common agenda for achieving Whanau Ora outcomes. Details of local involvement, including by the DHB, the Waipareira Trust, PHOs and other partners, are given on pages 38-39 of the agenda.

The Committee Chair noted that that this collective impact work is gaining momentum all over New Zealand.

The authors of the report were thanked.

Resolution (Moved Lee Mathias/Seconded Christine Rankin)

That the report be received.

Carried

6 General Business

No matters were raised.

7 Resolution to Exclude the Public

(Moved Warren Flaunty/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>
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<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>
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</table>
| 1. Draft Annual Plans                     | 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 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. |"
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<th>Reason for passing this resolution in relation to each item</th>
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<td>section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
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<td>[Official Information Act 1982 S.9 (2) (j)]</td>
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|  |  | 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)] |

**Carried**

3.22p.m – 3.37p.m – public excluded session

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

The meeting concluded at 3.37p.m.

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SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS’ COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 27 APRIL 2016

_________________________________ CHAIR
## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 30th May 2016

<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>
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<tbody>
<tr>
<td>CPHAC</td>
<td>16/03/16</td>
<td>Regional After Hours Services – the Boards to be kept informed on what approach the PHOs support, when that is known.</td>
<td>Tim Wood</td>
<td></td>
<td>Still under consideration by DHB CEOs (as at 30 May 2016).</td>
</tr>
<tr>
<td>CPHAC</td>
<td>27/04/16</td>
<td>To make sure the March Pacific Health report to CPHAC has been or is sent to the Hon. Peseta Sam Lotu-liga</td>
<td>Debbie Holdsworth</td>
<td></td>
<td>Action.</td>
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<tr>
<td>CPHAC</td>
<td>27/04/16</td>
<td>Breast Cancer Screening – information from papers on the issue of whether or not this should end at age 69 to be provided to CPHAC.</td>
<td>Karen Bartholomew</td>
<td></td>
<td>The World Health Organisation (WHO) International Agency for Research on Cancer (IARC) expert working group has comprehensively addressed the age extension question for breast screening. The expert working group has provided an initial statement in 2015 in advance of the report that the benefits outweigh the harms for women aged 50-69 years, and that and that the benefit of reduced mortality extends to women screened at age 70–74 years. The full report detailing the evidence base and recommendations is due out imminently. The initial statement is available at: <a href="https://www.iarc.fr/en/media-centre/pr/2015/pdfs/pr234_E.pdf">https://www.iarc.fr/en/media-centre/pr/2015/pdfs/pr234_E.pdf</a></td>
</tr>
</tbody>
</table>
5.1 Primary Care Update Quarter 3, 2015/16

Recommendation

That the report be received.

Prepared by: Tim Wood (Deputy Director Funding and Development Manager - Primary Care), Dr Stuart Jenkins (Clinical Director – Primary Care), Trish Palmer (Funding and Development Manager, Mental Health and Addictions)

Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

ATD - Access To Diagnostics
A&M - Accident and Medical
ALT - Alliance Leadership Team
CPSA - Community Pharmacy Services Agreement
CRP - C-Reactive Protein test
DAR - Diabetes Annual Review
DSLA - Diabetes Service Level Alliance
DSME - Diabetes Self Management Education
DHB - District Health Board
ECHO - Echocardiography
GPs - General Practitioners
INR - International Normalised Ratio
IPIF - Integrated Performance Incentive Network
MCC - Medicines Classification Committee
MACGF - Metro Auckland Clinical Governance Forum
MoH - Ministry of Health
MRI - Magnetic Resonence Imaging
NZCMHN - New Zealand College of Mental Health Nurses
NHT - National Health Target
PBFF - Population Based Funding Formula
PHO - Primary Health Organisation
POAC - Primary Options for Acute Care
SMOOTH - Safer Medication Outcomes on Transfer Home
SMO - Senior Medical Officer
VDR - Virtual Diabetes Register

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 third quarter (Q3) of the 2015/16 financial year. The report is presented under the following headings:

- Primary Care Highlight (Q3), 2015/16 Annual Plan – Community Pharmacy Influenza Immunisation Service
- National Health Targets (NHT)
- Integrated Performance Incentive Framework (IPIF) – the five transitional measures
- Exception reporting and highlights against the 2015/16 Annual Plan deliverables.
1. **Primary Care Highlight (Q3), 2015/16 Annual Plan**

1.1 **Community Pharmacy Influenza Immunisation Service**

Influenza is a significant public health issue in New Zealand and each year it has a large health and financial impact on our community, with 10%-20% of New Zealanders infected. It is a vaccine-preventable disease and it is estimated that up to 156,000 New Zealanders consult their general practitioners (GPs) annually because of influenza-like illness. In particular, the elderly population has the worst outcomes related to influenza in New Zealand.

Improving influenza immunisation coverage results potentially reduces demand for both primary and secondary care health services during the winter periods.

Community pharmacy is an integral part of primary health care and plays a significant role in helping New Zealanders get well, stay well and live well. Since 2011, several vaccines have been considered by the Medicines Classification Committee (MCC) at Medsafe. These have then been re-classified from prescription medicines to restricted medicines when administered by a registered Pharmacist. The Pharmacist is required to have successfully completed a vaccinator training course approved by the Ministry of Health (MoH), and complies with the immunisation standards of the Ministry of Health (MoH).

As a part of the 2015/2016 contract extension of the Community Pharmacy Services Agreement (CPSA) 2012, each DHB was allocated a portion of a one-off $750,000 fund (based on the DHB’s population-based funding formula (PBFF)) for local community pharmacy initiatives focused on quality improvement and patient-centric services.

Six community pharmacies in Auckland DHB and nine in Waitemata DHB were contracted to provide a community pharmacy-based influenza immunisation service to eligible people aged 65 and over using the funding allocation from the one-off fund. Since March 2016, the pharmacies have successfully delivered the vaccination to approximately 60 people.

This new approach to immunisation encourages clinical integration and collaboration between providers of health services to:

- increase the pool of vaccinators
- reduce burden on primary and secondary health care services
- improve access and coverage to vaccination
- deliver faster and convenient services to better meet the population health needs.

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 National Health Target (NHT). The Scorecard shows for each measure the actual performance of both DHBs during Q3 2015/16, against the NHT.

---

2. Immunisation in New Zealand: Strategic Directions 2003–2006
### Health Targets - Auckland DHB

<table>
<thead>
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<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
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<td>More Heart &amp; Diabetes Checks - Total</td>
<td>97%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>More Heart &amp; Diabetes Checks - Māori</td>
<td>89%</td>
<td>90%</td>
<td></td>
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<tr>
<td>More Heart &amp; Diabetes Checks - Pacific</td>
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</tr>
<tr>
<td>More Heart &amp; Diabetes Checks - Other</td>
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### Health Targets - Waitemata DHB

<table>
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<th>Actual</th>
<th>Target</th>
<th>Trend</th>
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<td>93%</td>
<td>95%</td>
<td></td>
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<td>More Heart &amp; Diabetes Checks - Other</td>
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### Improving outcomes - Auckland DHB

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<th>Trend</th>
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<td>Diabetes annual checks - Other</td>
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<td>75%</td>
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<td>Diabetes management - Pacific</td>
<td>44%</td>
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### Improving outcomes - Waitemata DHB

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<tr>
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<td>75%</td>
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</tr>
<tr>
<td>Diabetes management - Other</td>
<td>74%</td>
<td>75%</td>
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</table>

### Performance indicators - Auckland DHB

- **Achieved**: On target
- **Substantially Achieved but off target**: N/A
- **Not Achieved but progress made**: N/A
- **Not Achieved**: Off target

### Performance indicators - Waitemata DHB

- **Achieved**: On target
- **Substantially Achieved but off target**: N/A
- **Not Achieved but progress made**: N/A
- **Not Achieved**: Off target

### How to read

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

### Key notes

1. Actuals and targets in grey bold italics are for the most recent reporting period available, where data is missing or delayed.
2. Trend lines represent the data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented.
3. Small data range may result small variations perceived to be large.

### Contact

Victoria Child, Reporting Analyst, Planning & Health Intelligence Team, victoria.child@waitematadhb.govt.nz
Planning, Funding and Health Outcomes, Waitemata DHB

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**Figure 1: Auckland & Waitemata DHB Primary Care Scorecard (Q3)**

Auckland and Waitemata DHB Monthly Performance Scorecard

**Primary Care Outcome Scorecard**
March 2016
2015/16

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**Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting 08/06/16**
2. 1 Better Help for Smokers to Quit

**Target:** 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

The ‘Better Help for Smokers to Quit’ result is reported both as a NHT and at PHO level within the Integrated Performance Incentive Framework (IPIF) (see Section 3). Waitemata DHB has successfully achieved the target in Q3 with performance at 90%. Auckland DHB’s performance improved from 86.0% to 87.6% (↑1.6% from the previous quarter).

Auckland PHO exceeded the target with Q3 performance at 92.4%. Target results for ProCare showed performance at 90.1% for Waitemata and 89.2% for Auckland DHBs. Alliance Health Plus (AH+), National Hauora Coalition (NHC) and Waitemata PHOs have yet to meet the target, but all are making good progress towards achieving it and it is anticipated that this will happen by Q4, 2015/16.

The final Q3 results released by the MoH rank Waitemata DHB as the third highest performing DHB and Auckland DHB as the ninth. The results are also shown in the Scorecard under Health Targets as well as in Figure 2 below:

- Auckland DHB - 87.6 %, ↑1.6% from the previous quarter; and
- Waitemata DHB – 90% ↑1.4% from the previous quarter.

**Figure 2 : Auckland and Waitemata DHBs ‘Better Help for Smokers to Quit’ Performance**

Note: Preliminary MOH data for 2015-16, Q3

All PHOs are continuing to have a focus on achievement of the target and provide comprehensive support to general practices to ensure that people who smoke receive brief advice and support to quit. PHOs have
continued to increase activities to reach more smokers and achieve the target. Some examples of the interventions and activities that PHOs are planning are summarised below:

- **Phone Call and Texting service** – this is one of the most common interventions identified by the PHOs. Most of the PHOs are planning to phone patients for whom an intervention has not been recorded and to provide advice and support to quit over the phone at a general practice level. These interventions are designed to reach patients who have not received ABC\(^1\) pathway interventions. For example, ProCare’s Smokefree Coordinators are working with their Practice Engagement Team to support practices with a high number of smokers. General practices have also had the opportunity to text brief advice to their smokers for free. This intervention is likely to improve ProCare’s performance for this quarter.

- **Reviewing practice level data** – This is being undertaken on a weekly to monthly basis to identify practices that are underperforming and have not achieved the required level of progress in achieving the target. These practices are visited by Smokefree Co-ordinators to encourage the practices to contact patients identified as benefiting from the SmokeFree programme. The coordinators also keep regular contact with the practices via visits, phone calls and emails to ensure an ongoing focus on the health target.

- **Updating contact details** – A number of the PHOs are finding individual patient contact details become quickly out of date. The PHOs are therefore working with their practices to update patient contact details.

- **Additional resource** – Both Alliance Health Plus and National Hauora Coalition have recruited two additional casual staff members to help with the phone calls and data entry.

Auckland and Waitemata DHBs are working closely with PHOs to ensure that they are focussed on achieving the target in Q4. All PHOs are required to provide a weekly report with activities and updated data to the DHB. The weekly updates provide useful information on the progress being made and interventions and activities applied at a practice level by the PHOs.

Overall, both Auckland and Waitemata DHBs are expected to meet the target by the end of 2015/16.

### 2.2 More Heart and Diabetes Checks

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

Both Auckland and Waitemata DHBs have met the More Heart and Diabetes Checks NHT in Q3 2015/16. The final results from the MoH show that Auckland DHB has achieved 92.2%, whilst Waitemata DHB has achieved 90.7% (see Figure 3).

All but one PHO within Auckland and Waitemata DHBs have reached the 90% target. In Auckland DHB, 88.6% of the eligible Maori population and 90.6% of the eligible Pacific population has had a ‘More Heart and Diabetes Check’. The equivalent percentages for Waitemata DHB were 86.1% and 88.7% respectively.

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\(^1\) 'A' is for Asking about and documenting every person’s smoking status; ‘B’ is for giving Brief advice to stop to every person who smokes; and ‘C’ is for strongly encouraging every person who smokes to use Cessation support (a combination of behavioural support and stop-smoking medicine works best), and offering them help to access it.
2.3 Improving Population Health - Diabetes Annual Reviews

**DHB Target:** A minimum of 75% of people who have had a Diabetes Annual Review (DAR) will have an HbA1c of $\leq 64$ mmol/mol.

The data issue reported in the previous CPHAC report has been resolved and updated information is presented in this report.

In Auckland DHB (Q3 2015/16), 86% of those who are on the Virtual Diabetes Register (VDR) have had a Diabetes Annual Review (DAR). Of those who have had a DAR in Q3, approximately 67% showed good diabetes management for Auckland. As shown in Figure 4, there has been a noticeable drop in the percentage of good management for the Pacific population. The Planning and Funding team is currently working with the PHOs to validate this information as part of the work to implement the regionally approved clinical indicators for diabetes.
Within Waitemata DHB (Q3, 2015/16), 51% of those who are on the VDR have had a DAR. Of those who have had a DAR in Q3, approximately 71% showed good diabetes management (see Figure 5). The DSLA work is targeted to address the performance gaps in order to improve clinical outcomes for patients living with diabetes particularly for Maori, Pacific and Quintile 5 population groups.

Figure 4: Good Diabetes Management – ADHB Trend Data

![ADHB % Good Diabetes Management](chart)

**Definition:** % of people with diabetes who have had a diabetic annual review in the reporting period who have an HbA1c <= 64mmol/mol

Within Waitemata DHB (Q3, 2015/16), 51% of those who are on the VDR have had a DAR. Of those who have had a DAR in Q3, approximately 71% showed good diabetes management (see Figure 5). The DSLA work is targeted to address the performance gaps in order to improve clinical outcomes for patients living with diabetes particularly for Maori, Pacific and Quintile 5 population groups.

Figure 5: Good Diabetes Management – WDHB Trend Data

![WDHB % Good Diabetes Management](chart)

**Definition:** % of people with diabetes who have had a diabetic annual review in the reporting period who have an HbA1c <= 64mmol/mol

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Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting 08/06/16

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3. Integrated Performance Incentive Framework (IPIF)

The Integrated Performance and Incentive Framework (IPIF), is a quality improvement programme that will support the health system to address equity, safety, quality, access and cost of services. The IPIF has been developed by clinicians, sector leaders and the MoH.

The IPIF results for Q3 (and the previous quarters, Q1 and Q2), for each of the Auckland and Waitemata PHOs are shown in Tables 1 to 5. Note that any updates to the cervical screening and immunisation activity will be reported in the Women Children and Youth scorecard at the next CPHAC meeting.

Table 1: Q1, Q2 and Q3 2015/16 IPIF Target vs. Actual for Auckland PHO

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 IPIF Result</th>
<th>Q2 IPIF Result</th>
<th>Q3 IPIF Result</th>
<th>Quarterly IPIF Target Achieved for APHO</th>
<th>Q4 Target - National Target</th>
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<td>93%</td>
<td>92%</td>
<td>92%</td>
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<td>90%</td>
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<tr>
<td>Better Help for Smokers to Quit</td>
<td>93%</td>
<td>93%</td>
<td>92%</td>
<td>Yes</td>
<td>90%</td>
</tr>
<tr>
<td>Increased Immunisation – 8 Month Olds</td>
<td>93%</td>
<td>94%</td>
<td>95%</td>
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<td>95%</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
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<td>95%</td>
</tr>
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Table 2: Q1, Q2 and Q3 2015/16 Target vs. Actual for ProCare

<table>
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<th>Q1 IPIF Result</th>
<th>Q2 IPIF Result</th>
<th>Q3 IPIF Result</th>
<th>Quarterly IPIF Target Achieved for ProCare</th>
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<td>More Heart and Diabetes Checks</td>
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### Table 3: Q1, Q2 and Q3 2015/16 Target vs. Actual for Waitemata PHO

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<td>Better Help for Smokers to Quit</td>
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### Table 4: Q1, Q2 and Q3 2015/16 Target vs. Actual for Alliance Health Plus (hosted by CMDHB)

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<tr>
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4. Progress Against the 2015/16 Annual Plan Deliverables

4.1 The Auckland Waitemata Rural Alliance

The Auckland Waitemata Rural Alliance has completed both stages of its rural general practices’ services stocktake. The purpose of the stocktake was to obtain clarity on the range of services provided by rural general practice in both DHBs and on any patient charges. The intent is to use this information to develop a pathway to a consistent set of services with common access criteria and standards. The process was as follows:

**Stage 1:** Emailing a template to all rural general practices requesting a list of all services and treatments provided by each general practice team.

**Stage 2:** summarising the services/treatments from the first stage and asking practices to identify their top ten, high clinical activities from the list. This included any services/treatments that their practice would like to provide but aren’t currently, and the resources and support they would need to better enable the practice to provide those services/treatments.

The second stage was completed and returned by 9 out of 11 Rural Alliance general practices (82%). This information was then used to guide discussion at the Rural Alliance meeting held on 21st April 2016. The process has determined the baseline information, created a clearer understanding of the current rural environment and has helped to identify the preliminary areas of focus for the Work Plan. Although documentation is yet to be finalised, initial areas of focus will be:

- **Access to Ultrasounds** – scoping the feasibility of various options for provision locally to eliminate patient travel. The options being considered are: private/public partnership, general practice provision and training, expanded Primary Options for Acute Services (POAC)
- **Point of Care (POC) Testing** – The following tests have been identified as suitable for point of care testing in rural general practices to aid in diagnostics and finalisation of care plans; International Normalised Ratio (INR), C-Reactive Protein test (CRP), Troponin, D-Dimer, Full Blood Count. Work is being undertaken to explore the options of having Point of Care testing available in rural general practices for these tests.

### Table 5: Q1, Q2 and Q3 2015/16 Target vs. Actual for National Hauora Coalition (hosted by CMDHB)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 IPIF Result</th>
<th>Q2 IPIF Result</th>
<th>Q3 IPIF Result</th>
<th>Quarterly IPIF Target Achieved for NHC</th>
<th>Q4 Target - National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>90%</td>
<td>91%</td>
<td>91%</td>
<td>Yes</td>
<td>90%</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>82%</td>
<td>80%</td>
<td>80%</td>
<td>No</td>
<td>90%</td>
</tr>
<tr>
<td>Increased Immunisation – 8 Month Olds</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>Yes</td>
<td>95%</td>
</tr>
<tr>
<td>Increased Immunisation - 2 Year Olds</td>
<td>94%</td>
<td>95%</td>
<td>96%</td>
<td>Yes</td>
<td>95%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>No</td>
<td>80%</td>
</tr>
</tbody>
</table>
- **Suite of additional activities for POAC** – The stocktake highlighted the opportunity to develop an expanded range of services and interventions for rural general practices through a POAC model. Consideration of either creating a ‘Rural POAC’ or adding to the existing POAC model is underway.

### 4.2 Primary Mental Health

**Stepped care model**

The Primary Mental Health services delivered by the PHOs are based on the stepped care model, as articulated in Rising to the Challenge (the Mental Health and Addictions Service Development Plan, 2012–2017). These services, with the exception of the Prime Minister’s Youth Mental Health Initiative, are targeted to Maori, Pacific and quintile 5 patients. Auckland and Waitemata DHBs use similar service specifications for the adult primary mental health agreements with the PHOs, and apply the available funding to the PHOs weighted towards the Maori, Pacific and quintile 5 populations.

Additional funding provided by the MoH to target alcohol screening and brief interventions in primary care settings has transitioned to DHB baseline funding for 2015/2016. This funding continues to support and extend brief interventions that are already in place as part of existing primary mental health initiatives.

**Auckland DHB**

The Primary/Secondary Integration Strategic Group and the linked Tāmaki Locality Mental Health Project continue to look at opportunities for increased integration between primary and secondary mental health services. Additionally, the Youth Alliance, led by ProCare, provides primary mental health interventions to youth (aged 12 to 19 years). The Q1, Q2 and Q3 volumes for Auckland DHB are shown in Table 6.

### Table 6: Quarter 1, 2 and 3 Auckland DHB volumes, 2015/16

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland PHO</th>
<th>Procare</th>
<th>AH+</th>
<th>NHC</th>
<th>Youth Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td></td>
<td>190</td>
<td>111</td>
<td>55</td>
<td>2437</td>
<td>2158</td>
</tr>
<tr>
<td>Māori</td>
<td>40</td>
<td>35</td>
<td>42</td>
<td>482</td>
<td>450</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>24</td>
<td>23</td>
<td>24</td>
<td>419</td>
<td>351</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>Asian</td>
<td>43</td>
<td>35</td>
<td>35</td>
<td>660</td>
<td>582</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>200</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>191</td>
</tr>
<tr>
<td>Other</td>
<td>55</td>
<td>38</td>
<td>36</td>
<td>130</td>
<td>120</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>69</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>352</td>
<td>242</td>
<td>192</td>
<td>4128</td>
<td>3661</td>
</tr>
<tr>
<td>Target</td>
<td>84</td>
<td>84</td>
<td>84</td>
<td>352</td>
<td>352</td>
</tr>
</tbody>
</table>

Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting 08/06/16
Waitemata DHB

In previous years, Waitemata DHB has funded PHOs by enrolled population. For 2014/15 Waitemata DHB has moved to funding by enrolled Māori/Pacific and quintile 5 populations (using the same methodology as used by Auckland DHB). Due to the consequential changes in PHO funding, Waitemata DHB has agreed to phase this funding change over 2014/15, and the first two quarters of 2015/16. This funding arrangement will be reviewed prior to 2016/17, when utilisation data is analysed and the business cases for the ‘Our Health in Mind’ Action Plan (2016-2021) have been approved.

HealthWest provide primary mental health interventions to youth (aged 10 to 24 years), as part of the Waitematā Youth Health Hub. Raeburn House provide 12 group programmes per annum with access prioritised to GP referrals. Group programmes offered include Mindfulness, depression and anxiety. The Q1, 2 and 3 volumes for Waitemata DHB are shown in Table 7.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Waitematā PHO</th>
<th>Procare</th>
<th>HealthWest</th>
<th>Raeburn House</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>260</td>
<td>243</td>
<td>1788</td>
<td>1536</td>
</tr>
<tr>
<td>Māori</td>
<td>38</td>
<td>50</td>
<td>505</td>
<td>542</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>15</td>
<td>12</td>
<td>234</td>
<td>359</td>
</tr>
<tr>
<td>Asian</td>
<td>17</td>
<td>10</td>
<td>316</td>
<td>253</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>17</td>
<td>86</td>
<td>70</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>340</td>
<td>332</td>
<td>2929</td>
<td>2760</td>
</tr>
<tr>
<td>Target</td>
<td>348</td>
<td>348</td>
<td>547</td>
<td>547</td>
</tr>
</tbody>
</table>

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

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

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

An initial ‘pilot’ credentialing programme for primary health care nurses has been completed with 27 practice nurses graduating in late February 2016. The programme has been independently evaluated to assess the programme of learning, the model of service delivery and future programme sustainability. The key findings of the draft evaluation have been distributed amongst stakeholders. These findings demonstrate that the credentialing process was found to be very valuable by participants, and stakeholders rated the programme’s relevance, efficiency of implementation, effectiveness, and value for money as very good to excellent.
Auckland and Waitemata DHBs have agreed to fund the programme for 2016/17, with up to 60 practice nurses to be enrolled in the mental health and addictions credentialing programme. At this time Counties Manukau DHB has indicated interest but has not confirmed their involvement.

Tāmaki Mental Health and Wellbeing Initiative
The Tāmaki Mental Health and Wellbeing initiative primary care/NGO integration pilot began in September 2015. This pilot has linked three NGOs with two GP practices and is preparing to link a third general practice in Mount Wellington.

Discussions are underway on the expansion of the primary care/NGO integration into other Auckland DHB localities. The Tamaki Mental Health and Wellbeing initiative presented at the ADHB Innovate forum on the 5th of April is part of this process. Feedback from Innovate focused on what were the key enablers were to support this process, one key enabler identified was the prioritisation of a proportion of Support Hours to working with GP practices.

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

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

The DHBs performance in Q3 2015/16 is as follows:

- The total number of Metro Auckland POAC referrals in Q3 (January – March 2016), was 4,940 (24% below the target, see Table 8). Counties Manukau DHB is 40% below target; Auckland DHB is 30% below volumes, and Waitemata DHB is now 8% below the recently increased budgeted volumes for the quarter
- Overall, the total referrals received decreased by 3% compared with the same period in the previous year of 5,089 (Auckland DHB <10%; Counties Manukau DHB <3%; Waitemata DHB >2%)
- The average cost per referral remains consistent across Waitemata DHB and Auckland DHB. Counties Manukau DHB average cost is slightly higher this period ($213) compared with the same period previous year ($183). This can be attributed to the increase in the more complex nature of cases being managed, as well as the increase in requests for some more costly urgent investigations (CT, MRI, ECHO), to assist in early discharge or to avoid referral to Emergency Department. These are approved on a per case basis with appropriate endorsement, where hospital is under capacity pressure
- In Counties Manukau DHB, 86% of patients were safely managed in the community and avoided hospital presentation with 87% in Auckland DHB and 89% in Waitemata DHB
The review of the POAC and Access To Diagnostics (ATD) initiatives within the Metro Auckland area has been endorsed by the Metro Auckland Clinical Governance Forum (MACGF) and continues. The review is a key deliverable of both the Auckland and Waitemata DHBs 2015/16 Annual Plans.

<table>
<thead>
<tr>
<th>Actual number of POAC referrals (target number of referrals)</th>
<th>Waitemata DHB</th>
<th>Auckland DHB</th>
<th>Counties Manukau DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2,049 (1,886)</td>
<td>1,051 (1,510)</td>
<td>1,840 (3,080)</td>
</tr>
<tr>
<td>Average cost per referral (excl. GST), budget $200.00</td>
<td>$188.12</td>
<td>$159.88</td>
<td>$212.96</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals by ethnicity</th>
<th>Waitemata DHB</th>
<th>Auckland DHB</th>
<th>Counties Manukau DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>7%</td>
<td>8%</td>
<td>14%</td>
</tr>
<tr>
<td>Pacific</td>
<td>6%</td>
<td>13%</td>
<td>19%</td>
</tr>
<tr>
<td>Asian</td>
<td>9%</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>78%</td>
<td>65%</td>
<td>56%</td>
</tr>
</tbody>
</table>
5.2 Planning, Funding and Outcomes Update

Recommendation

That the report be received.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Ruth Bijl (Funding and Development Manager Women, Children and Youth), Trish Palmer (Funding and Development Manager Mental Health and Addiction Services), Kate Sladden (Funding and Development Manager Health of Older People), Aroha Haggie (Manager Maori Health Gain), Lita Foliaki (Manager Pacific Health Gain), Samantha Bennett (Manager Asian Health Gain) and Jane McEntee (General Manager Auckland Regional Public Health Service)

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

Glossary

ARRC - Aged Related Residential Care
ARPHS - Auckland Regional Public Health Service
ASA - Advertising Standards Authority
AWHI - Auckland Wide Healthy Housing Initiative
CHSAG - Child Health Stakeholder Advisory Group
CPHAC - Community and Public Health Advisory Committee
CSP - Community Services Plan
DHB - District Health Board
ED - Emergency Department
FOSPA - Fencing of Swimming Pools Act 1987
HAT - Healthy Auckland Together
HBHF - Healthy Babies Healthy Futures
HCSS - Home and Community Support Services
MoH - Ministry of Health
MDR-TB - Multi Drug-Resistant Tuberculosis
NCHIP - National Child Health Information Platform
NIHI - National Institute of Health Innovation
NIR - National Immunisation Register
PHAP - Pacific Health Action Plan
PHO - Primary Health Organisation
PRIMHD - Programme for the Integration of Mental Health Data
SME - Self Management Education
TRC - Tamaki Regeneration Company
Triple P - Positive Parenting Programme
XDR-TB - Extensively Drug-Resistant Tuberculosis
WALSH - West Auckland Living Skills and Housing

1. Executive Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata District Health Boards’ (DHB) planning and funding activities and areas of priority, since its last meeting on 27 April 2016. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting’s agenda.
2. Planning

2.1 Annual Plans

Both draft 2 Auckland and Waitemata DHBs’ Annual Plans were submitted to the Ministry of Health (the Ministry) on 30 May 2016, after being presented at respective May Board meetings for approval. Feedback from the Ministry was provided in early May and resulting changes have been incorporated into draft 2 along with later advice related to System Level Measures, Social Sector Trials, National Entities and the National Pharmacy Agreement. Further Ministry feedback on the Plans is expected in June.

2.2 Waitemata DHB Primary and Community Services Plan (CSP)

The first draft has been prepared and submitted to the 25 May Waitemata DHB Board meeting for review and feedback. This draft incorporates information gathered from the stakeholder forums as well as analysis of population health and service use data and information gained through a community survey. Work will continue over the next month to refine and update the CSP with continued engagement with key stakeholders.

3. Child, Youth and Women’s Health

3.1 Immunisation Health Target

Our current coverage for all infants fully immunised at 8 months of age is:

- ADHB 94% Total, 90% Maori, 96% Pacific, 97% Asian, 90% Other
- WDHB 93% Total, 89% Maori, 97% Pacific, 96% Asian, 89% Other

We will not achieve the end of quarter target for Waitemata DHB. We may achieve the end of quarter target for Auckland DHB. A range of additional initiatives have been identified and are being progressed to support progress against the health target. These include targeted education for LMCs/Pregnancy and Parenting providers and GPs/Practices that have high decline rates. Other strategies targeting communicating with families and whanau are being progressed, including leveraging off measles outbreaks in the Waikato. In essence, we will be looking at having vaccine conversations earlier (during pregnancy) and at making access to pregnancy vaccines easier where possible. We will be continuing our strong programme of work around primary care processes and systems supported by an effective population information system and outreach services for those that need extra support to access a timely childhood vaccination programme.

3.2 Rheumatic Fever and Housing

A co-design process regarding accessing warm, dry housing has been led by the Southern Initiative. With Counties Manukau DHB, we have been working to understand how better we could deliver improvements to children at risk of rheumatic heart disease, in relation to housing. We have met with the Ministry regarding our current programme, delivered through the Auckland Wide Healthy Housing Initiative (AWHI). Improvements to programme design as well as supply side responses have been identified. We would like to acknowledge the active contribution to this co-design process of community members, NGO, health staff and land-lord representatives.

3.3 Childhood Obesity

The Ministry met with DHBs regarding their expectations in relation to the obesity health target. There is still a lack of strong evidence regarding effective interventions in this area but the Ministry are happy to work with DHBs to unlock this information over time. A number of evaluations are underway in New Zealand which we are continuing to watch with interest. The Ministry were
positive regarding our progress to date and our regional approach in relation to a childhood obesity pathway. They were clear that part of the pathway needs to include referral to a general practitioner.

### 3.4 Other Child Health

The out-going Children’s Commissioner, Dr Russell Wills, presented the Waitemata DHB CEO Lecture Series in May. Russell has been a strong advocate for children and his strong links as a community paediatrician have been extremely valuable in helping articulate what else health can do to support vulnerable children. The new Children’s Commissioner, Judge Andrew Becroft, will bring a different approach but one that remains keenly aware of key issues including equity.

Within our own work we continue our strategic focus within child health on pregnancy and the first year of life. There remains much work to do but we remain committed to proportionate universalism, as discussed with CPHAC in September 2014 (Changing the Landscape of Childhood Vulnerability: An Inter-Agency and Community Challenge). In addition we have four government priorities: supporting vulnerable children, rheumatic fever, immunisation and child obesity. It should be recognised that families move in and out of vulnerability so we need engagement and systems to help us identify when a family might need more support. We also need service design that allows us to deliver services to the majority most efficiently to free up resources for those that need more support (proportionate universalism). The design of our health system, including funding models, does not always facilitate this approach most effectively. This approach is shown graphically in the diagram below where the triangle in the background represents our universal services – such as maternity care for all pregnant women and Well Child Tamariki Ora services for all children and the joined circles the additional priorities overlaid on this.

![Diagram showing proportionate universalism](image)

Also in May, the inter-sectoral Child Health Stakeholder Advisory Group (CHSAG), chaired by Dr Alison Leversha met to discuss the implications of changes proposed to Child, Youth and Family. This is expected to have some significant implications for services provided by health.

Finally, we are progressing a regional business case for the National Child Health Information Platform (NCHIP). As with the National Immunisation Register (NIR), a single shared record that shows whether or not a child has received all the core checks and services (such as newborn hearing
screening, immunisations, oral health and well child checks) will help us better identify children who need more support to access health care and improve our ability to stay connected with those families.

3.5 Youth
Waitemata DHB has been informed that the Ranui Social Sector trial will continue for a further six months. The trial has been considered a success in terms of gathering key agencies around a common agenda. It is expected that a focus on addictions will continue at the local level after the trial formally ends.

3.6 Women
In May, we launched our pregnancy and parenting website and app. This was commissioned from the University of Auckland jointly with Counties Manukau DHB. The purpose of the website and app is to provide a source of evidence based information as an adjunct to information provided by more traditional face to face health professional interactions.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)
The Director General’s Reference Group Report ‘Towards Better Home and Community Support Services for all New Zealanders’ has been released. There are 15 recommendations in the report that stem from two working groups set up to provide advice to the Reference Group covering:

- a review of home and community support services (workstream 1)
- the impact and affordability of transitioning to a regularised workforce (workstream 2)

The majority of recommendations are likely to be agreed to, however there are some fundamental issues that have not been agreed including a move to a national agreement.

4.2 Aged Related Residential Care (ARRC)
A request from the April 2016 CPHAC meeting was for information on the mix of beds in each DHB. The ARRC Bed Survey findings (quarter 3, 2015/16) have been received. The introduction of this survey is relatively recent. However, it provides a snap shot of the bed mix and occupancy rates in both DHBs as shown in the tables below and going forward will provide us with trends in the bed supply.

### Auckland DHB

<table>
<thead>
<tr>
<th>Beds</th>
<th>Number</th>
<th>Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated Rest home</td>
<td>1,165</td>
<td>81%</td>
</tr>
<tr>
<td>Dedicated hospital</td>
<td>1,112</td>
<td>90%</td>
</tr>
<tr>
<td>Dual* service</td>
<td>966</td>
<td>90%</td>
</tr>
<tr>
<td>ORA* rest home only</td>
<td>65</td>
<td>92%</td>
</tr>
<tr>
<td>ORA hospital only</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ORA dual service</td>
<td>119</td>
<td>97%</td>
</tr>
<tr>
<td>Dementia</td>
<td>335</td>
<td>84%</td>
</tr>
<tr>
<td>Psychogeriatric</td>
<td>44</td>
<td>89%</td>
</tr>
<tr>
<td>Dedicated YPD</td>
<td>7</td>
<td>57%</td>
</tr>
<tr>
<td>Other beds</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,814</strong></td>
<td><strong>87%</strong></td>
</tr>
</tbody>
</table>

*ORA – Occupy Rights Agreement
*Dual service – rest home or hospital
Waitemata DHB

<table>
<thead>
<tr>
<th>Beds</th>
<th>Number</th>
<th>Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated Rest home</td>
<td>1,027</td>
<td>90%</td>
</tr>
<tr>
<td>Dedicated hospital</td>
<td>722</td>
<td>92%</td>
</tr>
<tr>
<td>Dual service</td>
<td>1,122</td>
<td>93%</td>
</tr>
<tr>
<td>ORA rest home only</td>
<td>41</td>
<td>83%</td>
</tr>
<tr>
<td>ORA hospital only</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ORA dual service</td>
<td>31</td>
<td>103%</td>
</tr>
<tr>
<td>Dementia</td>
<td>374</td>
<td>93%</td>
</tr>
<tr>
<td>Psychogeriatric</td>
<td>111</td>
<td>92%</td>
</tr>
<tr>
<td>Dedicated YPD</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other beds</td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,432</strong></td>
<td><strong>92%</strong></td>
</tr>
</tbody>
</table>

To provide further context around trends in ARRC use at the different levels of care below are graphs of funded bed days for both DHBs from 2006/07 to 2014/15.
5. Mental Health and Addictions

5.1 Auckland and Waitemata DHB’s Mental Health and Addictions Employment Strategy - Everyone’s Business

From 1 July 2014 Auckland and Waitemata DHB NGO providers have reported service user employment status upon entering an NGO service and then by each quarter until they exit the service. The key outcomes of the Q1, Q2 and Q3 2015/16 period are:

- 35 (3.7%) of 957 people gained paid employment during their stay in supported Housing and Recovery Services after being unemployed at entry; and
- An additional 72 people (90%) maintained their paid employment status on entry through to exit from supported housing and accommodation services.

The number of people failing to gain employment or supported to maintain employment while accessing NGO Housing and Recovery services is a significant issue and is the burning platform for establishment of the “Everyone’s Business” strategy. This is the mental health and employment strategy for Auckland and Waitemata DHBs, that has set a target of at least 50% of people exiting from specialist mental health and addictions services will be in employment by 2020.

The two current actions being implemented from the strategy are:

1. DHB provider arm services will begin to report service users’ employment status and
2. NGO providers will establish Employment Specialist roles.

From 1 July 2016 DHB provider services are required to report employment status at entry and exit to the service within the Programme for the Integration of Mental Health Data (PRIMHD). It is anticipated that usable DHB provider arm data will be available during Q2 2016/17. Discussions are underway with NGO providers to develop employment focused/specialist employment roles within existing Support- Hour- based services. Currently two providers, namely Equip and West Auckland Living Skills and Housing (WALSH) Trust, are developing these roles within their services. In addition discussions are underway with Te Pou and Career Force to identify and establish training and on-going support of these roles as they are being developed within NGO sector to improve their success in achieving the 2020 strategy.

5.2 Auckland and Waitemata DHB’s Mental Health and Addictions Social Outcomes Indicators development

The social outcome indicators work undertaken by Auckland and Waitemata DHB NGOs continues to focus on measuring changes in employment status, and has included housing status for 2016/17. Housing status compares a person’s housing (based upon Statistics NZ definitions) status when they enter service to when they exit. The key outcomes of the combined Q1, Q2 and Q3 2015/16 period are:

- 943 (87%) of the 1024 people are discharged from NGO supported Housing and Recovery services into independent accommodation.
- 31 (77.5%) of the 40 people who are categorised as homeless on entry to NGO supported Housing and Recovery services are still homeless on discharge.

There are some limitations with Statistics NZ definition of Homelessness, as it is defined as living situations where people with no other options to acquire safe and secure housing: are without shelter, in temporary accommodation, sharing accommodation with a household or living in uninhabitable housing. The homeless data includes for example people who have recently separated from partners and are living with other whanau as an interim measure or adults who have returned to live with parents/whanau to access natural supports due to onset of mental illness episode. A current project is in place within the NGO sector to expand the data about “homeless”
accommodation in order to understand this state and then identify evidence based interventions based upon this analysis.

The majority of people exiting NGO services will be discharged to independent accommodation. Currently both the Auckland DHB Innovate group and the Waitemata Provider Executive Group (PEG) have dedicated accommodation workstreams with key focus areas to establish DHB provider arm reporting and to develop housing facilitation roles within NGO providers. Service Users’ accommodation status (from both DHB Provider Arm and NGO Services) will be a PRIMHD reporting requirement from 1 July 2016. Discussions are underway with NGO providers to develop dedicated housing facilitation roles within existing Support Hours based services. One provider, Equip, has established this role already.

5.1 Auckland DHB’s Tamaki Mental Health and Wellbeing Initiative

The Tamaki Mental Health and Wellbeing initiative primary care/NGO integration pilot began in September 2015. This pilot has linked three NGOs with two GP practices and is preparing to link a third GP practice.

The pilot working group is currently focused on the development of primary care/NGO integration in further ADHB localities. The development of further localities will be based on the learnings of the pilot, an example of this is providing some dedicated NGO resource (taken from existing Support Hours services) during the developmental phase of any new locality.

5.2 Waitemata High and Complex Needs Service Development

The NGO Provider, Goodwood Park Health Group Ltd, has established two interim services in Kumeu and Ranui. Currently five people have been transferred into this service and other potential service users are in the process of being assessed for eligibility.

Goodwood Park Health Group Ltd and Waitemata DHB are currently in the design phase of the enduring service, working alongside the architects who designed the He Puna Waiora inpatient unit. Currently site plans are with the Auckland Council for pre-approval, with final approval to be sought in July 2016. The construction of this facility is expected to be fully completed by May 2017.

Eligibility for the High and Complex Needs Services is for those people with serious and enduring mental illness and complicating factors, such as cognitive impairment and/or intellectual disability. Therefore, the expectation is that service users will require guardians to safeguard their welfare and/or finances. It has been identified that service users may not have family, whānau or friends who are prepared to act as guardians. The Waitemata DHB is currently exploring the establishment of an independent Trust to recruit, train and support volunteer guardians to support this service.

5.3 Suicide Prevention and Postvention Action Plan for Auckland and Waitemata DHBs

The Suicide Prevention and Postvention Action Plan for Auckland and Waitemata DHBs (SPPAP) was implemented in July 2015. The Suicide Prevention Advisory Committee has been focussing on two main areas of activity to implement the SPPAP.

5.3.1 Workforce development and training focusing on early detection of at-risk people

Trainings have been facilitated for community health and social support service staff, families, whānau and community members to identify and support individuals at risk and refer them to agencies that can help.

The Ministry undertook a pilot of an on-line training tool for screening for risk of suicide. The tool ‘QPR’ (Question; Persuade; Refer) targets community health workers, social support service staff,
families and whānau, and community members to help identify and support individuals at risk of suicide and refer them to agencies that can help. The training includes information for increased awareness and knowledge related to screening for suicidal thoughts and behaviours as well as practical skills training regarding when and how to ask the “Suicide Question”.

The MOH allocated 400 licences for community health workers across Waitemata and Auckland DHB. These licences were divided up amongst our health services throughout the two districts and a significant number of frontline community workers engaged in this training. There was good representations from Pacific, Maori, Asian cultural support services and also good uptake from clinical services, school nurses, and frontline support workers from youth, adult and older adult services. The Ministry has conducted an evaluation of this pilot but the report is not available yet.

SafeTALK, an American Programme adapted by Lifeline, is a suicide alertness training that prepares participants to identify people with thoughts of suicide and connect them with appropriate help. The workshop emphasizes the importance of recognizing the signs, communicating with the person at risk and getting help or resources for the person at risk.

In response to the impact of mental wellbeing of rural communities by ongoing climate and economic pressures, the Ministry of Health and Rural Health Alliance Aotearoa (RHĀNZ) delivered 40 SafeTALK training workshops across rural New Zealand. These workshops aimed at upskilling health and social service professionals in suicide risk assessment and prevention strategies.

During the month of March, four SafeTALK workshops were delivered to Kumeu, Warkworth, Wellsford and Great Barrier Island. For Auckland and Waitemata DHBs, these workshops were directly supported by the Rural Alliance’s Secretariat, the Programme Manager for Suicide Prevention, and Maori Health Gain Team. The four workshops attracted a total of 71 attendees with a good mix of primary care staff, allied services and support personnel. Requests common to all workshops centered on the availability of additional trainings, especially for practice nurses which will assist in future planning.

Following on from the delivery of the SafeTALK workshops to the rural community, a further five workshops facilitated by Lifeline were scheduled to be delivered for family and whānau. Two workshops have been delivered at Helensville (Māori community) and Glenn Innes (Pacific Community) respectively with further workshops organized for Grafton (Asian community), Newmarket and Orewa. These workshops align with the SPPAP with regards to a systematic approach targeting specific ethnic groups that reflects not only the needs but diversity within our population. It is estimated that two hundred people will be able to attend these series of workshops.

5.3.2 Development of the Suicide Prevention and Postvention Inter-agency Working Group
The Suicide Prevention and Postvention Inter-Agency Working Group is an integral element in ensuring that there is commitment from key agencies to support families, whānau, and communities AFTER a suicide. Suicide postvention includes all the activities undertaken after a suspected suicide to address the traumatic after-effects for the survivors of suicide, including bereavement and trauma recovery, as well as ensuring education and screening efforts to reduce the risk of further suicides. There has been evidence already about better coordination and responsiveness with support to school and whanau as result of increased awareness and collaborations between agencies.

A postvention notification pathway has been developed, in consultation with both the Suicide Prevention Advisory Committee and the Inter-agency Group. The coroner’s office advises the Suicide Prevention Programme Manager of any suspected suicides. The information is passed to the Postvention group and necessary follow-up with appropriate schools and services etc occurs to ensure the community’s needs have been addressed.
The primary focus of the WAVES programme is to provide people with the opportunity to participate in a psycho-educational programme that offers an experience of healing by connecting them with other people who have been bereaved by suicide. The purpose of WAVES in this context is to help adults learn more about grief and suicide, find meaning in their experiences, learn to manage emotions, reduce stigmatisation and feelings of isolation and assist them to move forward.

Skylight (a national organisation supporting people impacted by change, loss, trauma and grief) worked cooperatively with both Waitemata and Auckland DHB to train facilitators of the WAVES programme. Nine frontline community workers from both clinical and NGO services were trained as facilitators, and are currently developing a referral pathways for the community to access this support. Currently there is a process of negotiation undertaken with management of these services to ensure that trained facilitators are able to deliver the WAVES programme as part of their current role. The advisory committee recommended that trained facilitators are placed strategically throughout the two districts to ensure that people needing this support can access it.

6. Maori Health Gain

6.1 Healthy Babies Healthy Futures

The Healthy Babies Healthy Futures (HBHF) Programme is focused on preventing maternal and child obesity for four ethnic populations in the Waitemata and Auckland District Health Board regions through improved nutrition and increased physical activity. The implementation structure is partnership and community-based, and supports innovation and integration. Four ethnic-specific service providers deliver health promotion and education initiatives to their respective communities (Māori, Pacific, Asian and South Asian), while The University of Auckland National Institute of Health Innovation (NIHI) delivers a supporting text messaging service to the same populations. For the current financial year the programme has delivered the following results:

<table>
<thead>
<tr>
<th>TEXTMATCH ENROLMENTS:</th>
<th>YTD</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>193</td>
<td>250</td>
</tr>
<tr>
<td>Pacific</td>
<td>214</td>
<td>250</td>
</tr>
<tr>
<td>Asian</td>
<td>303</td>
<td>250</td>
</tr>
<tr>
<td>South Asian</td>
<td>241</td>
<td>250</td>
</tr>
<tr>
<td>Total</td>
<td>951</td>
<td>1000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GROUPS DELIVERED:</th>
<th>YTD</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Pacific</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Asian</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>South Asian</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOTHERS COMPLETED:</th>
<th>YTD</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>54</td>
<td>90</td>
</tr>
<tr>
<td>Pacific</td>
<td>88</td>
<td>90</td>
</tr>
<tr>
<td>Asian</td>
<td>81</td>
<td>75</td>
</tr>
<tr>
<td>South Asian</td>
<td>41</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>223</td>
<td>315</td>
</tr>
</tbody>
</table>
Recently the Ministry of Health confirmed that the Programme will continue to be funded for another two-year period based on the work completed and the direction HBHF is heading given the new service improvements to be implemented. An external evaluation is being conducted with the final report expected in October 2016.

6.2 Māori Health Plan

We have received the initial feedback from the Ministry of Health for the draft 2016/17 Waitemata District Health Board Māori Health Plan. The Ministry has approved seven of the twelve indicator areas with the remaining five areas receiving tentative approval and requiring only minor changes to be acceptable. We are making the required changes in consultation with our MoU partners, Māori providers, PHOs and internal stakeholders. The Māori Health Gain Advisory Committee will also be provided with an opportunity to provide input to the updated activities.

7. Pacific Health Gain

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

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

One Living Without Violence programme is being implemented in a Samoan congregation in Westmere. The next training of Living Without Violence facilitators will be held on 10th and 11th June in the Onehunga area and about 40 people have registered to participate.

One Incredible Years (IY) parenting programme is currently being implemented in the Tongan Methodist Church in Ponsonby and two are currently being implemented in West Auckland.

Incredible Years (IY) and Positive Parenting Programme (Triple P) are two parenting programmes that are endorsed by the Ministry of Health (MOH) and Ministry of Education. Triple P is an eight week programme as compared to the 14 week IY programme. MOH contracts Waipareira Trust to train Triple P facilitators and we are in negotiation with Waipareira to train Pacific facilitators. Community feedback also supports the 8 week programme. We will be able to deliver more programmes with the current funding allocation.

Two consultation meetings have been held regarding oral health of Pacific children in West Auckland and two more will be held in the Auckland DHB area. This will feed in to the Pacific Oral Health Strategy that is being developed by the Auckland Regional Dental Health Service.

7.2 PHAP Priority 2 – Pacific People are smoke-free

The Pacific Quit Smoke Service provided by Auckland Regional Public Health Service (ARPHS) will cease as of 30 June 2016. The new provider/s of quit smoke services have not been formally announced but we are holding informal talks with a Pacific provider that is part of negotiations with the Ministry of Health as to furthering that ethnic specific quit smoke approach with Cook Island women, Tongan men and Samoan people, as the Pacific ethnic groups with the highest smoking rates.

We met with Dr Robyn Whittaker from National Institute of Health Innovation (NIHI), and West Fono Health Trust regarding a text messaging quit smoke support service in the Samoan language, that NIHI has developed with the Ministry of Health, Western Samoa. We will work with the new quit smoke provider to explore whether this will be a useful tool in the new quit smoke service and whether this could be developed in other Pacific languages.
### 7.3 Priority 3 – Pacific people are active and eat healthy

We have initiated discussions with Pacific researchers, Pacific Heartbeat (National Heart Foundation), Pacific primary care providers, the Pacific Health Action Plan Working Group, in the process of identifying a specific Pacific response to childhood obesity. The appointment of Dr Corina Grey, a public health physician, to work with the Pacific team will ensure that all Pacific specific interventions will be designed in a way that will enable data to be collected so that evaluation can be undertaken. Although there are no new resources currently, we can re-focus the HAVZ and Enua Ola programme to focus on the nutrition and physical activity needs of children and young people.

### 7.4 PHAP Priority 4–People seek medical and other help early

The Fanau Ola Integrated Services contract that ADHB has with AH+ PHO has provided its Q3 2015/16 report. The number of families enrolled with the service continue to increase, so whilst the contract requires the services to work with 322 families in a period of a year, the total number of families with the service as of end of Q3 is 458. We are continuing to work with AH+ to identify the number of hours that are going into individuals and family members and outcomes that are being achieved. This analysis is not at a point that will enable us to determine a funding level different from the current, so we have agreed with AH+ to renew the current contract with the same volumes and funding for another six months whilst we continue with the analysis.

The translation of the Stanford Chronic Disease Self-Management Education Programme Leader’s Manual into Samoan is now complete and was sent to Stanford University, California at the beginning of this month. The Manual will be launched on 3rd June. Three Samoan Self-Management programmes are currently delivered in the communities through Alliance Health+. Most of the participants are people with long term conditions and carers of people with long term conditions. A 4-day Leader’s Training for Samoan Self-Management Education facilitators is currently being delivered for 8 community lay facilitators.

### 7.5 PHAP Priority 5 - Pacific people use hospital services when needed

The Pacific GM for Hospital Services reports on this priority.

### 7.6 PHAP Priority 6 – That Pacific people live in houses that are warm and are not overcrowded

We maintain a relationship with Ministry of Business, Innovation and Employment. At a meeting with Tamaki Regeneration Company (TRC), they said that their connection to the Tongan community could be stronger. We assisted organising a meeting between leaders of the Tongan community and Tamaki Housing, the social housing arm of TRC. The General Manager of Tamaki Housing was able to answer many questions from the community that clarified a lot of issues for them. Subsequently, the Tongan leaders decided that it is important that they have a structure that will enable them to communicate with Tamaki Housing and the TRC in an ongoing manner, and we provide some support to enable this to happen.

### 7.7 General

**New Pacific Health Action Plan**

We have established a working group to guide the development of the new Pacific Health Action Plan, from July 2016 onwards. Six community people are part of the group as well as Procare, AH+ and Pacific provider representatives. The Working Group has confirmed the goals of the current Plan to continue, but with a renewed emphasis on child health and childhood obesity. They would also like to consider further responses to mental health and addictions as well as health of older people.
We will continue to work on developing a draft plan which we will consult on, both in the community and within the DHB.

**Safe Talk Workshop**
A Safe Talk workshop was held for Pacific people at Tamaki College, Glen Innes. 35 people attended, most from the Glen Innes, Panmure and Oakei areas. This is one of the workshops delivered as part of the implementation of the DHB’s suicide prevention strategy. The workshop was well received and generated good discussions. We are confident that if other workshops are offered, they will also be well attended.

**8. Asian, Migrant and Refugee Health Gain**

Key projects driving efforts towards the goal of increasing health gain in targeted Asian, migrant and/or refugee populations where health inequalities impact on their health status in the Auckland and Waitemata DHBs are:

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

Asian International Benchmarking Report to be completed by end June comparing health outcomes for Asian subpopulations around the world, in order to identify potential emerging areas that may impact on the health of specific Asian groups in the Auckland and Waitemata DHBs’ catchments.

**8.2 Increase Access and Utilisation to Health Services**

**Indicator: Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 76% (ADHB) and 84% (WDHB) targets by 30 June, 2016 (current rates 74% (ADHB) and 83% (WDHB) as at April, 2016)**

- Between Q1-Q2 there was a 1% increase in the Asian PHO enrolment rate for Waitemata DHB which equates to 2,616 new enrolments. The Auckland DHB rate has remained the same at 74% between the two quarters, however due to record net migration there were still 1,175 new enrolments.

- ‘Healthcare - where should you go?’ campaign will be rolled out in June tailored to promote culturally appropriate messaging about enrolling with a family doctor and the benefits of it to students and new migrants living in the Auckland City Centre and inner city suburbs.

**Indicator: Reducing acute flow to Auckland City Hospital’s Emergency Department (ED)**

A suite of interventions to increase awareness of the health and disability system includes: video podcasts (English, Mandarin (completed and promoted), and Hindi (completed), settlement information sessions to migrants and the workforce, targeted library engagement, information and links to videos added to Immigration NZ’s- NZ Now healthcare page. A link to your local doctor website posted on the Immigration NZ’s- NZ Now Facebook page and added to the calendar for future posts as well. It will also feature in two of the main publications, SETTLEMENT ACTIONZ and LINKZ. 2), social media Facebook page for the INAKL International Student Network, and presentation at the Auckland International Education Conference (6/7).

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

- The Refugee Primary Care Wrap Around Service Agreements with PHOs have been reviewed for the 2016-17 financial year. Professional development opportunities for primary health and the frontline workforce to upskill them on the soft skills and cultural competencies required to support refugee families at the practice level include:
- A refugee health network forum to primary health professionals on ‘Navigating the adult disability system for former refugees’ was delivered on 25 May.
- Receptionists’ cross-cultural training to frontline primary health staff is scheduled for 29 June, 2016.

Indicator: Increase the number of Indians (35-49 years) who have a heart and diabetes check through targeted engagement

- A targeted collaborative initiative is being finalised with Waitemata DHB, The Asian Network Inc, Diabetes NZ (Auckland Branch), Healthy Families Waitakere, The Taxi Co-op, and Green Prescription. The intent is to raise awareness about heart and diabetes checks and pathways to GP visits as well as culturally appropriate healthy lifestyle activities including green prescription initiatives, healthy eating options and Taxi Co-op workplace initiatives.

9. Auckland Regional Public Health Service (ARPHS)

9.1 BCG vaccine availability update

All eligible babies on the BCG vaccination waiting list have been offered vaccination, with approximately 2,000 eligible babies being vaccinated by 13 May 2016. Babies currently being vaccinated are those born in the last two months. A further 26 BCG Clinics are planned until 31 May 2016, which is when the current vaccine supply expires. It is unlikely that a new supply of vaccine will become available in New Zealand before 2017.

9.2 Community water fluoridation

In mid-April the government announced proposed legislative changes to allow DHBs, rather than local authorities, to decide on which community water supplies are fluoridated in their areas. This decision recognises that health boards have the expertise to consider the technical health evidence relevant to the decision. Under this proposal a local authority would be required to follow the DHB directive. The cost of making decisions on fluoridation would be met by DHBs. It is anticipated that a Bill will be developed for initial consideration by Parliament by the end of 2016. If passed before the end of the Parliamentary term in 2017 it is likely that legislation would come into force from mid-2018.

ARPHS has produced two resources (poster and pamphlet) for use across the region promoting benefits of community water fluoridation. These resources are available on ARPHS’s website at http://www.arphs.govt.nz/health-information/promoting-health-wellbeing/water-fluoridation. The resources explain fluoridation in simple terms, and are designed for those who might want a non-technical overview of fluoridation basics. The resources also address the myths that have become standard feature of the fluoridation ‘debate’.

9.3 Favourable District Licensing Committee decision

ARPHS’s legal counsel opposed a renewal of a grocery store’s alcohol off-licence on the basis of eligibility. For the first time the District Licensing Committee found in favour of the Medical Officer of Health and refused the licence. The application was refused because it was established that the premises principal business was the sale of tobacco, and therefore, could no longer meet the definition of a ‘grocery store’.

9.4 Update on the Building Pools Amendment Bill

In April 2016 the Building (Pools) Amendment Bill was reported back to Parliament after hearings by the Local Government and Environment Select Committee. The Bill is intended to replace the current Fencing of Swimming Pools Act 1987 (FOSPA) with a “performance-based” approach to
restricting unsupervised access of young children to domestic pools under the Building Act 2004. ARPHS and the DHBs, along with other stakeholders, expressed concerns that the Bill would lead to erosion of domestic pool safety and result in a gradual increase in preventable childhood drownings. The following table lists the issues and recommendations in the ARPHS/DHB submission, and what is in the revised version of the Bill.

<table>
<thead>
<tr>
<th>DHB-ARPHS Issues and recommendations</th>
<th>Revised Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primacy needs to be given to child safety</td>
<td>Partial improvement. The purpose of the amendments in the Building Act now includes: “to prevent drowning of, and injury to, young children...”. However some provisions in the original Bill which could compromise child safety remain.</td>
</tr>
<tr>
<td>Require inspection of pool fences on three year cycle (which is current good practice), rather than five years as proposed in the original Bill</td>
<td>Supported. Inspections will be every three years, undertaken by Council staff or qualified pool inspectors</td>
</tr>
<tr>
<td>Remove the effectively “voluntary” approach to high risk flexible pools</td>
<td>No improvement.</td>
</tr>
<tr>
<td>Prohibit and phase out direct access to the pool area from the adjacent house.</td>
<td>Not supported. The Bill will continue to allow doors directly between the house and pool area, with the proviso that children must not be able to open the door readily, and that either (i) the door has an audible alarm; or (ii) the door closes automatically. There is no requirement for a latch, as in FOSPA.</td>
</tr>
<tr>
<td>Fencing should be required for hot tubs and spas</td>
<td>Not supported. Hot tubes and spas (now called “small heated pools”) do not require a barrier other than a closable lid unless the pool is less than 760mm above ground or deck level, or the pool surface area is more than 5m2.</td>
</tr>
<tr>
<td>Pool suppliers and installers should ensure barriers are in place when pool is installed</td>
<td>Not supported. The only requirement for suppliers is to supply purchasers with information on Building Code responsibilities.</td>
</tr>
<tr>
<td>Owners should be required to inform Council that they have a pool which is required to have a fence (e.g. though Building Consent).</td>
<td>Not supported.</td>
</tr>
<tr>
<td>Current broad Council responsibility in FOSPA to ensure compliance should continue</td>
<td>Supported in part. Councils can enforce duties of pool owners (which was not in the original Bill).</td>
</tr>
<tr>
<td>Barriers should be designed to prevent access by children aged under six years (the current standard), rather than aged under five years</td>
<td>Not supported.</td>
</tr>
</tbody>
</table>

In summary, the Bill has been amended to require current good practice of three-yearly inspections. ARPHS is concerned other amendments were not made. Of particular concern is that the Bill continues to allow direct access from houses, even though this is known to be hazardous.

9.5 Ports of Auckland maritime exercise

Auckland and Waitemata DHBs’ Community and Public Health Advisory Committee Meeting 08/06/16
The Auckland Maritime Public Health Framework was revised following a meeting with stakeholders in September last year. Some participants felt it was important to test the validity of the amended framework and ensure all stakeholders were comfortable with their roles and responsibilities. ARPHS subsequently organised an interagency table top exercise on 3 May 2016 to test the regional preparedness plans for a major maritime public health emergency. Approximately 40 operational management leads participated from 16 agencies. There is general agreement the region is more prepared if a maritime public health emergency should occur.

### 9.6 Healthy Auckland Together (HAT) update

HAT made a submission to the Advertising Standards Authority (ASA) review of its Code for Advertising to Children and the Children’s Code for Advertising Foods. Children are more vulnerable to marketing messages than adults, and are more likely to accept marketing messages as truthful, accurate and unbiased. The current complaints process is self-regulating in nature. HAT recommended the development of a co-regulation model, supported by independent monitoring and evaluation. More substantial limitations on advertising to children were requested. In particular, it was noted that the scope of the Code needed to be broadened, as advertisers now target children through a variety of settings i.e. sponsorship, websites, social media, video games etc. A corresponding media release was picked up by Radio NZ, World TV and NewsHub.

HAT partners are continuing to collaborate on a range of initiatives throughout the Auckland region.

### 9.7 Submissions

ARPHS completed and submitted four submissions in April 2016.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 April</td>
<td>Review of the Code for Advertising to Children and the Children’s Code for Advertising Food</td>
<td>See HAT summary above.</td>
</tr>
<tr>
<td>26 April</td>
<td>Reporting on Status of Older Aucklanders – Domains and Indicators (closed submission)</td>
<td>Auckland Council’s Research and Evaluation Unit are developing a report on the status of older Aucklanders. As a first step it had developed a list of domains and indicators as a means to measure the wellbeing of older people, and sought stakeholder feedback on these. ARPHS provided comments on each relevant domain, as well as providing a list of health sector contacts that Council could potentially consult.</td>
</tr>
<tr>
<td>27 April</td>
<td>PHARMAC consultation on proposal to list bedaquiline</td>
<td>PHARMAC sought feedback on its proposal to list bedaquiline (Sirturo) for treatment of extensively drug-resistant tuberculosis (XDR-TB). ARPHS recommended that the proposal be amended to enable the use of bedaquiline, where indicated, in the adult treatment regimen of any multi drug-resistant tuberculosis (MDR-TB). This recommendation was not adopted by PHARMAC in its final decision, noting that it had received clinical advice that the</td>
</tr>
</tbody>
</table>
indication should be restricted to those with XDR-TB.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 April</td>
<td>Seapath cycling and walking path</td>
<td>SeaPath is a proposed walking and cycling path between Esmonde Road in Takapuna and Northcote Point on the North Shore. ARPHS supported the proposed path to ensure the provision of safe active transport choices.</td>
</tr>
</tbody>
</table>
### 9.8 Upcoming submissions

The table below reflects anticipated submissions, which may change as our scanning and screening of opportunities continues.

<table>
<thead>
<tr>
<th>Due Date</th>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 May</td>
<td>Asbestos: WorkSafe draft Code of Practice for Management and Removal</td>
<td>WorkSafe’s proposed Code provides guidance for complying with the Health and Safety at Work Act 2015 and its Regulations, including the Health and Safety at Work (Asbestos) Regulations 2016. It has a broad scope, providing advice on asbestos management and removal; air and health monitoring requirements; tools and personal protective equipment; and contamination standards.</td>
</tr>
<tr>
<td>23 June</td>
<td>Healthy Homes Guarantee Bill</td>
<td>This private members Bill sets out to require minimum standards for heating and insulation for rental properties. MBIE would set the standards.</td>
</tr>
</tbody>
</table>
7. Resolution to Exclude the Public

Recommendation:

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>
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<td>1. Minutes of the ADHB and WDHB Community and Public Health Advisory Committees Meeting with Public Excluded 27/04/16</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Confirmation of Minutes As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&amp;D Act.</td>
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<td>2. Co-opted member appointments</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]</td>
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