Waitematā
District Health Board

Best Care for Everyone

Community and Public Health Advisory Committee Meeting

Wednesday 28 October 2020

10.00am

Venue

Waitematā District Health Board
Boardroom
Level 1, 15 Shea Tce
Takapuna

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

WAITEMATĀ DISTRICT HEALTH BOARD
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) MEETING
28 October 2020

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna **Time: 10.00am**

COMMITTEE MEMBERS	MANAGEMENT
Kylie Clegg – Committee Chair (WDHB Board member)	Dale Bramley - WDHB, Chief Executive
Warren Flaunty – Committee Deputy Chair	Peta Molloy - WDHB, Board Secretary
Judy McGregor – Ex-officio as WDHB Board Chair	Debbie Holdsworth – Director Funding
John Bottomley - WDHB Board member	Karen Bartholomew - Director Health Outcomes
Chris Carter - WDHB Board member	
Sandra Coney - WDHB Board member	
Allison Roe - WDHB Board member	
cc: All Board Members	

Apologies:

AGENDA

KARAKIA
ACKNOWLEDGEMENTS
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?

PART I – Items to be considered in public meeting

	1.	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
10.00am	2.1	Confirmation of Minutes of the meeting held on 05/08/20 Actions Arising from previous meetings
	3.	**DECISION PAPER**
10.05am	3.1	Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023, Auckland and Waitematā District Health Board
	4.	**STANDARD REPORTS**
10.25am	4.1	Planning, Funding and Outcomes Update - Planning - Primary Care - Health of Older People - Child, Youth and Women - Mental Health and Addictions - Pacific Health Gain - Māori Health Gain - Asian, Migrant and Refugee Health Gain
	5.	**INFORMATION ITEMS**
10.45am	5.1	Oral Health in the Auckland Region
11.10am	5.2	System Level Measures – Quarter 4 Report
11.30am	5.3	Auckland Regional Public Health Service Briefing
11.55am	**6.**	**GENERAL BUSINESS**

Waitematā District Health Board

Community and Public Health Advisory Committee

Member Attendance Schedule 2020

Member	February	May	August	October
Kylie Clegg (Committee Chair)	✓	Meeting Cancelled due to COVID-19	✓	
John Bottomley	✓		✓	
Chris Carter	✓		✗	
Sandra Coney	✓		✗	
Warren Flaunty	✓		✓	
Judith McGregor	✓		✓	
Allison Roe	✗		✓	

✓attended
✗apologies
** attended part of the meeting only*
^ leave of absence
 # absent on Board business

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Kylie Clegg (Committee Chair)	Trustee - Well Foundation Director - Auckland Transport Director - Sport New Zealand Director - High Performance Sport New Zealand Limited Trustee and Beneficiary - Mickyla Trust Trustee and Beneficiary, M&K Investments Trust (includes shareholdings in a number of listed companies, but less than 1% of shares of these companies, includes shareholdings in MC Capital Limited, HSCP1 Limited, MC Securities Limited, HSCP2 Limited, Next Minute Holdings Limited). Orion Health has commercial contracts with Waitematā District Health Board and healthAlliance	05/02/20
Warren Flaunty (Committee Deputy Chair)	Chair – Trust Community Foundation Trustee (Vice President) – Waitakere Licensing Trust Shareholder – EBOS Group Shareholder – Green Cross Health Director – Life Pharmacy Northwest Chair – Three Harbours Health Foundation Director – Trusts Community Foundation Ltd Trustee – Hospice West Auckland (past role)	05/02/20
Judy McGregor (Board Chair)	Chair – Health Workforce Advisory Board Associate Dean Post Graduate - Faculty of Culture and Society, AUT Member - AUT's Academic Board New Zealand Law Foundation Fund Recipient Consultant - Asia Pacific Forum of National Human Rights Institutions Media Commentator - NZ Herald Patron - Auckland Women's Centre Life Member - Hauturu Little Barrier Island Supporters' Trust	11/09/19
John Bottomley	Consultant Interventional Radiologist – Waitematā District Health Board	17/12/19
Chris Carter	Chairperson – Henderson-Massey Local Board, Auckland Council Trustee – Lazarus Trust	18/12/19
Sandra Coney	Member – Waitakere Ranges Local Board, Auckland Council Patron – Women's Health Action Trust	18/12/19
Allison Roe	Chairperson – Matakana Coast Trail Trust Member – Rodney Local Board, Auckland Council Member – Wilson Home Committee of Management (past role)	22/08/18

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act 2000, a member of a DHB Board who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the Board.

A Board member is interested in a transaction of a DHB if the member is:

- a party to, or will derive a financial benefit from, the transaction; or
- has a financial interest in another party to the transaction; or
- is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is (i) the Crown; or (ii) a publicly-owned health and disability organisation; or (iii) a body that is wholly owned by 1 or more publicly-owned health and disability organisations; or
- is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or
- is otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out responsibilities, then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

A board member who makes a disclosure as outlined above must not:

- take part in any deliberation or decision of the Board relating to the transaction; or
- be included in the quorum required for any such deliberation or decision; or
- sign any document relating to the entry into a transaction or the initiation of the transaction.

The disclosure must be recorded in the minutes of the next meeting and entered into the interest register.

The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if a majority of other members of the Board permit the member to do so. If this occurs, the minutes of the meeting must record the permission given and the majority's reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

Board members are expected to avoid using their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducement and which could compromise the Board's integrity.

IMPORTANT

Note that the best course, when there is any doubt, is to raise such matters of interest in the first instance with the Chair who will determine an appropriate course of action.

Ensure the nature of the interest is disclosed, not just the existence of the interest.

Note: This sheet provides summary information only.

2.1 Minutes of the Community and Public Health Advisory Committee meeting held on 5 August 2020

Recommendation:

That the draft Minutes of the Community and Public Health Advisory Committee held on 5 August 2020 (including the public excluded minutes) be approved.

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

DRAFT Minutes of the meeting of the Waitematā District Health Board

Community and Public Health Advisory Committee

Wednesday, 5 August 2020

held at Waitematā DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna
commencing at 10.00am

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT:

Kylie Clegg (Committee Chair)
Warren Flaunty (Committee Deputy Chair)- *present until 11.20am*
Judy McGregor (Ex-officio as Board Chair)
John Bottomley
Allison Roe – *present by video conference*

ALSO PRESENT:

Peta Molloy (Board Secretary)
Debbie Holdsworth (Director Funding)
Karen Bartholomew (Director Health Outcomes)
Tim Wood (Deputy Director Funding)
Deanne Manuel (Committee Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Kate Moodabe (Total Healthcare PHO)
Kirsty Gover (Comprehensive Care PHO)
Cheryl Hamilton (Auckland Women's Health Council)
David Codyre (Auckland Wellbeing Collaborative)
Daryl Bishop (Ember Korowai Takitini)
Elaine Wogan (Pathways)

WELCOME:

The Board Chair welcomed everyone present.

APOLOGIES:

Apologies were received and accepted from Sandra Coney, Chris Carter, Dr Dale Bramley and early departure from Warren Flaunty.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no interests declared that might give conflict with a matter on the agenda.

1 AGENDA ORDER AND TIMING

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

2 BOARD AND COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Board Meeting held on 19 February 2020 (Agenda pages 7-14)

Resolution (Moved Warren Flaunty/Seconded John Bottomley)

That the draft Minutes of the Community and Public Health Advisory Committee held on 19 February 2020 be approved.

Carried

Actions arising from previous meetings (Agenda page 15)

The updates were noted.

Additional information on Healthy Auckland Together programme will be included on the next Committee agenda.

3 DECISION PAPER

There was no decision item in the agenda.

4 INFORMATION PAPERS

4.1 Integrated Primary Mental Health and Addictions Services (agenda pages 16-20)

David Codyre (Clinical Director, Auckland Wellness Collaborative), Daryl Bishop (CEO, Ember Korowai Takitini), Elaine Wogan (General Manager, Pathways) and Tim Wood (Deputy Director Funding) were present for this item. They provided a summary of the report noting the following:

- The establishment of Auckland Wellbeing Collaborative allowed for development of the Integrated Primary Mental Health and Addictions Services programmes in a collaborative environment involving the metro Auckland DHBs, Treaty partners, Māori and Pacific health organisations, people with lived experience, Primary Health Organisations (PHOs) and Non-government organisations (NGOs).
- The co-designed process of Awhi Ora and Te Tumu Waiora allowed a model that is fit, effective and acceptable to the community. The programmes also allowed access to a range of support services to improve outcomes.
- NGOs have shown their support and commitment to Awhi Ora.
- The Te Tumu Waiora pilot demonstrated that it contributed to improved outcomes and the 'wrap around' service provided a pathway for equity of access.
- The impact as a result of increased number of people who are able to access this service was also highlighted.

- There will be gains in continuing the collaboration. It allows building and strengthening of relationships between health practitioners as well as access to community knowledge and skills.
- 10% of funding is set-aside for kaupapa Māori services.

Matters raised and response to questions included:

- A risk identified in the implementation included workforce training, which was further hindered by COVID-19. Work is on-going to attract workforce within the community.
- Work is also on-going to ensure the mental health component of the service is not 'diluted' as part of provision of general health services.
- The Awhi Ora programme allowed access in the community and could also support enrolment to a general practice.
- Roll-out of the programme is prioritised to communities with highest needs. The impact of COVID-19 will also be considered.
- Some of the current workforce commenced as volunteers, allowing training to be provided. There are some challenges on recruiting Clinicians.
- Funding is until June 2021, but it is anticipated that this will be continued. Evaluation of the programme will include Māori and Pacific outcome data.

The committee thanked the team for the updates received the report.

4.2 HPV Self-Testing for Cervical Screening Update (agenda pages 21- 33)

Karen Bartholomew (Director Health Outcomes), Jane Grant (Nurse Specialist), Georgina McPherson (Lead Colposcopist), Jesse Solomon (Portfolio Manager), Kate Moodabe (GM, Total Healthcare PHO) and Ruth Bijl (Funding and Development Manager) were present for this item. A summary was provided noting the following:

- Work for the project started five years ago with the aim to influence national policy.
- An update to the Committee noted there is intention for self-testing to be part of the national programme in 2021.
- However, implementation is unlikely next year due to the unavailability of supportive infrastructure.
- Positive experiences of women were also highlighted.

A video was presented to the Committee noting the experience of clinicians at Surrey Medical Centre with HPV self-testing.

Matters raised and response to questions included:

- Drop of screening coverage could not be attributed to availability of the HPV vaccine. Issues with coverage are multi-factorial issue. Access has been impacted by the recent measles outbreak and COVID-19. Prior to this coverage has dropped since the change in the primary care performance programme (IPIF) to the System Level Measures (SLM) approach which does not have a cervical screening target. There is also reported contribution of confusion about the initiation of primary HPV testing, where women will only have to screen every 5 years (rather than 3 years).

- The HPV self-testing programme provides a choice for women and will support improved access, equity and coverage.
- The new national screening register is not currently in place. A PHO recommendation includes using an interim database as there is strong sector support.

The Committee agreed to recommend the Board write to the Ministry of Health seeking clarification on the implementation timeline of the programme noting: the urgency of implementing self-testing based on World Health Organisation's global call for action, recommendations from the Parliamentary Review Committee and the results of the local self-testing programme to address the equity issues of the current National Cervical Screening Programme.

Resolution (Moved John Bottomley / Seconded Allison Roe)

That the Community and Public Health Advisory Committee

a) Note:

i) That the equity focused Research Programme on human papilloma virus (HPV) Self-Testing is now complete with results awaiting publication.

ii) The HPV Self-Testing research programme has demonstrated that the approach is acceptable and will improve equity of access, including for those women who are most underserved in the current screening programme. This research aligns well with similar work undertaken by research colleagues in Northland District Health Board.

iii) The Parliamentary Review Committee, in 2018, strongly recommended that HPV Self-Testing alongside primary HPV screening is implemented with urgency in the New Zealand national cervical screening programme.

iv) On the basis of the successful local research and the clear international evidence, there is increasing support in metro -Auckland for local implementation of HPV self-testing, ahead of national programme implementation, to address low coverage and worsening inequities. The volume of deferred screens related to COVID-19 has provided further urgency. It is likely that the national implementation of a primary HPV programme will be further delayed; noting that supportive infrastructure such a new national cervical screening register is not yet in place.

b) Recommends to the Board:

That the Board write to the Ministry of Health seeking clarification on the implementation timeline for HPV primary screening, noting the urgency for implementation due to:

- **The current low programme coverage and longstanding inequities**
- **The further impact of COVID-19 on screening coverage**
- **Local DHB research on self-testing**
- **The urgency expressed in the Parliamentary review**
- **The WHO Call to Action on cervical cancer**

Carried

The committee thanked the team for the update.

5 STANDARD REPORT

5.1 Planning Funding and Outcomes Update (agenda pages 34-51)

Kate Sladden (Funding and Development Manager Health of Older People), Ruth Bijl (Funding & Development Manager Women, Children & Youth), Meenal Duggal (Funding & Development Manager, Mental Health and Addiction Services), Leani Sandford (Portfolio Manager, Pacific Health Gain), Raj Singh(Programme Manager Asian, Migrant and Former Refugee Health Gain), Tim Wood (Deputy Director Funding, Funding and Development Manager) and Shayne Wijohn (Māori Health Gain Manager) were present for this item of the agenda.

The Chair noted that the report will be taken as read and opened the discussion for questions or clarifications.

Matters raised and response to questions included:

- Impact of Data-Sharing Framework and HealthSafe on health outcomes have been demonstrated in the diabetes retinal screening, diabetes and cardiovascular disease (CVD) programmes. Data sharing for retinal screening in particular supported a review of the model of care to identify strengths and improve service delivery.
- The Board will be updated in relation to the planning around COVID-19 which will include a synthesis of the audit conducted for the aged residential care facilities on its response to the pandemic.
- Success of the Pae Ora public health approach during the COVID-19 response and the need for workforce training for future preparedness were highlighted.
- Other learning during the COVID-19 response includes the success of the Kaimanaaki programme. Initial evaluation noted that the non-clinical roles were able to engage with 4,811 households and provided needed support for families. Referrals to primary health care and quit smoking programmes were also provided.
- Community providers have similar roles but there is potential to develop the work of the Kaimanaaki with training.
- Inpatient capacity of the Auckland City Mission is similar to Pitman House. There is an increase in social detoxification capacity.
- Work is continuing on the catch up of immunisation coverage, noting the work with Māori providers, follow-up by the National Immunisation Register and outreach immunisation. Immunisation continues to be encouraged.
- Allison Roe requested additional information related to the use of vaccines for expectant mothers.

The Committee noted the update.

6 GENERAL BUSINESS

No items of general business were raised.

7 RESOLUTION TO EXCLUDE THE PUBLIC (agenda page 52)

Resolution (Moved John Bottomley / Seconded Warren Flaunty)

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 items, for the reasons and grounds set out below:

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Termination Services	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**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)] **Conduct of Public Affairs** The disclosure of information would not be in the public interest because of the greater need to maintain the effective conduct of public affairs through the protection of members, officers and employees from improper pressure or harassment. [Official Information Act 1982 S.9 (2) (g)(ii)]

Carried

The open meeting concluded at 11.23am.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATĀ DISTRICT HEALTH BOARD – COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE HELD ON 05 AUGUST 2020.

_____COMMITTEE CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committee as at 22 October 2020

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back/ Update
19/02/20	4.2	Metro-Auckland Healthy Weight Action Plan for Children Committee to be provided with more information on the 'Healthy Auckland Together' (HAT) programme on succeeding report.	Karen Bartholomew	Information included in this agenda (Agenda Item 5.3)

3.1 Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023, Auckland and Waitematā District Health Boards

Recommendation:

That the Community and Public Health Advisory Committee recommends to the Board:

That the Board endorses the Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023.

Prepared by: Samantha Bennett (Asian, New Migrant and Former Refugee Health Gain Manager)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

AHS	Asian Health Services
CALD	Culturally and Linguistically Diverse
DHB	District Health Board
MELAA	Middle Eastern, Latin American and African

1. Executive Summary

Although some Asian groups experience high life expectancy and overall good health status, there are health disparities experienced for priority Asian and Middle Eastern, Latin American and African (MELAA) groups that require targeted effort. The focus of the strategic Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan aims to prioritise effort to:

- Improve health outcomes where there are health inequalities
- Increase equity of access to and utilisation of health services for targeted groups
- Continue to fund equity of access to primary healthcare services for former refugee and current asylum seeker background populations.

The three-year Plan summarises collective business as usual initiatives across Planning, Funding and Outcomes (Waitematā DHB and Auckland DHB) and Waitematā DHB's Asian Health Services (AHS) provider arm that represents existing work specific to Asian, new migrant, former refugee, and current asylum seekers.

This Plan will be managed by the Asian, Migrant and Former Refugee Health Gain Manager, and overseen by the Asian and MELAA Health Governance Group (Waitematā DHB and Auckland DHB). A quarterly Asian scorecard will guide monitoring on progress of the key areas of focus where data is available. Successful implementation of the Plan will require collaboration across the three metropolitan DHBs (where appropriate), and the health and community sectors.

2. Strategic Alignment

The Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023 aligns with the following strategic themes:

	**Community, whanau and patient centred model of care**	The Plan will support inclusion of culturally appropriate responses to service access and utilisation for priority ethnic groups where access is lower or groups who are underserved
	**Emphasis and investment on both treatment and keeping people healthy**	The plan focuses on culturally appropriate planning of health initiatives (and information) that enable targeted groups to make informed decisions about their (and their loved ones) health and access behaviours.
	**Intelligence and insight**	Monitoring of disaggregated ethnicity data will enable planners and service managers to better understand the cultural nuances that impact on access, utilisation and health outcomes for targeted groups

3. Introduction/Background

The Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan focuses on key health areas identified from:

- 2019 Health Needs Assessments (Waitematā DHB and Auckland DHB)
- 2017 International Benchmarking of Asian Health Outcomes for Waitematā and Auckland DHBs
- Asian, Migrant & Refugee Health Plan 2017-2019(Waitematā DHB and Auckland DHB)
- Consultation with the Metro Auckland Asian and MELAA Primary Care Service Improvement Group
- Health service utilisation data
- Feedback from engagement with partners and stakeholders
- Aligning to common Counties Manukau Health's population priorities for health equity.

The following top four higher level areas for action in this Plan are:

1. **Capability and capacity building: Granular data monitoring to level 4.**
   - Making sure our data tells us about the subgroups we are interested in.

2. **Access: Equity of access and utilisation of healthcare services:**
   - Awareness of the New Zealand Health and Disability System
   - PHO enrolment (eligible new migrants, (equity of access) to former refugees, and babies at 3 months) and access to primary health services
   - Better management of long term conditions (equity of access) to cardiovascular disease – Indian and South Asian; diabetes – Chinese and South East Asian (Filipino)
   - Mental health and addictions (youth, and perinatal maternal mental health)
   - Immunisations (HPV, 5 year event, Influenza over 65 years)
   - Pre-school oral health (Chinese, Filipino and Middle Eastern).

3. **Health promotion/prevention** including culturally tailored and/or targeted preventive healthy lifestyle activities.

4. **Adopting a partnerships approach** to engage segments of the population i.e. students, former refugees and current asylum seekers in awareness raising of health services and health education; and collaborative work with Asian and MELAA ethnic consumers.

4. Risks/Issues

There are limitations to this Plan largely due to the challenges when needing to plan in a fiscally constrained environment where resource must be applied to those populations with the greatest inequities – ie. Māori and Pacific in the first instance. This necessarily impacts on the activities chosen and the need to work innovatively and collaboratively to improve the health outcomes for 'targeted' Asian and MELAA groups and foreseeable risk factors such as a rapidly growing diverse population, ageing population, and waning 'healthy migrant effect'.

This Plan will be managed by the Asian, Migrant and Former Refugee Health Gain Manager, and overseen by the Asian & MELAA Health Governance Group (Waitematā DHB and Auckland DHB). A quarterly Asian scorecard will guide monitoring on progress of the key areas of focus where data is available.

5. Conclusion

Targeted Asian and MELAA groups from new migrant, former refugee or current asylum seeker backgrounds should be included in the foreground of strategic planning for the Waitematā District Health Board with the aim to improve health outcomes for priority ethnic groups where there are health disparities.

Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023

Waitematā and Auckland District Health Boards

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Waitematā District Health Board
Best Care for Everyone

Contents

Foreword

Auckland's population is growing and changing rapidly. More than 180 different ethnicities call this city their home with almost 40 per cent of Aucklanders born outside New Zealand.

The Asian population in particular has experienced rapid growth over the last two decades. Census 2018 data tells us that while there was an increase in the proportion of Asians living in every region in New Zealand, the biggest growth occurred in the metropolitan Auckland region. Over a quarter (28 per cent) of Auckland residents identified with an Asian ethnicity, and Auckland was home to almost two thirds (63 per cent) of all Asian peoples in New Zealand. Closer to home, Asian constitutes 23 per cent in Waitematā DHB and 35 per cent in Auckland DHB, with the greatest population increase principally first from China, India, and more recently the Philippines. Filipinos are now the third largest ethnic group in Auckland DHB and is projected to surpass the total Korean population in Waitematā DHB by the next Census.

Whilst the Asian population contributes a significant share to our districts' diversity, so to do other culturally and linguistically diverse communities such as those from Middle Eastern, Latin American, and African (MELAA) backgrounds. At the 2018 Census, there were 35,838 usual residents living in the metropolitan Auckland region, who identify within the broader MELAA category (2.3% of Auckland's population) – an increase of 10,893 people, or 43.7%, since the 2013 Census. The fastest population growth in the region was from the Latin American communities doubling in population size between 2013 and 2018 and most significantly in the Auckland DHB catchment.

As part of the many new migrants that have arrived in recent years, former refugees and current asylum seekers (and their families) have also made a significant contribution to our diversity. The New Zealand annual refugee quota programme will increase from 1,000 to 1,500 from July 2020 – we will continue to welcome and support those families who engage with our health services in both Waitematā and Auckland DHBs.

As this rapid growth of cultural and ethnic diversity has enriched our districts in a myriad of ways, it also highlights the unique health and wellbeing challenges some of our communities face. Overall the health outcomes of the Waitematā and Auckland DHBs' Asian population - when compared to New Zealand and overseas - are very good and in many areas Asian health status within the two DHBs would make us an international leader in achieving excellent health outcomes.

However, there are some ethnic groups who experience particularly specific health inequities and/or disparities that impact on their health outcomes. Such risk factors include settlement and/or resettlement determinants, equity of access to health services, early and timely access to and utilisation of culturally appropriate health services, burden of lifestyle-associated risk factors, language, and awareness of the health & disability system.

We are highly committed to achieving and maintaining equitable health outcomes for the multiple, varied population groups in Auckland as part of this three-year Health Plan, and look forward to working with our many partners who are passionate about ethnic health and wellbeing in this city.

Dr Dale Bramley,

Chief Executive Officer

Waitematā District Health Board

Introduction

New Zealand and specifically Auckland are experiencing a changing and increasing demography of our culturally and linguistically diverse (CALD) ethnic communities from Asian and Middle Eastern, Latin American and African (MELAA) backgrounds who are very diverse in language, culture, traditions and health needs. This Asian, New Migrant, Former Refugee and Current Asylum Seeker Health Plan 2020-2023 reflects the overarching Government theme 'Improving the well-being of New Zealanders and their families' and summarises collective business as usual initiatives across the "Funder" (Waitematā and Auckland District Health Boards (DHB)) and Waitematā DHB's Asian Health Services (AHS) provider arm that represents existing work specific to Asian, new migrant[1], former refugee[2], and current asylum seekers.

Although some Asian groups experience high life expectancy and overall good health status, there are health disparities experienced for priority Asian & MELAA groups that require targeted effort. The focus of the Plan aims to prioritise effort to:

- Improve health outcomes where there are health inequalities
- Increase equity of access to and utilisation of health services, and
- Continue to fund equity of access to primary healthcare services for former refugee and current asylum seeker background populations.

Our Focus

The Plan focuses on key health areas identified from: i) 2019 Health Needs Assessments (Waitematā[3] and Auckland[4] DHBs), ii) 2017 International Benchmarking of Asian Health Outcomes for Waitematā and Auckland DHBs report[5] (Appendices 1&2), iii) Asian, Migrant & Refugee Health Plan 2017-2019[6] (Waitematā and Auckland DHBs), iv) Consultation with the Metro Auckland Asian & MELAA Primary Care Service Improvement Group, v) Health service utilisation data, vi) Feedback from engagement with partners and stakeholders, and vi) Aligning to common Counties Manukau Health's population priorities for health equity. The following top four higher level areas for action in this Plan are:

i. **Capability and capacity building:** Granular data monitoring to level 4.
   - Making sure our data tells us about the subgroups we're interested in.

ii. **Access:** Equity of access and utilisation of healthcare services:
   - Awareness of the New Zealand Health & Disability System

[1] A new migrant for the purpose of this Plan is considered living in New Zealand less than 2 years.
[2] Information about refugee and protection. Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/supporting-refugees-and-asylum-seekers/refugee-and-protection-unit
[3] Accessible online from http://www.waitematadhb.govt.nz/assets/Documents/health-needs-assessments/Health-Needs-Assessment-Waitemata-DHB-2019.pdf
[4] Accessible online from https://adhb.health.nz/assets/Documents/About-Us/Planning-documents/ADHB-Health-Needs-Assessment-2017.pdf
[5] Accessible online from http://www.waitematadhb.govt.nz/dhb-planning/health-needs-assessments/international-benchmarking-of-asian-health-outcomes-for-waitemata-and-auckland-dhbs/
[6] Accessible online from www.waitematadhb.govt.nz/dhb-planning/health-plans/

- PHO enrolment (eligible new migrants, (**equity of access)** to former refugees, and babies at 3 months) and lower access to primary health services
- Better management of long term conditions (**equity of access**) to cardiovascular disease – Indian and South Asian; diabetes – Chinese and South East Asian (Filipino)
- Mental health and addictions (youth, (**equity of access)** to perinatal maternal mental health)
- Immunisations (HPV, 5 year event, Influenza over 65 years), and
- Preschool oral health (Chinese, Filipino and Middle Eastern).

iii. Health promotion/prevention including culturally tailored and/or targeted preventive healthy lifestyle activities.

iv. Adopting a partnerships approach to engage segments of the population i.e. students, former refugees and current asylum seekers in awareness raising of health services and health education; and collaborative work with Asian & MELAA ethnic consumers.

Strategic Approach

We will align our efforts in this Plan to national, regional and local directions (Appendix 3).

Governance

This Plan will be managed by the Asian, Migrant and Former Refugee Health Gain Manager, and overseen by the Asian & MELAA Health Governance Group (Waitematā and Auckland DHBs). Progress updates will be shared with the Community & Public Health Advisory Committee (CPHAC) and Auckland DHB Funder. A quarterly Asian scorecard (Appendix 4) will guide monitoring on progress of the key areas of focus where data is available. Successful implementation of the Plan will require collaboration across the three metropolitan DHBs (where appropriate), and the health and community sectors.

Limitations and risks

There are limitations to this Plan largely due to the challenges when needing to plan in a fiscally constrained environment where funding must be applied to those populations with the greatest need – ie. Maori and Pacific in the first instance. This necessarily impacts on the activities chosen and the need to work innovatively and collaboratively to improve the health outcomes for 'targeted' Asian and MELAA groups and foreseeable risk factors such as a rapidly growing diverse population, ageing population, and waning 'healthy migrant effect'.

Te Tiriti o Waitangi

Waitematā and Auckland DHBs recognise and respect Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. The four Articles of Te Tiriti o Waitangi provide a framework for Māori development, health and wellbeing by guaranteeing Māori a leading role in health sector decision making in a national, regional, and whānau/individual context. The New Zealand Public Health and Disability Act 2000 furthers this commitment to Māori health advancement by requiring DHBs to establish and maintain a responsiveness to Māori while developing, planning, managing and investing in services that do and could have a beneficial impact on Māori communicates.

Te Tiriti o Waitangi provides four domains under which Māori health priorities for Waitematā and Auckland DHBs can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the DHBs' provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with mana whenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHBs' activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHBs have a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

These guiding principles are applicable to our diverse Asian, new migrant, former refugee, current asylum seeker and international student communities as they contribute to cultural safety and in particular, their contribution to positive health outcomes and experience of care.

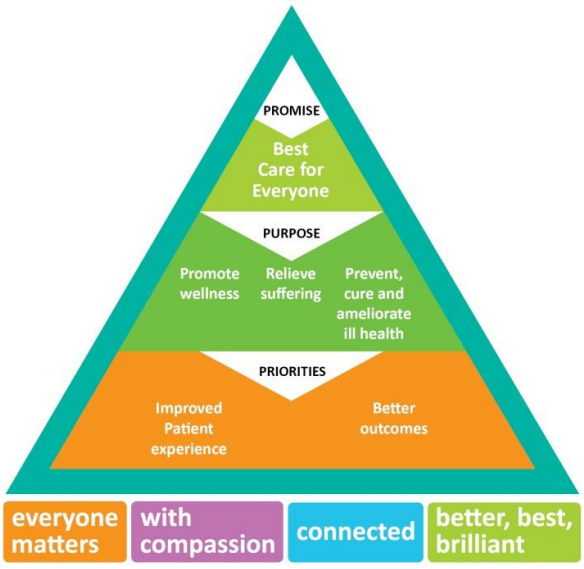
Our Decision Making Kaupapa

Waitemata DHB strategic direction

Best care for everyone

Our promise, purpose, priorities and values are the foundation for all we do as an organisation.

- Our **promise** is that we will deliver the **'best care for everyone'**. This means we strive to provide the best care possible to every single person and their family engaged with our services. We put patients first and are relentless in the pursuit of fundamental standards of care and ongoing improvements enhanced by clinical leadership.
- Our **purpose** defines what we strive to achieve, which is to:
  - Promote wellness
  - Prevent, cure and ameliorate ill health
  - Relieve suffering of those entrusted to our care.



- We have two **priorities**:
  - Better outcomes
  - Patient experience.

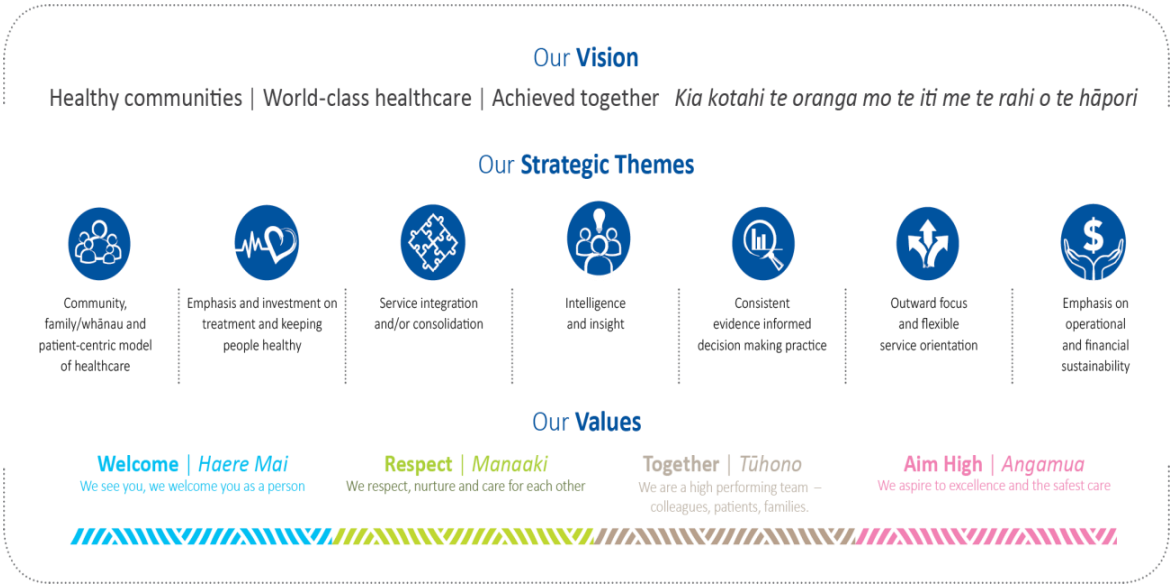
The way we plan and make decisions and deliver services on a daily basis is based on our **values** – **everyone matters; with compassion; better, best, brilliant** and **connected**. Our values shape our behaviour, how we measure and continue to improve.

To realise our promise of providing 'best care for everyone' we have identified seven **strategic themes** outlined below. These provide an overarching framework for the way our services will be planned, developed and delivered.

Auckland DHB strategic direction

Our **vision** is *Healthy Communities, World-class Healthcare, Achieved Together*. This means we are working to achieve the best outcomes for the populations we serve, people have rapid access to healthcare that is high quality and safe, and that we work as active partners across the whole system with staff, patients, whānau, iwi, communities, and other providers and agencies.

Our **strategic themes** outlined below provide an overarching framework for the way our services will be planned, delivered, and developed to deliver our vision. Our **values** shape our behaviour and describe the internal culture that we strive for.



Our Partners

Waitematā and Auckland DHBs acknowledge that maintaining national and international leadership in Asian health requires strong collaborative partnerships. This means a committment to working with with and alongside communities, government agencies, Primary Health Organisations (PHO), Non-Governmental Organisations (NGO), health and social service providers, academia, institutes, associations, and settlement/resettlement agencies; and learning from our regional health colleagues across the Auckland region and nationally.

The Asian, migrant and former refugee health gain team are actively working with Counties Manukau Health and other regional Asian, migrant and former refugee health leaders to learn and share best practice and collaborate where we can to improve targeted disparities collectively. This includes coordinating and leading governance platforms such as the Asian & MELAA Health Governance Group (Waitematā and Auckland DHBs); Metro Auckland Asian & MELAA Primary Care Service Improvement Group; and contributions to other mainstream groups (where appropriate). We also lead and coordinate other key professional groups such as the Metro Auckland Regional Former Refugee Health Network Executive Group; and Metro Auckland PHO Former Refugee Services Operatonal Group.

The Asian Health Services (Waitematā DHB) continues to be an important local partner to support the health of Asian patients and their families within the Waitematā district provider arm services. We will work in partnership with the Asian Health Services.

A significant national service is the eCALD[7](Culturally and Linguistically Diverse) programme of courses and resources to support the health workforce to develop their cultural competence for working with CALD patients, clients, families and colleagues. We will cross-promote cultural competency courses to our health partners.

Engagement with interpreters services is key to enable access to essential language support to CALD patients who use DHB funded health services and primary health services. We will promote access to our in-house interpreter services.

Community engagement with Asian, migrant, former refugee, current asylum seeker and international student partners and communities is essential to enable them to participate in, or provide feedback on planning, policies and services is so that DHB activities are reflective of the community's ethnically and culturally diverse population. We will work with Waitematā DHB's Community Engagement Manager, and other DHB colleagues.

An overarching enabler is patient experience which aims to improve the care our population receives, engage people as partners in their care and provide services that are responsive to the individual and cultural needs of patients and their whānau. We will work with Waitematā DHB's Patient Experience Team, and support Auckland DHB's efforts for Asian and MELAA patients.

[7] Accessible online from http://www.ecald.com/

The People We Serve

‘Asian’ as defined in New Zealand

The New Zealand health and disability sector classifies ethnicity data according to the Ministry of Health protocols. The term ‘Asian’ used in the New Zealand Census and related data sets, refers to people with origins in the Asian continent, from China in the north to Indonesia in the south and from Afghanistan in the West to Japan in the East. This differs from the definition used in other countries such as the United Kingdom or the United States of America.

This definition includes over 40 sub-ethnicities and these communities have very different cultures and health needs. Reviewing health data using this broad ‘Asian’ classification is problematic if the health status of Chinese, Indian and Other Asian communities is averaged. The risk is that averaged results can appear ‘healthy’, but potentially masks true health disparities such as cardiovascular disease and diabetes in sub-ethnicity groups. Furthermore, many people classified as being ‘Asian’ do not identify with the term which may lead to under-utilisation of ‘Asian’ targeted services.

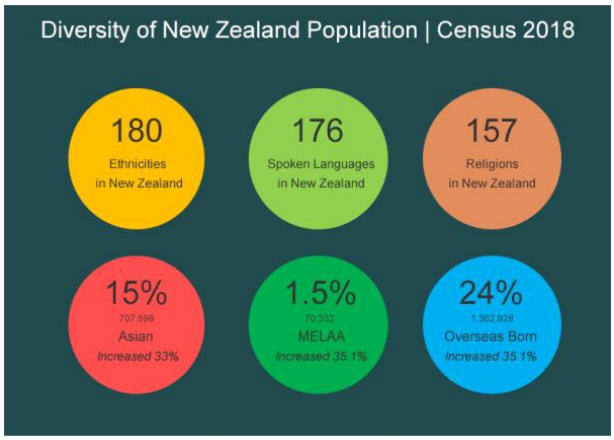
‘MELAA’ as defined in New Zealand

The Middle Eastern, Latin American and African (MELAA) populations ethnicity grouping consists of extremely diverse cultural, linguistic and religious groups. There are two key challenges for planners and funders of services to MELAA groups with respect to collecting and reporting ethnicity, 1. Reports only capture MELAA at level 1 ‘Other’ category, and 2. Reports capture MELAA as a single aggregated ethnic group output at level 2 category which is problematic to inform, plan, and monitor services that target the unique needs of the Middle Eastern, Latin American and African ethnic groups separately.

Changing Demography

Diversity of New Zealand population

Across New Zealand our diverse Asian and new migrant communities are growing faster than any other population group based on the Census 2018. The Asian population is the 3rd largest major ethnic group in New Zealand, making up 15% of the New Zealand population (707,598), which almost doubled in size since 2001.



Source: Ecald, Census 2018

9

Auckland and Waitematā

Asian

While there was an increase in the proportion of Asians living in every region in the Census 2018, the biggest growth occurred in the metro Auckland region. In 2018, the Asian population was made-up of 28% of the total population across the region and for Auckland and Waitematā Asian constitutes 35% (191,300) (Auckland DHB) and 23% (147,210) (Waitematā DHB)[8].

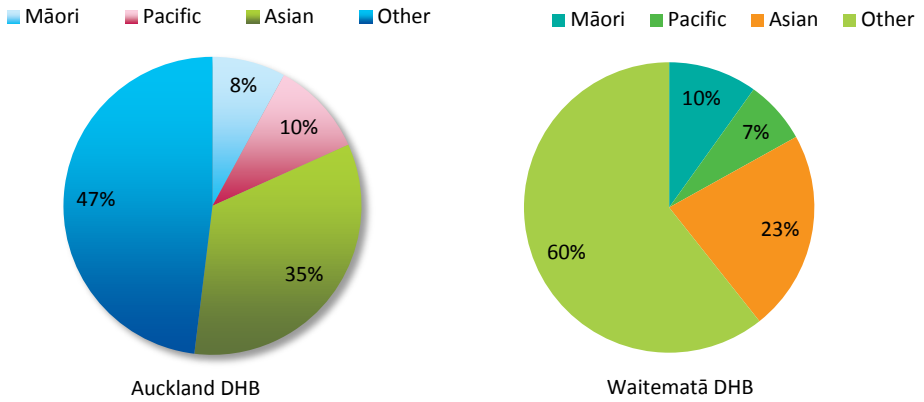


Figure 1: Ethnicity of Auckland DHB and Waitematā DHB populations, 2018/19
Source: Based on Census 2013, '2018 Update' by Stats NZ

Metro Auckland's population is growing and changing with more than 180 ethnicities living in the city, almost 40% of Aucklanders were not born in New Zealand. In the last 15 years the greatest increase of any ethnic group has been in those of Asian origin, principally first from China, India, then Korea, however more recently the Philippines with significant population growth in Waitematā DHB. Filipinos are the third largest ethnic group in Auckland DHB and will soon overtake Korean in Waitematā. The top five in-demand languages in both DHBs in 2018/19 are outlined in table 1. Access to language support and culturally appropriate information and services are key.

Table 1: Top five in-demand languages in Auckland DHB and Waitematā DHB, 2018/19

	Auckland DHB	%	Waitematā DHB	%
1	Mandarin	35	Mandarin	38
2	Cantonese	17	Korean	16
3	Tongan	8	Cantonese	10
4	Samoan	6	NZ Sign Language	5
5	Korean	5	Samoan	3

[8] Projected population by ethnicity (prioritised), 2019/20 financial year. Based on Census 2013, '2018 Update' by Stats NZ

By 2025, Asian is expected to grow to make-up 38% (Auckland DHB) and 26% (Waitematā DHB) of the total population across the metro DHBs. Socio-demographic and health status information tells us that life in New Zealand is changing for these communities.

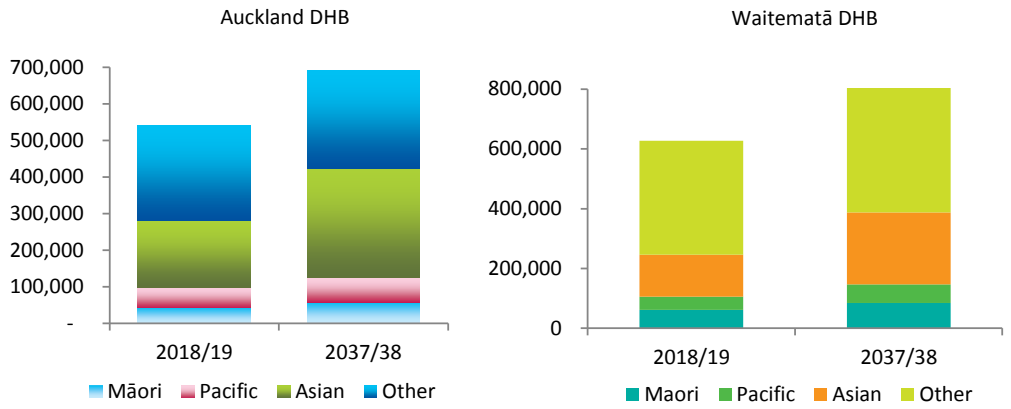
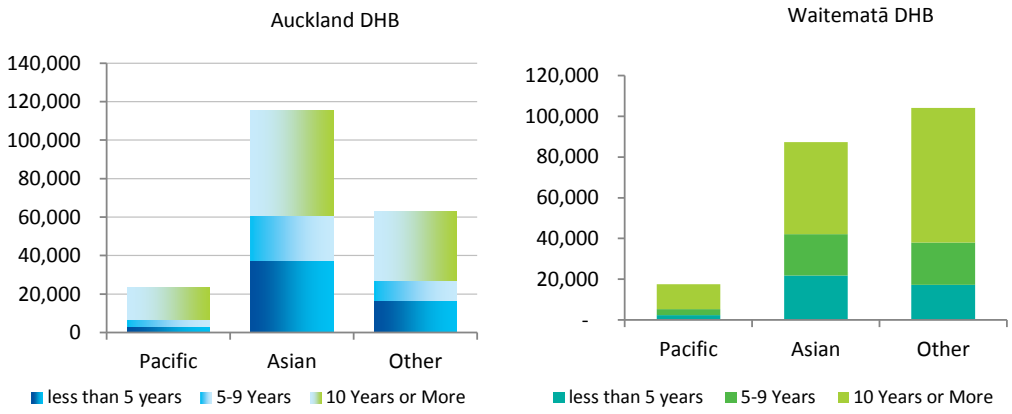


Figure 2: Projected change in Auckland DHB and Waitematā DHB populations by ethnicity, 2037/38
Source: Census 2013

Migrants

We know that New Zealand and Auckland are the destination of choice for many new migrants both permanent and temporary. Both Auckland and Waitematā DHBs have a large migrant population with Filipinos the fastest growing ethnic group. Two out of five (42%) Auckland and over a third (37%) Waitematā residents were born overseas (compared to 25% nationally). In Auckland, this includes 63,113 peoples of European/Other ethnicity, 23,486 Pacific peoples and 115,700 Asian peoples; as a percentage, 82% of Asian peoples, 45% of Pacific peoples and 27% of peoples of European/Other ethnicity. Of these migrants, 28% have lived in New Zealand less than 5 years. Census 2018 highlights that 70% of new migrants live in Auckland DHB.[9]

In Waitematā, this includes 104,077 peoples of European/Other ethnicity, 17,539 Pacific peoples and 87,356 Asian peoples; as a percentage, 81% of Asian peoples in Waitematā were born overseas, 43% of Pacific peoples and 29% of peoples of European/Other ethnicity. Of these migrants, 20% have lived in New Zealand less than 5 years.



[9] Census Usually Resident, CUR

Figure 3: Number of migrants living in Auckland DHB and Waitematā DHB by duration of residence 2013
Source: Census 2013 Usually Resident population

Other than ethnic origins, the people grouped under the generic label of 'Asian' are very diverse in health status, health beliefs and practices, housing, geographical distribution, migration history, English language proficiency and socioeconomic status.[10]

These factors alongside available services and community networks impact how we monitor population health, design and deliver supporting health services. While the three metropolitan Auckland DHBs are committed to collaboration, each will need to complement these activities with a focus on specific health improvement actions that are specific to local population needs.

Former refugees and current asylum seekers

Conversely, although some ethnic groups may have arrived on these shores as a new migrant by 'choice', refugees and current asylum seekers (and their families) have come to New Zealand asking for refuge and protection.[11] Auckland has been home to former refugees from Africa, the Middle East and Asia since the 1980s. Former refugees have come from countries including Cambodia, Vietnam, Laos, Iraq, Iran, Somalia, Ethiopia, Eritrea, Rwanda, Burundi, Sudan, Sri Lanka, Congo, Afghanistan and Burma. More recently, there have been an increasing number of Quota refugees[12] who are Myanmarese (Rakhine, Chin, Kachin, Burmese, Karen, Mon, Karenni, Shan), African (Somali, Eritrean, Ethiopian) and Middle Eastern (Afghani and Persian) who have/are resettling in the Auckland region.

In September 2018, the New Zealand government announced the annual refugee quota would increase to 1,500 from July 2020. The delivery of government funded health services for quota refugees will change from 2020 as a result of this quota increase[13]. A national Quota Refugee Health Services Model will roll out across the country. Auckland and Waitematā DHBs are working closely with Immigration New Zealand (INZ) and Ministry of Health (MoH) to support the implementation of the onshore health services with a key focus on primary care as an enabling setting.

In 2018/19, there were 510 claims for refugee and/or protected person status with INZ's Refugee Status Unit - of which 153 asylum seeker[14] claims were approved largely from Asian and Middle Eastern countries (MBIE, 2019).[15]

[10] Suneela Mehta, *Health Needs Assessment of Asian people living in the Auckland Region* (Auckland: Northern DHB Support Agency, 2012).
[11] Lifeng Zhou and Samantha Bennett, *International Benchmarking of Asian Health Outcomes for Waitemata DHB and Auckland DHB*. (Auckland: Waitemata District Health Board, 2017).
[12] A person who has entered New Zealand under the United Nations High Commissioner for Refugees mandated quota system.
[13] The Refugee Quota Increase Programme (RQIP). Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/refugee-resettlement-strategy/rqip
[14] A current asylum-seeker is someone whose request for sanctuary has yet to be processed.
[15] There are over 500 claims for refugee and protected person status per year (INZ, 2019)

Top five claims by nationality are:
1. China, 2. India, 3. Sri Lanka, 4. Iran, and 5. Saudi Arabia (Figure 4).[16]

Top five approvals by nationality were:
1. China, 2. Iran, 3. Saudi Arabia, 4. Egypt, and 5. Russia.

Top five in-demand languages are:
1. Mandarin, 2. Arabic, 3.Spanish, 4.Dari/Farsi, and 5.Turkish.

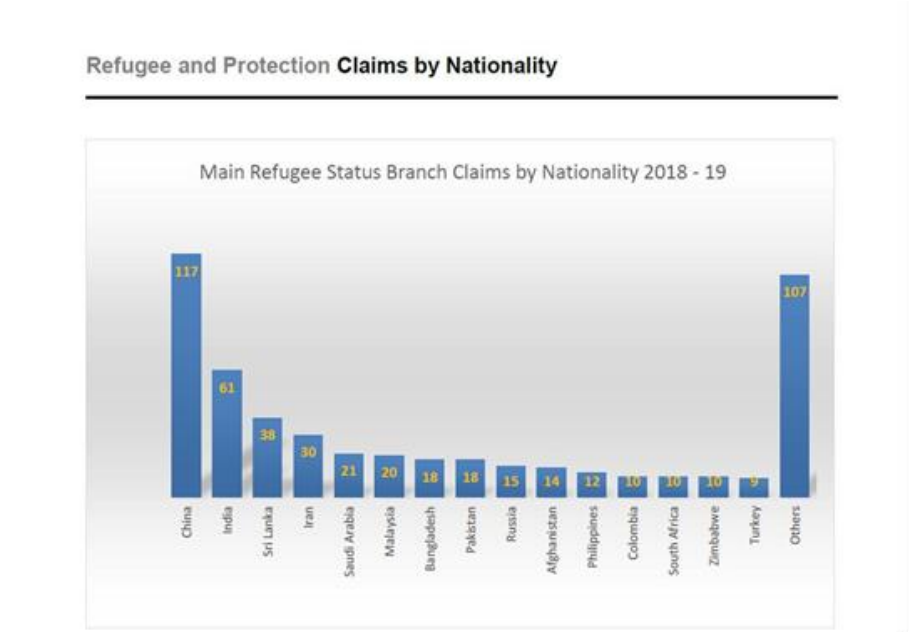


Figure 4: Main Refugee Status Branch Claims by Nationality, 2018/19
Source: Immigration New Zealand, 2019

From what is available, we know that former refugees and asylum seekers arrive with unique health care needs including: musculoskeletal and pain issues; poor oral health; longstanding undiagnosed chronic conditions; infectious diseases; neglected injuries; and mental health problems including Post-Traumatic Stress Disorder (PTSD); depression; and anxiety. Many conditions often require long term management and support at both a primary or secondary care level. Although, the health profile of an asylum seeker may vary from that of a former refugee individual, language support is a key enabler to positive health outcomes for these vulnerable groups.

Furthermore, individuals from transgender, non-binary and gender diverse backgrounds are among those who are seeking refugee and protection status, and require equitable access to primary care services in the first instance. The majority of claimants are living in the Auckland region and require early access to and utilisation of culturally appropriate health services in particular primary care, and language support.

[16] Accessible online from
https://www.immigration.govt.nz/documents/statistics/rsbrefugeeandprotectionstatpak.pdf

International students

In 2018, our International student numbers reached 68,004 in Auckland (INZ & MOE, 2018). The majority of students live in the Auckland CBD and inner fringe suburbs close to city based institutes. A key outcome indicator within the New Zealand International Student Wellbeing Strategy aims to ensure that International students are aware of and can access effective and culturally appropriate healthcare.[17] Areas of concern for students include timely access to health services; mental health and wellbeing; and sexual and reproductive health.[18]

Middle Eastern, Latin American and African populations

According to Census 2018 (Census Usually Residents population, CUR) the MELAA populations was made up of 1.5% of the total population (70,332) in New Zealand, and were the fastest growing ethnic groups increasing by 35.1%. In the metro Auckland region, MELAA constitutes 2.2% of the total population[19] (Tables 2-4) and has increased 0.3% (10,950) between 2013 to 2018. The Middle Eastern population made up close to half of the MELAA group in the metro Auckland region followed by Latin American at over 30% then African over 20%, however the fastest population growth in the region was in the Latin American communities doubling in population size between 2013 (5,835) and 2018 (11,205) and most significantly in the Auckland DHB catchment.

Similar to Asians, MELAA face significant barriers to accessing health care. In addition, areas of focus to improve health outcomes are long term conditions e.g. CVD/Diabetes; oral health, women's health screening, prevention, and management programmes.

Table 2: MELAA Population by Ethnic Group, Metro Auckland Region, Census 2018 (total response ethnicity, CUR)

MELAA Ethnic Group	Total	%
Middle Eastern	17,103	47.5
African	7,794	21.6
Latin American	11,205	31.1
Total L2 MELAA Responses	35,946	100

Table 3: MELAA Population by Ethnic Group, Waitematā DHB, Census 2018 (total response ethnicity, CUR)

MELAA Ethnic Group	Total	%
Middle Eastern	6,375	48.9
African	2,706	20.7
Latin American	3,999	30.7
Total L2 MELAA Responses	13,023	100

Table 4: MELAA Population by Ethnic Group, Auckland DHB, Census 2018 (total response ethnicity, CUR)

MELAA Ethnic Group	Total	%
Middle Eastern	5,511	38.1
African	3,255	22.5
Latin American	5,763	39.8
Total L2 MELAA Responses	14,454	100

[17] Accessible online from https://education.govt.nz/assets/Documents/Ministry/Strategies-and-policies/internationlStudentWellbeingStrategyJune2017.pdf
[18] Student consultations as part of Auckland Agency Group
[19] Accessible online from https://knowledgeauckland.org.nz/media/1446/melaa-2018-census-info-sheet.pdf

Performance Expectations for 2020-2023

To identify key health inequities as a focus for health planning, we require a comparator population group that shows the **true story of inequities and inequalities**, i.e. what is the gap in health outcomes and scale of health gain we plan for? Waitematā and Auckland DHBs along with Counties Manukau Health have chosen the New Zealand 'European/Other' population as our health equity comparator group. For this reason, our baseline measures and related trend graphs in this Plan reflects this as our "local health equity target" in addition to the national targets reflecting government performance expectations. See appendix 5 for definitions of indicators/measures.

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
Mātua, Pēpi me Tamariki								
Immunisation	Percentage of babies are fully or exclusively breastfed at 3 months[21]	59%	69% (European)	62%	59%	69% (European)	61%	70%
	Percentage of pregnant women receiving pertussis vaccination in pregnancy	58%	61%	68%	54%	53%	66%	50%
	Percentage of five year olds will have their primary course of immunisation on time	88%	88%	90%	86%	83%	91%	95%
	Percentage of two year olds will have their primary course of immunisation on time	93%	92%	97%	91%	89%	96%	95%
	Percentage of eight month olds will have their primary course of immunisation on time	95%	96%	97%	93%	90%	98%	95%
	Percentage of eligible girls fully immunised with HPV vaccine	75%	83%	63%	57%	54%	63%	75%
Oral Health	Percentage of children aged birth – 4 years enrolled in DHB-funded Community Oral Health Services[21]	91%	111%	82%	95%	106%	95%	95%

[20] Data is Q1 2019/20 unless otherwise stated.
[21] June 2019.

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
	Percentage of children aged 5 years who are caries free – Asian Ethnicity[22]	58%	81% (European) 45% (MELAA) 55% (African) 65% (Latin American) 44% (Mid-Eastern)	55% (Asian Overall) 52% (Chinese) 61% (Indian) 54% (SE Asian) 59% (Other Asian)	58%	77% (European) 63% (MELAA) 62% (African) 58% (Latin American) 29% (Mid-Eastern)	47% (Asian Overall) 44% (Chinese) 59% (Indian) 38% (SE Asian) 46% (Other Asian)	ADHB 61% WDHB 67%
	Average number of DMFT at year 8 – L1 and L2 Asian and MELAA Ethnicity	0.63	0.36 (European) 0.80 (MELAA Overall) 0.69 (African) 0.74 (Latin American) 0.93 (Mid-Eastern)	0.59 (Asian Overall) 0.58 (Chinese) 0.50 (Indian) 1.08 (Southeast Asian) 0.52 (Other Asian)	0.61	0.49 (European) 1.09 (MELAA Overall) 1.12 (African) 0.39 (Latin American) 1.33 (Mid-Eastern)	0.63 (Asian Overall) 0.67 (Chinese) 0.5 (Indian) 0.83 (Southeast Asian) 0.57 (Other Asian)	ADHB <0.65 WDHB <0.59 at year 8
Rangatahi								
Youth Health	Chlamydia test rate of the youth aged 15-24 years[23]	11.3%	27.4 (Females) 7.7 (Males)	8.1 (Females 1.6 (Males)%	12.4%	25.1% (Females) 5.8% (Males)	10.7% (Females) 1.7% (Males)	6%
	Baseline self-harm hospitalisations (10-24 years) (Rate per 100,000 population)	412	448	202	493	553	158	-
Mātua me Whānau								
Cardiovascular Disease[24][25]	Percentage of eligible population who have had their cardiovascular risk assessed in the last five years	93%	94%	92% (Asian) 92% (Indian)	84%	87%	64% (Asian) 90% (Indian)	90%

[22] Dec 2019. Results for this measure will likely continue to deteriorate as ARDS recently changed their recall timeframe for children with caries, who will be seen more often (6-monthly) than those who are caries free (18-monthly).
[23] Q2 2019.
[24] No data going forward.
[25] To align with 2018 Ministry of Health Cardiovascular Disease Risk Assessment and Management for Primary Care Guidelines, South-Asians include: Indian, including Fijian Indian, Sri Lankan, Afghani, Bangladeshi, Nepalese, Pakistani and Tibetan.

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
	CVD Secondary Prevention: Percentage of enrolled patients with known cardiovascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)[26]	62%	61%	62% (Asian NFD) 57% (Chinese) 70% (Indian) 62% (Other Asian) 56% (South East Asian)	61%	61%	59% (Asian NFD) 55% (Chinese) 65% (Indian) 57% (Other Asian) 64% (South East Asian)	70%
	CVD Primary Prevention: Percentage of enrolled patients with cardiovascular risk ever recorded >20%, (aged 35 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)[26]	48%	44%	39% (Asian NFD) 43% (Chinese) 54% (Indian) 50% (Other Asian) 68% (South East Asian)	46%	45%	44% (Asian NFD) 34% (Chinese) 48% (Indian) 33% (Other Asian) 55% (South East Asian)	70%
Diabetes	HbA1c Glycaemic control: Percentage of eligible population with HbA1c ≤ 64mmol/mol recorded in the last 15 months (based on PHO enrolled numerator and denominator)[26]	60%	65%	75% (Asian NFD) 75% (Chinese) 67% (Indian) 69% (Other Asian) 67% (South East Asian)	61%	64%	58% (Asian NFD) 73% (Chinese) 65% (Indian) 68% (Other Asian) 65% (South East Asian)	80%
	Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140mmHg[26]	65%	64%	73% (Asian NFD) 71% (Chinese) 68% (Indian) 68% (Other Asian) 72% (South	62%	62%	54% (Asian NFD) 65% (Chinese) 65% (Indian) 71% (Other Asian) 78% (South	80%

[26] July 2019 (Metro Auckland data).

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
				East Asian)			East Asian)	
	Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker [26]	72%	75%	74% (Asian NFD) 55% (Chinese) 71% (Indian) 71% (Other Asian) 77% (South East Asian)	76%	78%	85% (Asian NFD) 61% (Chinese) 77% (Indian) 71% (Other Asian) 78% (South East Asian)	90%
Cancer	Percentage of women aged 25–69 years who have had a cervical screening event in the past 36 months (Statistics NZ Census projection adjusted for prevalence of hysterectomies)[27]	62%	74%	50%	70%	72%	69%	80%
Immunisation	Percentage of people aged over 65 years receive free flu vaccinations	52%	51%	58%	51%	51%	53%	75%
	Respiratory infection hospitalisation rate, over 65 years (Rate per 100,000)[28]	1,897	1,665	1,364	12,072	1,994	942	-
Self harm and suicide	Decrease in Asian deaths coded as suicides (Ministry of Health) and provisional suicides (Ministry of Justice), by age[29]	40	23	7	51	36	6	-
	Self-harm hospitalisations 65 years and over by ethnicity (Rate per 100,000 population)	89	88	69	67	68	70	-

[27] Sep 2019.
[28] Respiratory infection hospitalisation rate (per 100,000) by prioritised ethnicity, 65+ yrs, combined females and males, Waitematā and Auckland DHBs, 2018/19.
[29] Annual data from the National Mortality Collection 2016. Numbers may differ from preliminary Coroner reports.

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
Rōhe o Waitematā me Auckland								
Access To Care	Percentage of the population enrolled in a PHO[30]	83%	90%	71%	92%	93%	94%	95%
	98% of newborns are enrolled with a PHO, general practice by 3 months of age	93%	100%	93%	92%	100%	94%	98%
Patient Experience	Percentage of Asians and MELAA[31] rating overall care as 'Very Good' or 'Excellent' in the ADHB Inpatient and Outpatient surveys	**Inpatient** 85%	**Inpatient** 86% (European /Other)	**Inpatient** 82% (Asian) 84% (Chinese) 78% (Indian)	-	-	-	90%
	Net promoter score on WDHB Friends and Family Test for Asians rating 'extremely likely' to 'recommend our ward to friends and family if they need similar care or treatment'[31]	-	-	-	77	79	85 (Asian) 83 (Chinese) 87 (Indian)	65

[30] Sep 2019.
[31] Annual data 2018/19.

Mātua, Pēpi me Tamariki - Parents, Infants and Children

Good child health is important not only for children and family now, but also for good health later in adulthood. A number of the risk factors for many adult diseases such as diabetes, heart disease and some mental health conditions such as depression arise in childhood. In addition, child health, development and wellbeing have broader effects on educational achievement, violence, crime and unemployment. In 2020-2023, our action focus for Asian & MELAA infants, children and family is on **breast feeding, immunisation (human papillomavirus), healthy weight and good oral health.**

Breastfeeding

Why is this a priority?

Research shows that children who are exclusively breastfed for the early months of life are less likely to suffer adverse effects from childhood illnesses such as respiratory tract infections, gastroenteritis, otitis media, etc. Breastfeeding benefits the health of mother and baby, as well as reducing the risk of Sudden Unexpected Death in Infancy (SUDI), asthma, diabetes and obesity.

Where do we want to get to?

- 70% of Asian babies are fully or exclusively breastfed at 3 months.

DHB	European/Other	Asian*	Target
ADHB	69%	62%	70%
WDHB	69%	61%	70%

**Q4 2018/19. Plunket data only.*

What are we trying to do?

Maintain the number of exclusively or fully breastfed Asian & MELAA babies at 3 months of age.

To achieve this we will focus on:

Continue to promote breastfeeding information and support for Asian & MELAA women.

Who will we work with?

Women, Child and Youth team, Well Child Tamariki Ora (WCTO) Providers, Health Babies Healthy Futures (Asian providers), Asian NGOs, midwives, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Continue to support the Healthy Babies Healthy Futures programme which targets Asian mothers to support them to exclusively breastfeed their babies for the first six months: - Promote the benefits of breastfeeding to 6 months and beyond.	70% of babies are fully or exclusively breastfed at 3 months. Coverage rates for Asian equal to European/Other. 95% of Asian and MELAA infants receive all core WCTO contacts in the first year of life.
	YR 1-YR 3 (Q1-Q4): Support the Metro-Auckland Healthy Weight Action Plan for Children 2017-2020.	
	YR 1-YR 3 (Q1-Q4): Support the development and promotion of breast feeding resources to Asian and MELAA communities.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

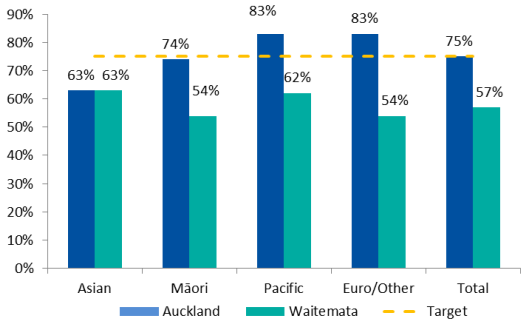
Immunisation - Children

What are we trying to do?

We want up-to-date immunisations for pregnant women and children up to five years. We want MELAA (and Asian) girls and women to be protected against cervical cancer. Screening and immunisation together will offer the most effective protection.

Where are we at and where do we want to get to?

75% of eligible Asian girls are fully immunised with HPV vaccine



** All coverage as at Sep 2019*

Source: MoH Quarterly NIR Report.

Why is this a priority?

Cervical cancer is caused by certain types of HPV.[32] There is no treatment for persistent HPV infections but immunisation is now available to help protect young women against the two common types of high-risk HPV that cause up to 70 percent of cervical cancer.

To achieve this we will focus on:

Ensure MELAA (and Asian) girls and boys (and their families) are aware of availability of the HPV vaccine to support improved uptake of the vaccine.

Who will we work with?

Women, Child and Youth teams, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, WCTO Providers, schools, Asian NGOs, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā/ Counties Manukau	YR 1-YR 3 (Q1-Q4): Develop and implement the Metro Auckland Asian & MELAA Primary Care Health Action Plan 2020-2023 to engage PHOs and institutes in opportunistic promotion of the HPV vaccination with focus on 'Other' – MELAA groups.	75% of eligible Asian & 'Other' girls are fully immunised with HPV vaccine
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Ensure promotional materials (in priority Asian & MELAA languages) developed by the Ministry of Health are available for the Asian & MELAA communities and promoted in localities where high number of MELAA (and Asian) peoples live.	
	YR 1-YR 2 (Q1-Q4): Explore parent attitudes towards the HPV vaccination for boys and girls amongst African and Middle Eastern groups.	1 report
	YR 1-YR 3 (Q1-Q4): Promote immunisations including five year old event and the pertussis vaccination in pregnancy to Asian & MELAA partners and communities: • Active promotion of culturally appropriate messaging within high enrolled Asian and former refugee general practices • Leveraging on ethnic partner's cultural events, outreach and communication platforms to promote culturally appropriate messaging.	50% of pregnant women receiving pertussis vaccination in pregnancy 95% of eight month olds, two year olds and five year olds will have their

[32] HPV stands for human papillomavirus, a group of very common viruses that infect about four out of five people at some time in their lives. HPV causes cells to grow abnormally, and over time, these abnormalities can lead to cancer.

		primary course of immunisation on time
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Oral Health

Why is this a priority?

Good oral health practices in the first five years of a child's life are critical for lifelong oral health. Early childhood caries or dental decay remains the most prevalent chronic and irreversible disease in the western world.

In New Zealand, disparities still exist in oral health by ethnicity, deprivation level, and age group. This is evident where South East Asian e.g. Filipino and Chinese children have higher rates of caries and decayed, missing and filled teeth (dmft) at age of 8 years among Asian in both districts. Indian had the best oral health outcomes of all the Asian subgroups in both districts.

For MELAA groups, Latin American have the best oral health outcomes for both dmft and caries free as compared to African and Middle Eastern groups across both districts.

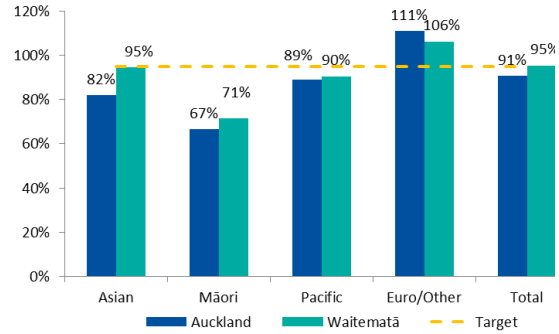
Prevention of oral disease in infants and pre-schoolers reduces the risk of dental, gingival and periodontal disease in permanent teeth and will have positive impact on their long term oral health, general health and well-being.

What are we trying to do?

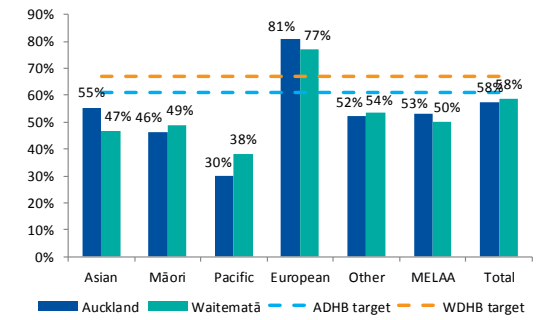
Enable access to health care to reduce inequalities in oral health status for Filipino, Chinese, and Middle Eastern children. This work will also contribute to the Metro-Auckland Healthy Weight Action Plan for Children 2017-2020.

Where are we at and where do we want to get to?

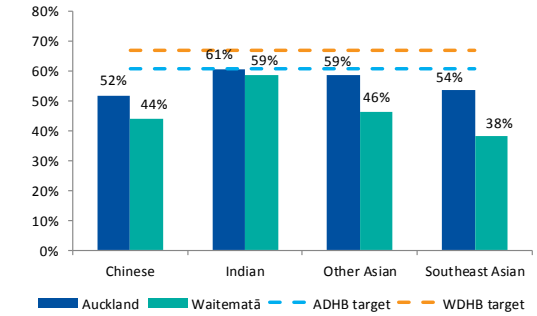
95% of 0-4 year old Asian children enrolled with pre-school oral health services



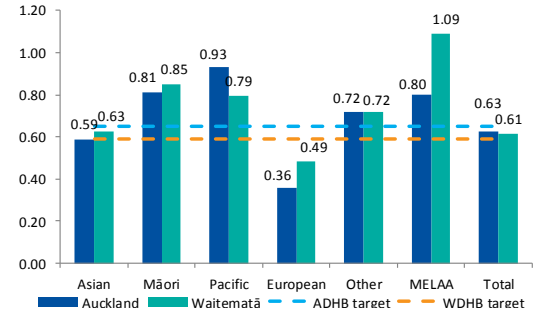
Children caries free at age of 5 years, 2019 – L1 Ethnicity



Children caries free at age of 5 years, 2019 – L2 Asian Ethnicity



Average number of dmft at year 8, 2019 – L1 Ethnicity



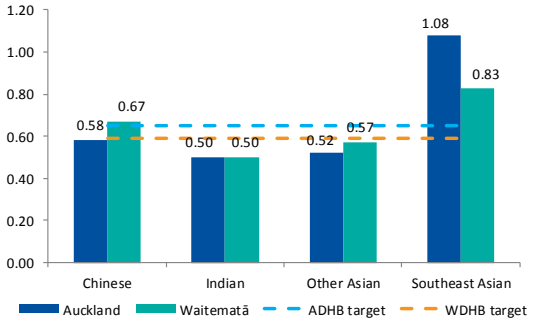
To achieve this we will focus on:

Support the implementation of the Preschool Oral Health Action Plan for Metropolitan Auckland region, and promote oral health messaging to targeted ethnic communities.

Who will we work with?

Auckland Regional Dental Services (ARDS), Women, Child and Youth team, WCTO providers, midwives, Asian NGOs, and ethnic partners/communities.

Average number of dmft at year 8, 2019 – L2 Asian Ethnicity



**All coverage as at June 2019*

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-4): Support Asian & MELAA implementation of the: • Preschool Oral Health Action Plan for Metropolitan Auckland region • Metro-Auckland Healthy Weight Action Plan for Children 2017-2020	95% of pre-schoolers enrolled in DHB oral health services 61% (ADHB) and 67% (WDHB) children caries free at the age of 5 years – L2 Asian and Other Ethnicity Average number of dmft at year 8 <0.65 ADHB and <0.59 WDHB – L2 Asian and Other Ethnicity
	YR 1 (Q1-Q4): Publish the study findings from the *Investigating Chinese, Indian, Filipino and Middle Eastern parents' and caregivers' knowledge, attitudes and behaviours towards their child's healthy eating and oral health*	
Auckland/ Waitematā /Counties Manukau	YR 1-3 (Q1-Q4): Work with ARDS to develop or redesign culturally tailored oral health and healthy eating information for Filipino, Chinese and Middle Eastern groups.	
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Engage with ethnic partners and communities to promote culturally appropriate oral health messaging to Indian, Filipino, Chinese and Middle Eastern parents/caregivers and children.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Rangatahi – Young People

Good health enables young people to succeed in their studies, opportunities to achieve their dreams and aspirations, and to make meaningful contributions to their families and communities. We are committed to supporting young people living in Waitematā and Auckland DHBs to be healthy, feeling safe and supported. In 2020-2023, our action focus for Asian, new migrant and former refugee young people is on **supporting youth access to - and utilisation of - youth appropriate health services** as part of the System Level Measures Improvement Plan, and other initiatives.

Mental Health & Addictions

Why is this priority?

Findings from the Suicide Mortality Review Committee's *Understanding deaths by suicide in the Asian population of Aotearoa New Zealand report* highlights that suicide is increasing for Asian peoples in Aotearoa New Zealand combined with challenges of their integration and settlement in this country, has implications for social services and the mental health system. The rate of Asian suicide fluctuates but has been slowly rising, from 5.93 per 100,000 in 2007/08 to a high of 8.69 in 2017/18; in 2018/19 the rate was 7.63[33]. Asian self-harm hospitalisations rates (10-24 years) have increased in 2017 (168) and 2018 (202) in Auckland DHB.

Table 5: Self-harm hospitalisations (10-24 years) (Rate per 100,000 population), Auckland and Waitematā DHBs, 2018

Self-harm hospitalisations (10-24 years) (Rate per 100,000 population)						
	ADHB Total	**ADHB Eur/Other**	**ADHB Asian**	**WDHB Total**	**WDHB Eur/Other**	**WDHB Asian**
Rate	412	448	202	493	553	158
Events Number	466	213	77	599	370	39

Those Asian youth are experiencing high rates of mental distress and late presentation for treatment due to a number of factors[3435] such as:

- socio-cultural and familial factors
- stigma and shame to ask for help
- ability to recognise the signs or symptoms of mental distress
- lack of awareness of the health and disability system and not knowing how to access services
- cultural barriers and the need for culturally appropriate services, and
- institutional racism and discrimination, and mental health.

We know that accessing services later can be attributed to level of acculturation and years lived in New Zealand.[36] Edgewalking, substance abuse, discrimination, family pressures about education/study are cited by former refugee youth as reasons for their mental health concerns.

[33] Accessible online from https://www.hqsc.govt.nz/assets/SUMRC/PR/Understanding-deaths-by-suicide-Asian-population.pdf

[34] Accessible online from https://www.asianfamilyservices.nz/uploads/7/5/0/8/75085209/korean_suicide_prevention_resources_development_v8_final_2.pdf

[35] Waitematā DHB, 2019. Asian Youth Suicide Prevention Project #WannaTalk- Asian Youth Life Skills Workshop Evaluation Report.

What are we trying to do?
Reduce self-harm and interpersonal violence amongst Asian & former refugee youth (15-24 years old), and improve their wellbeing through earlier intervention and access to integrated culturally appropriate mental health and additions (MH&A) care.

To achieve this we will focus on:
Support the roll out of the Integrated primary mental health and addiction service, System Level Measures Improvement Plan, and other ethnic targeted initiatives so that young people experience less mental distress and disorder, and are supported in times of need.

Who will we work with?
Northern Regional Alliance, Mental Health & Addictions team, Primary Care team, Asian Health Services (Waitematā DHB), Asian Mental Health Services teams (Waitematā and Auckland DHBs), Metro Auckland Asian & MELAA Primary Care Service Improvement Group, NGO Mental Health Providers, Refugees As Survivors New Zealand, Asylum Seeker Service Trust, Asian NGOs, Auckland Agency Group, Rainbow health services/partners, institutes, student associations, youth agencies, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā/ Counties Manukau	YR 1-YR 3 (Q1-Q4): Work with the Metro Auckland Asian & MELAA Primary Care Service Improvement Group to support the: • Roll out of the Integrated primary mental health and addiction service to ensure the initiatives are culturally appropriate.	Baseline self-harm hospitalisations (10-24 years) Reduction in suicide rates across 'at risk' populations including Asian youth
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Support the youth-specific actions of the: • Every Life Matters - He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 • Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand • Waitematā and Auckland DHB Suicide Prevention and Postvention Action Plan 2020-2023. ○ Raise awareness of the cultural barriers and nuances that influence low uptake of youth-based mental health services.	
Auckland/ Waitematā/ Counties Manukau	YR 1-YR 3 (Q1-Q4): Support the Auckland Agency Group to provide guidance, from an Auckland perspective, for health initiatives which support achievement of the outcomes of the International Education Strategy regarding international student experience and wellbeing.	
Auckland/ Waitematā	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

[36] Accessible online from https://www.hqsc.govt.nz/assets/SUMRC/PR/Understanding-deaths-by-suicide-Asian-population.pdf

Sexual and Reproductive Health

Why is this priority?

Sexual and reproductive health is a taboo subject among many Asian cultures. Religious, cultural, financial, language, embarrassment, stigma, shame, confidentiality issues and lack of health education are often barriers preventing Asian young peoples accessing sexual and reproductive health services. These issues extend out to gender identity and transgender needs for young people who are more likely to have limited family understanding and support for their needs.

In relation to international students, host countries have a degree of pastoral responsibility to their students. It is well documented that international students have a higher need for mental health and sexual health due to the change in environment and the limited exposure some students have to sex and relationship education in their country of origin. To compound this issue, travel and medical insurance products to international students - in relation to coverage for sexually transmitted infections (STI) testing and treatment in general practice - is limited. This results in the underutilisation and late access to treatment.[37]

What are we trying to do?

Young people are less likely to see a family doctor (GP) each year than older adults. Promote opportunistic preventive care at every family doctor (GP) visit and STI testing in sexually active young people, irrespective of symptoms in settings such as universities.

To achieve this we will focus on:

Support monitoring of trends in STIs such as chlamydia, gonorrhoea, syphilis and HIV. Work with partners to support gender diverse youth and families through a Community Engagement approach. We hope to increase understanding within these communities of the needs of young people and to reduce the social stigma and isolation experienced by them.

Who will we work with?

Auckland DHB's Transgender Health Worker, Primary Care team, Auckland Sexual health Services Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Auckland Agency Group, Asian NGOs, Body Positive, NZ Aids Foundation, Rainbow Youth, Transgender groups and networks, student associations, institutes, youth agencies, and ethnic partners/communities.

DHB	What are we going to do?
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Monitor STI trends for Asian (and if possible by visa/immigration status) via: • Syphilis Weekly IMT Report • ESR STI Surveillance Dashboard[38]
	YR 1-YR 3 (Q1-Q4): Support engagement with Auckland DHB's Transgender Health Worker, and Transgender groups and

[37] Accessible online from https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services/eligibility-limited-range-publicly-funded-health-services-0/people-receiving-treatment-infectious-diseases

[38] Accessible online from https://www.esr.cri.nz/our-services/consultancy/public-health/sti/

DHB	What are we going to do?
	networks.
	YR 1-YR 3 (Q1-Q4): Support the Auckland Agency Group to provide guidance, from an Auckland perspective, for health initiatives which support achievement of the outcomes of the International Education Strategy regarding international student experience and wellbeing.
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.

Mātua me Whānau– Adults and Family Group

Adults and older people face different health issues than younger people. Diabetes, heart disease, cancer, and mental health and addictions are some of the conditions adults experienced. We are committed to supporting adults and older people living in our districts to be healthy, and managing their health conditions well. This supports them to look after their loved ones, enjoy lives with them, succeed in careers, and see their grandchildren grow up. In 2020-2023, our action focus for Asian & MELAA adults and their families is on **cardiovascular disease management, diabetes management, mental health and addictions, health of older people and immunisation (over 65 years).**

Long Term Conditions – Cardiovascular Disease and Diabetes

Why is this a priority?

Equity of health outcomes and improved health outcomes for people with diabetes including Asian is a priority for the Diabetes Service Level Alliance.

Cardiovascular disease is one of the leading causes of death among Asian peoples. In particular, Indian people have a higher prevalence of risk factors associated with CVD, and Indian aged 35 to 74 years had higher CVD hospitalisation rates as compared to the European/Other group in Auckland and Waitematā DHBs.[39]

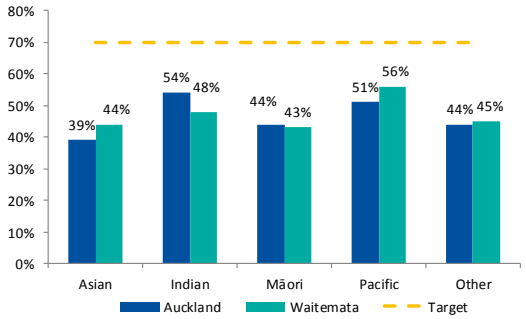
Maintaining the number of eligible Indians who receive a CVDRA, improving management for Indian with CVD and diabetes management for Other Asian and South East Asian are areas of focus in this Plan.

What are we trying to do?

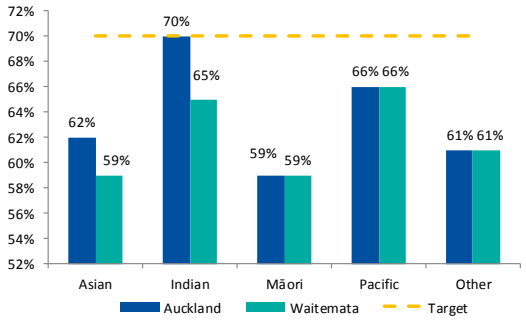
Reduce cardiovascular disease related morbidity and mortality among Indian people via improved access to quality cardiovascular and diabetes care. Improve diabetes management for Other Asian and South East Asian.

Where are we at and where do we want to get to?

CVD Primary Prevention: Percentage of enrolled patients with cardiovascular risk ever recorded >20%, (aged 35 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)



CVD Secondary Prevention: Percentage of enrolled patients with known cardiovascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)



**All coverage as at July 2019 (prescribed)*

[39] Mehta S, Health needs assessment of Asian people living in the Auckland region. Auckland: Northern DHB Support Agency, 2012.

To achieve this we will focus on:

The Auckland and Waitematā DHBs have an established Alliance agreement with the PHOs across both districts and the two Memorandum of Understanding partners. Diabetes and cardiovascular disease have been identified by the Alliance Leadership Team as the priority areas in the Alliance Work Plan.

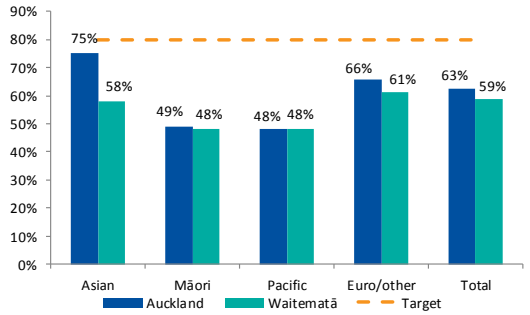
Cardiovascular disease management includes both secondary prevention (active triple therapy prescription in the past 6 months to patients who have had a CVD event – excluding haemorrhagic stroke) and primary prevention (prescribed dual therapy in the past 6 months to patients aged 35 – 74 years with a CVD risk score > 20%). Supporting the Transforming Diabetes Care Roadmap 2018 with the aim of equity of health outcomes and improved health outcomes for people with diabetes.

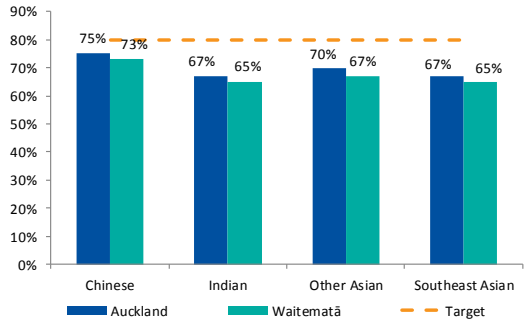
Who will we work with?

Northern Regional Alliance, Primary Care team, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Asian Health Services (Waitematā DHB), Asian NGOs, Green Prescription providers, and ethnic partners/communities.

Where are we at and where do we want to get to?

HbA1c Glycaemic control: Percentage of eligible population with HbA1c ⩽ 64mmol/mol recorded in the last 15 months (based on PHO enrolled numerator and denominator) 29





All coverage as at July 2019 (prescribed)

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-4): Improve Heart Health: • Continue to perform CVDRA checks with eligible South-Asian[40] and Asian groups. • Implementation of updated CVDRA guidelines to ensure best practice, including lifestyle and exercise guidance.	90% CVDRA coverage for South-Asian and Asian 70% of CVD patients on triple therapy 70% of CVD risk patients on dual therapy
	YR 1-YR 3 (Q1-4): Support the Transforming Diabetes Care Roadmap 2018:	1 report

[40] To align with 2018 Ministry of Health Cardiovascular Disease Risk Assessment and Management for Primary Care Guidelines, South-Asians include: Indian, including Fijian Indian, Sri Lankan, Afghani, Bangladeshi, Nepalese, Pakistani and Tibetan. -Eligible age range change for Maori, Pacific or South Asian peoples: Men - Age 30 yrs (previously 35 yrs); Women – Age 40 yrs (previously 45 yrs)

DHB	What are we going to do?	Measures
	• Coordinate and facilitate one Asian focus group to better understand the experiences of people who live with Type 2 Diabetes.	80% of diabetes patients have good HbA1c glycaemic control 80% of diabetes patients have good blood pressure control 90% of diabetes patients with microalbuminuria are under management
	YR 1-YR 3 (Q1-4): Support the recommendations from the retinal screening review consistently across Auckland and Waitemata DHBs.	
	YR 1-YR 3 (Q1-4): Support the implementation of the Metro Auckland Foot Screening and Community Foot Protection Service Standards- 2019 across Auckland and Waitemata DHBs	
	YR 1-YR 3 (Q1-4): Ensure Asian peoples are accessing podiatry, dietetics and health psychology at the same rates as other ethnicities by providing these services in community based settings.	% of Asian peoples accessing podiatry, dietetics and health psychology* **Waitematā only*
	YR 1-YR 3 (Q1-4): Increase the proportion of South Asian participants enrolled with Green Prescription services.	2% of clients engaged with Green[41] Prescriptions - 9% Waitematā - 18% Auckland
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

[41] As at June, 2019, Auckland (17.2%, 758 people); Waitematā (6%, 332 people).

Mental Health & Addictions

Why is this a priority?

Asian peoples in Auckland have significantly lower rates of access to Perinatal Maternal Mental Health services (PMMH), and Mental Health & Addiction services compared to other ethnic groups, despite a high and increasing burden of mental health issues.

What are we trying to do?

Improve early access rates to PMMH services, and MH&A services.

In Waitematā DHB, there is an Asian Mental Health Work Stream Plan 2017-2020 which has been developed in alignment to the Waitematā Stakeholder Network Mental Health and Addiction Strategic Plan 2015-2020.

The Asian Mental Health Work Stream Plan includes initiatives that enable Waitematā DHB mental health services to demonstrate cultural capability and improve the equity and wellbeing of Asian peoples through better access to MH&A Services.

To achieve this we will focus on

Support the Regional Perinatal and Infant Mental Health Clinical Governance Group, Collaborative Primary Mental Health and Addictions Nurse Credentialing Programme Governance Group, Waitematā Stakeholder Network Mental Health and Addiction Strategic Plan, and Auckland DHB's Mental Health and Addictions Commissioning Board.

Who will we work with?

Northern Regional Alliance, DHBs, Mental Health & Addictions team, Primary Care team, Asian Health Services (Waitematā DHB), Asian Mental Health Services teams (Waitematā and Auckland DHBs), Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Metro Auckland Collaborative Group, NGO Mental Health Providers, Refugee As Survivors New Zealand, Asian NGOs, eCALD services, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā / Counties Manukau	YR 1-YR 3 (Q1-Q4): Develop an action plan to include activities to promote wellbeing, respond to suicide distress, respond to suicidal behaviour and support people after a suicide.	Decrease in Asian deaths coded as suicides (Ministry of Health) and provisional suicides (Ministry of Justice), by age
	YR 1-YR 3 (Q1-Q4): Work with the Metro Auckland Asian & MELAA Primary Care Service Improvement Group to: • Support the roll out of the Integrated primary mental health and addiction service to ensure the initiatives are culturally appropriate. • Link with the Metro Auckland Collaborative Group on the implementation of the Integrated primary mental health and addiction service.	
	YR 1-YR 3 (Q1-Q4): Support the Regional Perinatal and Infant Mental Health Clinical Governance Group:	

DHB	What are we going to do?	Measures
	• Research on *'Supporting Equitable Perinatal Mental Health Outcomes (Asian communities)'.*	
	YR 1-YR 3 (Q1-Q4): Support the Collaborative Primary Mental Health and Addiction Nurse Credentialing Programme Governance Group.	
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Support the: • Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand. • Waitematā and Auckland DHB Suicide Prevention and Postvention Action Plan 2020-2023 ○ Raise awareness of the cultural barriers and nuances that influence low uptake of mental health services.	
Waitematā	YR 1-YR 3 (Q1-Q4): Implement the [Asian Mental Health] Work Stream Plan 2017-2020.	
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Support early engagement with mental health services for current asylum seeker claimants.	
Auckland/ Waitematā	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; and Asian Mental Health & Addictions Stakeholder Network Group (Waitematā DHB).	

Sexual and Reproductive Health

Why is this priority?

Reported cases of infectious syphilis have steadily increased in New Zealand since 2013, with most cases reported from areas with large cities. This is reflective of the global increase in reported syphilis cases. There is an increasing proportion of syphilis cases reported in heterosexual males and females, and the rise in cases of congenital syphilis, suggest increasing transmission in groups not considered as high risk in recent years.[42] 'Based on surveillance data from the Syphilis outbreak, we see high numbers from the Asian community and when broken down by specific Asian communities such as the Indian community, the rates are even higher. At least two thirds of the Indian community affected by Syphilis were from men who have sex with men (MSM) background and some from quite complex social environments (Appendix 6).

The Ministry of Health has confirmed that testing costs as well as treatment costs for HIV, syphilis and gonorrhoea (section C diseases) are covered by the public health act for non-eligible individuals including those who get tested and the result is not positive.[43]

Two Long Acting Reversible Contraceptions (LARC) - Mirena® and Jaydess® intrauterine systems (IUS) are now fully funded for eligible publically funded women who are seeking long-term contraception.

[42] ESR Dec 19 data

[43] Accessible online from https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services/eligibility-limited-range-publicly-funded-health-services-0/people-receiving-treatment-infectious-diseases

What are we trying to do?
Gain insight into the needs of the Asian communities in areas such as Syphilis (which can be different to that of the general population) to guide culturally appropriate planning and delivery of sexual health services.

To achieve this we will focus on:
Support monitoring of trends in Syphilis. Provide culturally appropriate information to women about DHB women's health services.

Who will we work with?
Primary Care, sexual health services, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Gynaecology Day Stay Clinics, Asian NGOs, Body Positive, NZ Aids Foundation, Auckland Sexual Health Services, Transgender groups and networks, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Monitor STI trends for Asian (and if possible by visa/immigration status) via: • Syphilis Weekly IMT Report • ESR STI Surveillance Dashboard[44]	
	YR 1-YR 3 (Q1-Q4): Promote culturally appropriate information about Epsom Day Unit and LARC information to ethnic women.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Health of Older People

Why is this a priority?
The Healthy Ageing Strategy recognises that inequities in health status need to be reduced, in particular for Māori, Pacific peoples, migrant and refugee communities, and people with disabilities. People age in different ways, and our population is diverse. We must recognise and respect the range of ways older people access and interact with services for Asian and MELAA populations. The foreseeable risk to migrant Asian groups is the waning 'healthy migrant effect', intergenerational issues, language, financial and the significant population size living in metro Auckland that is ageing (7.8%, Auckland; 9.0% ,Waitematā).[45] Older people interacting in our health system should experience culturally appropriate care that meets the health and support needs of an increasingly ethnically diverse population.

What are we trying to do?
Improve the health outcomes and independence of older Asian & MELAA peoples by supporting the national Healthy Ageing Strategy's vision that Older people live well, age well and have a respectful end of life in age-friendly communities, and key strategic themes.

[44] Accessible online from https://www.esr.cri.nz/our-services/consultancy/public-health/sti/

[45] Population projections based on '2018 Update' based on Census 2013

To achieve this we will focus on:

Activities that include Asian and MELAA older peoples' health and support needs and voice in the planning, implementation and monitoring of projects and/or groups .

Who will we work with?

Health of Older People's team, Disability Advisor, NGOs e.g Age Concern, Aged Care providers, Asian DHB geriatricians.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1 (Q1-Q4): Supporting the work on models of care and services for people with dementia and their carers.	
	YR 1 (Q1-Q4): Review current resources available to older adults and families about aged residential care services.	1 report
	YR 1-YR 3 (Q1-Q4): Increase the quality of service provision to Asian residents in Aged Residential Care: • Coordinate the Facility Owners Group meeting (including Chinese and Korean) run bi-monthly (6).	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

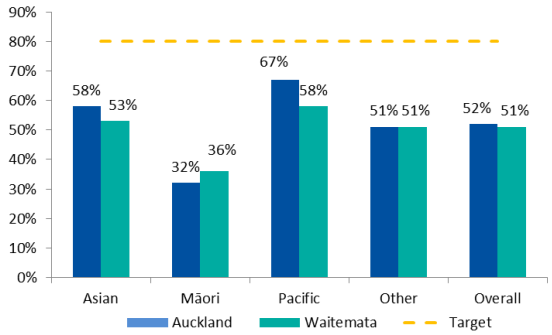
Immunisation against Influenza

Why is this a priority?

Asian & MELAA peoples 65 years and over may not be aware they are eligible for free Seasonal Influenza vaccines. They often are staying at home looking after infants and children, thus may increase the chances of spreading the flu with family members.

Where are we at and where do we want to get to?

Rate of seasonal influenza immunisation of eligible 65+ years population, Auckland and Waitematā DHBs (January - September 2019)



**Jan-Sep 2019*

What are we trying to do?

Increase the number of Asian & MELAA older peoples who received Seasonal Influenza vaccines.

To achieve this we will focus on:

Promotion of Seasonal Influenza vaccines through culturally appropriate activities and communication.

Who will we work with?

Primary Care team, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, WCTO providers, Asian NGOs, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Work with PHO Immunisation Coordinators to ensure general practices are recalling and providing the Influenza vaccine for those eligible.	75% of people aged over 65 receive a flu vaccine Respiratory infection hospitalisation rate, over 65 years (per 100,000)
Auckland/ Waitematā /Counties Manukau	YR 1-YR 3 (Q1-Q4): Starting 1 April 2020: • Targeted activities as part of CMH's Community Flu Fighters programme in Asian communities • Active promotion of culturally appropriate messaging within high enrolled Asian and former refugee general practices • Leveraging on Asian and migrant partner's cultural events, outreach and communication platforms to promote culturally appropriate messaging • Leveraging on mainstream services/activities e.g. community pharmacies to promote culturally appropriate messaging.	
Auckland/ Waitematā	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Rōhe o Waitematā me Auckland

There are health systems that are potential barriers to health gain for Asian and MELAA peoples in our districts. In 2020-2023, our action focus is on regional planning and reporting, data quality, primary care enrolment, former refugee and current asylum seeker health.

Regional Asian Health Gain Planning and Reporting

Why is this a priority?
In order to maintain or improve Asian health status we must address the disparities within Asian 'high-risk' subgroups associated with access to and utilisation of health and disability services for newcomers, distribution of health determinants and risk factors, and a diminishing protective 'healthy migrant effect'.

Former refugee communities continue to resettle across the metropolitan districts under the Refugee Quota Programme; Family Reunion Refugees; Convention Refugee or Protected Person (Asylum Seeker),

A regional response is necessary to achieve best value from available resources, experience and skills by working collaboratively (where possible) to make a positive change in health outcomes for Asian, migrant, former refugee and current asylum seeker populations.

What are we trying to do?
The metropolitan Auckland DHBs have a common goal to improve or maintain health gain in their respective Asian populations. Together, we aim to review and learn from our health gain activities, insights and outcomes so we can benefit from our collective knowledge and relationships with community and health leaders.

What will we focus on?
Collectively work towards the areas of focus in the Metropolitan Auckland Asian & MELAA Primary Care Action Plan 2020-2023, share available Asian health status data, and leverage respective Asian health oversight, advisory and governance forums.

Where do we want to get to?
We will aim to develop a Metropolitan Auckland Asian & MELAA Primary Care Action Plan 2020-2023.

Who will we work with?
Northern Regional Alliance, PHOs, and Counties Manukau Health.

DHB	What are we going to do?	Measures
Auckland/ Waitematā/	YR 1-YR 3 (Q1-Q4): Support coordination of a Northern Region COVID-19 cultural response for our diverse ethnic communities across key functions	

DHB	What are we going to do?	Measures
Counties Manukau	(when needed): • Communications: Develop and promote translated COVID-19 resources to communities, and content for the ARPHS communities webpage[46] • Intelligence: Provide cultural advice and planning to the Intelligence team • Welfare: Provide advice and support to Welfare case management.	
	YR 1-YR 3 (Q1-Q4): Develop and implement a Metro Auckland Asian & MELAA Primary Care Action Plan 2020-2023.	1 Plan
	YR 1-YR 3 (Q1-Q4): Explore potential opportunities to work regionally to raise Asian and former refugee health equity awareness: • Input into the planning of Counties Manukau Health Asian initiatives to avoid duplication of effort and streamline resources (where possible).	
	YR 1-YR 3 (Q1-Q4): Continue to streamline the '*Improving Access to General Practice for Former Refugees and Current Asylum Seekers Agreements'* across the metropolitan Auckland region: • PHO Refugee Services Operational Group.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; Metro Auckland Asian & MELAA Primary Care Service Improvement Group; Metro Auckland PHO Refugee Services Operational Group; and Counties Manukau's Asian Advisor.	

Data Quality

Why is this a priority?
Accurate data is imperative for policy, planning and monitoring of many indicators important for Asian Health. A key area of interest is to establish complete and accurate breakdown data on level 2 Asian subgroups to identify 'at risk' subgroup population health outcomes.

What are we trying to do?
Advocate to improve the quality of ethnicity data collected by Auckland and Waitematā DHBs.

To achieve this we will focus on:
Implement the Standard of Ethnicity Data Protocols and action plans to improve ethnicity data collection.

Who will we work with?
Primary Care team, Health Intelligence team, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, and Waitematā and Auckland DHBs provider arm services.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Continue to develop a quarterly Asian performance scorecard to monitor trends in health outcomes	Asian Scorecard (4)
	YR 1-YR 3 (Q1-Q4):Promote via the Metro Auckland Asian & MELAA Primary Care Service Improvement Group accuracy of ethnicity reporting	Standard of Ethnicity Data Protocols[47]

[46] Accessible at https://www.arphs.health.nz/public-health-topics/covid-19/covid-19-information-for-our-communities/

DHB	What are we going to do?	Measures
	in PHO registers as measured by Primary Care Ethnicity Data Audit Toolkit.	implemented.
	YR 1-YR 3 (Q1-Q4): Identify services where there are gaps in collecting and reporting of level 1 'Asian' and 'Other' and level 2 categories subgroups ('Other Asian', 'Chinese', 'Indian', 'South East Asian' and 'Asian NFD').	
	YR 1-YR 2 (Q1-Q4): Work with identified services to ensure accurate collecting and reporting of level 2 'Asian' ethnicity subgroups (at a minimum).	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Primary Healthcare Enrolment

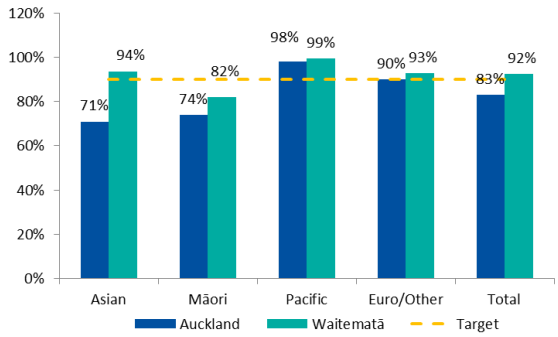
Why is this a priority?

Asian peoples have disproportionately lower PHO enrolment rates compared to European/Other in Auckland DHB (71% (Asian), 90% (European/Other).

The Auckland DHB's Asian PHO enrolment rate continues to remain significantly lower than the other Metro Auckland DHBs largely due to the high number of international students and transient temporary migrant population living in the Auckland district. [48]

Where are we at and where do we want to get to?

90% of patients are enrolled with a PHO



**Sep 2019*

Awareness of the New Zealand Health & Disability System is a key enabler to timely access and appropriate use of health services. The National Migrant Consultations 2018 report[49] highlighted that for new migrants -particularly those on working visas and skilled migrant visas - understanding how the health system works and addressing misconceptions is imperative to settlement experiences. Similarly, ethnicities from Chinese, Indian, Filipino and Middle Eastern backgrounds also expressed a lower level of awareness of the health system as part of the oral health study findings conducted in 2018.

Equitable access to timely primary care services and language support for newly arrived migrants, former refugee and current asylum seekers in general practice is essential. The role of primary care and access to a family doctor (GP) is critical to resettlement experiences for former refugees and current asylum seekers. The new national Quota Refugee Health Services Model will require greater engagement and support at the general practice level, and increasingly, the majority of current

[47] Accessible online from http://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols

[48] International students and temporary migrants domiciled in a district for 1 year are included in the denominator when calculating a DHB's PHO enrolment rate even though they are ineligible to enrol with a PHO. The Auckland DHB's PHO enrolment rate appears to be diluted as a result of a high ineligible healthcare population unable to enrol with a family doctor (PHO) yet included in the denominator.

[49] Accessible online from https://www.immigration.govt.nz/documents/about-us/national-migrant-consultations-2018.pdf

asylum seeker claimants live in Auckland during their claim process and require ongoing mental health support as part of their determination process.

What are we trying to do?
Deliver a suite of initiatives to increase newcomers' awareness of the New Zealand health & disability system; role and commensurate benefits of enrolling with or seeing a regular family doctor (GP) for holistic care including timely health checks, immunisations, family health services, integrated wrap around services; and knowing where to go for healthcare to get help when you're fee – for urgent, less serious conditions, injury and when it's an emergency.

To achieve this we will focus on:
Implement the Metropolitan Auckland Asian & MELAA Primary Care Action Plan 2020-2023, and support the health & wellbeing outcome areas for the: New Zealand Refugee Resettlement Strategy; New Zealand Migrant Settlement and Integration Strategy; and New Zealand International Student Wellbeing Strategy.

Who will we work with?
Uri Ririki - Child Health Connection Centre Service, Women, Child and Youth team, Primary Care team midwives, Ministry of Health, Ministry of Business, Innovation and Employment, , Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Auckland Agency Group, New Zealand Red Cross, WCTO Providers, ARDS, institutes, settlement agencies, student associations, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Work with the Metro Auckland Asian & MELAA Primary Care Service Improvement Group and Primary Care to implement the Action Plan 2020-2023.	95% of the population enrolled in a PHO

	YR 1-YR 3 (Q1-Q4): Promote the suite of multilingual interventions, such as podcast videos, Healthcare – where should I go?, health literate materials, and the Your Local Doctor websites (English, Chinese and Korean):
	• NZ health system podcast videos:
	  ○ Refresh English and Mandarin videos
	  ○ Develop Korean video
	• Develop online New Zealand Health & Disability System materials for Rohingya, Karen, Kayah, Amharic, Cambodian/Khmer, Farsi, Punjabi, Somali, Swahili, Tamil, Thai, Tigrinya, and Urdu.
	• Develop online Healthcare – where should I go? flyer for Rohingya, Karen, Kayah, Amharic, Cambodian/Khmer, Farsi, Punjabi, Somali, Swahili, Tamil, Thai, Tigrinya, and Urdu.
	• Deliver the NZ Health & Disability System presentations to universities, Private Training Establishments (PTE), settlement partners, ethnic associations/communities and libraries.	

	YR 1-YR 3 (Q1-Q4): Increase the proportion of Asian & MELAA newborn infants enrolled with a PHO at 3 months of age: • Work with the Uri Ririki - Child Health Connection Centre (CHCC) service to identify gaps and trends to late PHO enrolment, and identify solutions in partnership with the Service and Sector to increase early enrolment • Promote culturally appropriate PHO enrolment messaging to	98% of newborns are enrolled with a PHO, general practice at 3 mths of age

DHB	What are we going to do?	Measures
	Asian & MELAA newcomers • Work with the PHO Newborn Enrolment Coordinators to support access to Under 5 services and culturally responsive service provision.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Former Refugee & Current Asylum Seeker Health

Why is this a priority?

Available evidence suggest that both former refugee and current asylum seekers including those from transgender, non-binary and gender diverse backgrounds face significant barriers to accessing primary care, mental health and addiction, pharmacy, oral health and maternity services. Key barriers to accessing health services (including maternity services), include varied levels of resettlement support, difficulty accessing language services, financial and transport stressors, lack of knowledge of the health system, cultural competence of the health workforce, discrimination and lack of awareness within health services of refugee and current asylum seeker unique needs and experiences. Financial constraints mean individuals are generally not able to access private services and depend on public or community-based services.[50]

Former refugee and/or current asylum seeker families have low access to and utilisation of primary health services in New Zealand and thus require equity of access to general practice.[51]

What are we trying to do?

Enable equitable access to mainstream primary care (affordable or no-cost options) for former refugee and current asylum seeker patients in general practice; monitor health service access and utilisation (and long-term outcomes); and support the national Quota Refugee Health Services Model implementation and monitoring.

To achieve this we will focus on:

Fund the PHOs to manage the delivery of the '*Improving Access to General Practice for Former Refugees and Current Asylum Seekers Agreements'* with their participating general practices in the metropolitan Auckland region, promote the Service among former refugee and/or current asylum seeker communities, improve cultural competency among primary care practices, promote the use of language support, and deliver professional development to the primary health workforce.

Who will we work with?

Primary Care team, DHBs, Metro Auckland PHO Refugee Services Operational Group, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, PHOs, community health workers, New Zealand Red Cross, Mangere Refugee Resettlement Centre, Immigration New Zealand, Asylum Seeker Support Trust, asylum seeker lawyers/barristers, settlement agencies, Rainbow health services/partners, and ethnic partners/communities.

[50] Accessible online from https://www.racp.edu.au/docs/default-source/default-document-library/refugee-and-asylum-seeker-health-position-statement.pdf?sfvrsn=2

[51] Accessible online from https://www.ncbi.nlm.nih.gov/pubmed/28379739

DHB	What are we going to do?	Measures
Auckland/ Waitematā/ Counties Manukau	YR 1-YR 3 (Q1-Q4): Fund and manage the Improving Access to General Practice for Former Refugees and Current Asylum Seekers Agreements	Increase in number of former refugees enrolled with the Refugee Primary Care Services[52]
	YR 1-YR 3 (Q1-Q4): Strengthen pathways to PHO enrolment for former refugees: • Support the roll out of the Quota Refugee Health Services Model in primary care. • Promote pathways to primary care for Family Reunion Refugees (Refugee Quota Family Reunification Category and Refugee Family Support Category), and Convention Refugee or Protected Persons	
	YR 1-YR 3 (Q1-Q4): Coordinate bimonthly meetings with the Metro Auckland PHO Refugee Services Operational Group: • Minimum data sets to enable monitoring of service access and health outcomes.	
	YR 1-YR 3 (Q1-Q4): Raise awareness within former refugee and current asylum seeker communities of Service availability: • Work with our stakeholders, outreach services and community leaders to increase awareness, access to and uptake of the Services.	
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Q4: Lead and coordinate professional development to the primary health workforce: • Metro Auckland Refugee Health Network Executive Group • Metro Auckland Refugee Health Network (ARRHN) Forums • Cross Cultural Frontline Training.	
Auckland/ Waitematā / Counties Manukau	YR 1-YR 3 (Q1-Q4): Encourage and promote CALD training with the participating practices of this Service.	
	YR 1-YR 3 (Q1-Q4): Encourage and promote the use of interpreting services such as the DHBs' Primary Health Interpreting services in participating general practices of this Service.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; and Metro Auckland PHO Refugee Services Operational Group.	

[52] As at 1 March, 68 practices participating

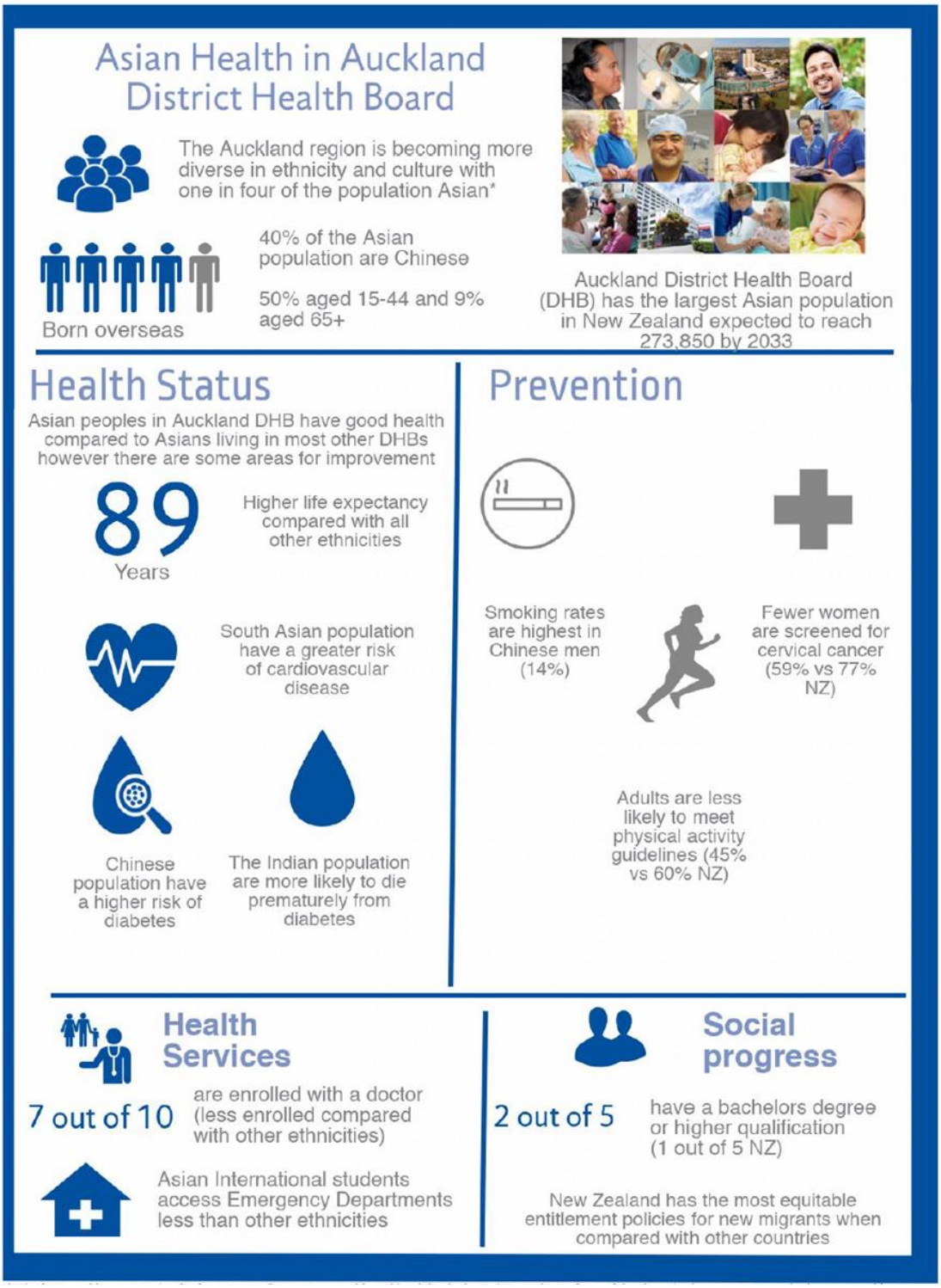
Glossary

ASH	Ambulatory sensitive hospitalisations
CALD	Culturally and linguistically diverse
CBD	Central business district
CHCC	Child Health Connection Centre
CPHAC	Community & Public Health Advisory Committee
CUR	Census Usually Residents population
CVD	Cardiovascular disease
CVDRA	Cardiovascular disease/cardiovascular disease risk assessment
DHB	District health board
dmft	Measure of children's oral health (Decayed/Missing/Filled/Teeth)
GP	General practitioner
HPV	Human papilloma virus
INZ	Immigration New Zealand
IUS	Intra uterine system
LARC	Long acting reversible contraceptions
MELAA	Middle Eastern, Latin American or African
MH&A	Mental health and addictions services
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-government organisation
PHIS	Primary health interpreting services
PHO	Primary health organisation
PMMH	Perinatal maternal mental health
PTE	Private training establishment
SLM	System level measure (national set of six health indicators)

Appendices

Appendix 1: Asian Health Benchmarking in Waitematā District Health Board, 2017

Appendix 2: Asian Health Benchmarking in Auckland District Health Board



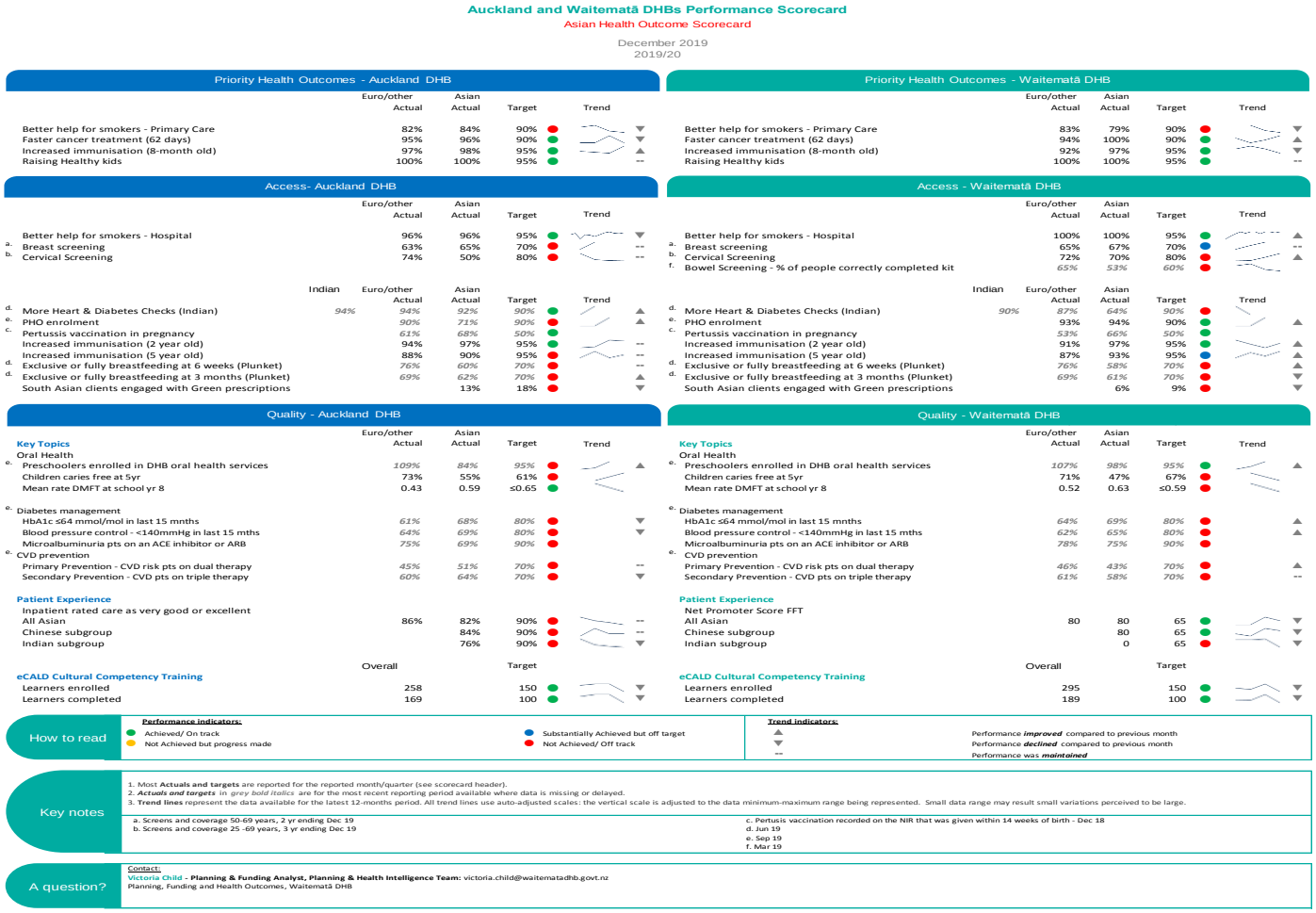
Appendix 3: Strategic Directions

- New Zealand Health Strategy: Future direction[53]
- New Zealand Migrant Settlement and Integration Strategy's - Outcome 5: Health and Wellbeing[54]
- New Zealand Refugee Resettlement Strategy - Health Outcome[55]
- New Zealand Community Engagement Framework[56]
- New Zealand International Student Wellbeing Strategy Outcomes Framework - Outcome 3: Health & Wellbeing[57]
- Plunket Asian Peoples Strategy
- All of Government (AoG) contracting
- Northern Region Health Plan
- Waitematā DHB Health Services Plan 2015-2025
- Waitematā DHB Primary and Community Care Plan
- Waitematā DHB Asian Mental Health & Addiction Governance Group's Asian Mental Health Work Stream Plans 2015-2020
- Auckland DHB Strategy
- Auckland Regional Public Health Service Strategic Plan 2017-2022
- Counties Manukau Health 2018/19-2019/20 Asian Health Outcome Priorities
- Counties Manukau Health 2018/19-2019/20 Asian Health Action Roadmap
- Auckland Metro Regional System Level Measures Improvement Plan.

Note, within the timeframe of this Plan, these Strategies/Plans below may be refreshed.

[53] Accessible online from https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf
[54] Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/how-we-support-migrants
[55] Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/refugee-resettlement-strategy
[56] Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/refugee-resettlement-strategy/rqip
[57] Accessible online from https://www.education.govt.nz/our-work/overall-strategies-and-policies/international-student-wellbeing-strategy/

Appendix 4: Auckland and Waitematā DHBs Asian Performance Scorecard (Dec 2019)



Auckland and Waitematā DHBs Performance Scorecard

Asian Health Outcome Scorecard

December 2019
2019/20

Priority Health Outcomes - Auckland DHB

	Euro/other Actual	Asian Actual	Target	Trend
Better help for smokers - Primary Care	82%	84%	90%	
Faster cancer treatment (62 days)	95%	96%	90%	
Increased immunisation (8-month old)	97%	98%	95%	
Raising Healthy kids	100%	100%	95%	

Priority Health Outcomes - Waitematā DHB

	Euro/other Actual	Asian Actual	Target	Trend
Better help for smokers - Primary Care	83%	79%	90%	
Faster cancer treatment (62 days)	94%	100%	90%	
Increased immunisation (8-month old)	92%	97%	95%	
Raising Healthy kids	100%	100%	95%	

Access- Auckland DHB

	Euro/other Actual	Asian Actual	Target	Trend
Better help for smokers - Hospital	96%	96%	95%	
a. Breast screening	63%	65%	70%	
b. Cervical Screening	74%	50%	80%	

	Indian	Euro/other Actual	Asian Actual	Target	Trend
d. More Heart & Diabetes Checks (Indian)	*94%*	*94%*	*92%*	*90%*	
e. PHO enrolment		*90%*	*71%*	*90%*	
c. Pertussis vaccination in pregnancy		*61%*	*68%*	*50%*	
Increased immunisation (2 year old)		94%	97%	95%	
Increased immunisation (5 year old)		88%	90%	95%	
d. Exclusive or fully breastfeeding at 6 weeks (Plunket)		*76%*	*60%*	*70%*	
d. Exclusive or fully breastfeeding at 3 months (Plunket)		*69%*	*62%*	*70%*	
South Asian clients engaged with Green prescriptions			13%	18%	

Access - Waitematā DHB

	Euro/other Actual	Asian Actual	Target	Trend
Better help for smokers - Hospital	100%	100%	95%	
a. Breast screening	65%	67%	70%	
b. Cervical Screening	72%	70%	80%	
f. Bowel Screening - % of people correctly completed kit	*65%*	*53%*	*60%*	

	Indian	Euro/other Actual	Asian Actual	Target	Trend
d. More Heart & Diabetes Checks (Indian)	*90%*	*87%*	*64%*	*90%*	
e. PHO enrolment		93%	94%	90%	
c. Pertussis vaccination in pregnancy		*53%*	*66%*	*50%*	
Increased immunisation (2 year old)		91%	97%	95%	
Increased immunisation (5 year old)		87%	93%	95%	
d. Exclusive or fully breastfeeding at 6 weeks (Plunket)		*76%*	*58%*	*70%*	
d. Exclusive or fully breastfeeding at 3 months (Plunket)		*69%*	*61%*	*70%*	
South Asian clients engaged with Green prescriptions			6%	9%	

Quality - Auckland DHB

	Euro/other Actual	Asian Actual	Target	Trend
Key Topics				
Oral Health				
e. Preschoolers enrolled in DHB oral health services	*109%*	*84%*	*95%*	
Children caries free at 5yr	73%	55%	61%	
Mean rate DMFT at school yr 8	0.43	0.59	≤0.65	
e. Diabetes management				
HbA1c ≤64 mmol/mol in last 15 mnths	*61%*	*68%*	*80%*	
Blood pressure control - <140mmHg in last 15 mths	*64%*	*69%*	*80%*	
Microalbuminuria pts on an ACE inhibitor or ARB	*75%*	*69%*	*90%*	
e. CVD prevention				
Primary Prevention - CVD risk pts on dual therapy	*45%*	*51%*	*70%*	
Secondary Prevention - CVD pts on triple therapy	*60%*	*64%*	*70%*	
Patient Experience				
Inpatient rated care as very good or excellent				
All Asian	86%	82%	90%	
Chinese subgroup		84%	90%	
Indian subgroup		76%	90%	
	Overall		Target	
eCALD Cultural Competency Training				
Learners enrolled	258		150	
Learners completed	169		100	

Quality - Waitematā DHB

	Euro/other Actual	Asian Actual	Target	Trend
Key Topics				
Oral Health				
e. Preschoolers enrolled in DHB oral health services	*107%*	*98%*	*95%*	
Children caries free at 5yr	71%	47%	67%	
Mean rate DMFT at school yr 8	0.52	0.63	≤0.59	
e. Diabetes management				
HbA1c ≤64 mmol/mol in last 15 mnths	*64%*	*69%*	*80%*	
Blood pressure control - <140mmHg in last 15 mths	*62%*	*65%*	*80%*	
Microalbuminuria pts on an ACE inhibitor or ARB	*78%*	*75%*	*90%*	
e. CVD prevention				
Primary Prevention - CVD risk pts on dual therapy	*46%*	*43%*	*70%*	
Secondary Prevention - CVD pts on triple therapy	*61%*	*58%*	*70%*	
Patient Experience				
Net Promoter Score FFT				
All Asian	80	80	65	
Chinese subgroup		80	65	
Indian subgroup		0	65	
	Overall		Target	
eCALD Cultural Competency Training				
Learners enrolled	295		150	
Learners completed	189		100	

How to read

Performance indicators:
- Achieved/ On track
- Not Achieved but progress made
- Substantially Achieved but off target
- Not Achieved/ Off track

Trend indicators:
- Performance ***improved*** compared to previous month
- Performance ***declined*** compared to previous month
- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
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. Small data range may result small variations perceived to be large.

a. Screens and coverage 50-69 years, 2 yr ending Dec 19
b. Screens and coverage 25 -69 years, 3 yr ending Dec 19
c. Pertusis vaccination recorded on the NIR that was given within 14 weeks of birth - Dec 18
d. Jun 19
e. Sep 19
f. Mar 19

A question?

Contact:
Victoria Child - **Planning & Funding Analyst, Planning & Health Intelligence Team:** victoria.child@waitematadhb.govt.nz
Planning, Funding and Health Outcomes, Waitematā DHB

Appendix 5: Definitions of scorecard indicators/performance measures

Better help for smokers – Primary Care - % of PHO enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking. Quarterly report from MOH.

Faster Cancer treatment - % of patients referred urgently with a high suspicion of cancer whose first treatment (or other management) occurred within the last 6 months and the treatment was within 62 days of the referral being received by the hospital.
Quarterly report from NRA.

Immunisation (8-month old, 2, 5-year old) – % of children who turned the milestone age in the reporting quarter who have completed their age appropriate immunisations by the time they turn the milestone age. Quarterly report from MOH.

Raising Healthy kids - % of children who had a B4 School Check and were identified as obese (BMI>98th percentile) and were referred to a registered health professional and acknowledged within 30 days or were already under care or declined the referral. Quarterly report from MOH.

Better help for smokers – Hospital – % of hospitalised smokers provided with advice and help to quit. Reported monthly from internal reporting.

Breast screening - Breast screen Aotearoa coverage (%) 50-69 years, 2 years ending at current quarter. Quarterly report from NSU website.

Cervical screening - National Cervical Screening Programme coverage (%) 25 -69 years, 3 years ending at current quarter. Based on statistics NZ census population projection adjusted for prevalence of hysterectomies. Quarterly report from NSU website.

Bowel Screening - % 60-74 year olds, 2 years ending at reported quarter who return correctly completed kits.

More Heart and Diabetes Checks/Cardiovascular Disease (CVD) risk assessment - % of the eligible PHO enrolled population who have had their cardiovascular risk assessed in the last five years. Quarterly report from MOH.

CVD Primary Prevention: Percentage of enrolled patients with cardio-vascular risk ever recorded >20%, (aged 35 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent).

CVD Secondary Prevention - Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/ Anticoagulant).

PHO enrolment – % of population (latest census based projections) who are enrolled with a PHO. Quarterly enrolment figures from MOH and latest census population projections.

Pertussis vaccination in pregnancy - % of pregnant women receiving pertussis vaccination in pregnancy. Pertussis vaccination recorded on the NIR that was given within 14 weeks of birth. Reported quarterly from NIR and NMDS records.

HPV vaccination - Percentage of eligible girls fully immunised with HPV vaccine. Final dose: The dose that completes HPV immunisation. For people aged under 15 years of age, two HPV vaccine doses are required to complete immunisation provided that the second dose is given more than 21 weeks after the first dose. For those aged 15 years and older, or those in whom the second dose was given less than 21 weeks after the first dose, three HPV vaccine doses are required to completeimmunisation.* Estimated HPV eligible population includes 12yrs female, male and total (includes female,male and indeterminate) on each tab and is based on the selected denominator. 2018/19, the national target is 75% of girls born in 2005 are fully immunised for HPV.

Flu vaccination – Percentage of individuals within the age band 65+yrs at the date of the report run date who have completed their annual influenza immunisation using Census estimated population projection denominator for the given vaccination year. MOH annual report.

Respiratory infection hospitalisation rate – Rate per 100 000 population of male and female 65+ year olds hospitalised for respiratory infections . Conditions include acute upper respiratory infections, influenza and pneumonia, and other acute lower respiratory infections.

Breastfeeding at 6 weeks, 3 months – % of newborn babies who are exclusively or fully breastfed at 6 weeks or 3 months as determined at WCTO contact. Quarterly data from Plunket report.

Clients engaged with Green prescriptions – Number of adults engaged in Green prescriptions. Data provided by Harbour Sport for WDHB, Sport Auckland for ADHB. South Asian data only available currently.

Oral Health

Pre-schoolers enrolled in DHB oral health services – % of 0-4 year olds enrolled with ARDS (Auckland regional dental service). Reported quarterly from ARDS enrolment data and Census population projections. High enrolment figures for the “other” ethnicity group is due to the mismatch of the census population projection and ARDS database ethnicity categorisations and the nature of projections based on census data from 2013.

Children caries free at 5 yr – % of children examined that are caries free at five years of age. Reported quarterly from ARDS data. Asian subgroup information not regularly available, masking trends in these subgroups..

Mean rate DMFT at school year 8 – Ratio of mean decayed, missing, filled teeth (DMFT) of children examined at year 8. Reported quarterly from ARDS data. Asian subgroup information not regularly available, masking trends in these subgroups.

Diabetes Glycaemic control: Percentage of eligible population with HbA1c ≤ 64mmol/mol recorded in the last 15 months (based on PHO enrolled numerator and denominator).

Diabetes Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140mmHg.

Diabetes Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker.

Inpatient rated care ADHB KPI = Patient Experience survey results ADHB - quarterly results for the % of patients who rate their overall stay in hospital as excellent or very good. Quarterly results calculated from monthly internal reports.

WDHB Net promoter score – The friends and family test is a patient feedback survey that produces the Net Promoter Score. The proportion of responses that are promoters and the proportion that are detractors are calculated and the proportion of detractors is then subtracted from the proportion of promoters to provide an overall 'net promoter' score. Those that say they are 'extremely likely' are counted as promoters. 'Likely' is neutral, 'neither unlikely nor likely', 'unlikely' and 'extremely unlikely' are all counted as detractors. Quarterly results from monthly internal reporting.

eCALD cultural competency training - Number of learners enrolled and learners that have completed eCALD cultural competency training in the previous quarter (online course participants are given 6 weeks to complete the course).
Quarterly report provided by Sue Lim (WDHB).

Deaths coded as suicides - Annual data from the National Mortality Collection 2016. Numbers may differ from preliminary Coroner reports

Traffic light criteria as per the Hospital Advisory Committee (HAC) report methodology:

Variance from target		Interpretation	Traffic light
On target or better		Achieved	●
95-99.9%	0.1% - 5% away from target	Substantially Achieved	●
90-94.9%*	5.1% - 10% away from target AND improvement from last month NB. The trend indicator in this case should always be ▲	Not achieved, but progress made	●
<94.9%	5.1% - 10% away from target, AND no improvement, OR >10% away from target	Not Achieved	●

Appendix 6: Ethnic groups with 10 or more Syphilis cases (2017-2020), as at 28 February, 2020

Ethnicity	2017	2018	2019	2020*	Total	Rank
New Zealand European	97	112	98	15	322	1
Maori	65	59	52	9	185	2
Indian	24	27	25	5	81	3
Latin American	13	22	16	3	54	4
Other European	26	22	25	4	77	5
Southeast Asian	10	14	19	1	44	6
Other Asian	7	12	8	2	29	7
Samoan	13	12	17	4	46	8
Cook Island Maori	2	10	7	1	20	9
Fijian	8	9	13	4	34	10
Chinese	8	8	16	2	34	11
European NFD	1	6	3	2	12	12
Middle Eastern	2	5	6	0	13	13
Tongan	1	4	8	2	15	14
African	4	3	4	1	12	15
Niuean	1	3	5	1	10	16

* *year in progress*

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

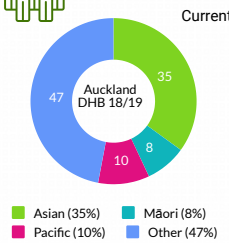
Waitematā District Health Board
Best Care for Everyone

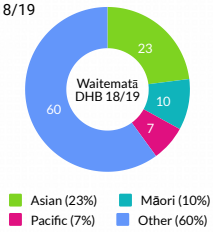
Overview
Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023
Auckland and Waitematā District Health Boards

Aim
- ✓ Improve health outcomes where there are health inequalities
- ✓ Increase access and utilisation
- ✓ Continue to support equitable access to primary health care for our targeted populations

Our population

Current 2018/19



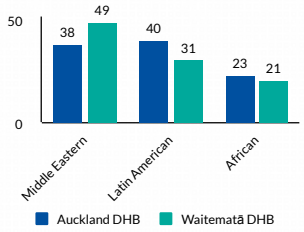


- Over **180 ethnicities** in Metro-Auckland
- **Asian fastest** growing group
- **Top 3** Asian groups:
  1. Chinese
  2. Indian
  3. Filipino in Auckland DHB, will soon surpass Korean (3) in Waitematā DHB

- By **2025** Asian expected to reach 38% in Auckland DHB and 26% in Waitematā DHB

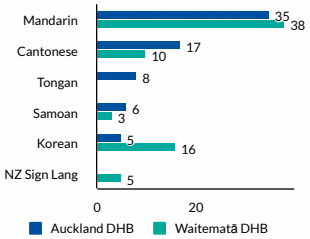
Middle Eastern Latin American and African (MELAA)

MELAA population by ethnic group, Census 2018 (%)



- Auckland DHB has the **largest** MELAA population in the country
- Latin American population **doubled** in Auckland DHB between 2013 and 2018

Top five in-demand languages, 2018/19 (%)



- 12% Asian and 8% MELAA speak 'no english'

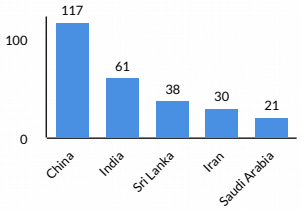
68,000 (2018) international students in Metro-Auckland

70% new migrants (<5years) live in Auckland DHB

Quota refugees:
- Quota increase from 1000 to 1500 from July 2020
- Approx 100 resettling in Metro-Auckland each year

Asylum seekers: 510 claims (2018/19) - **153** approved

Top 5 Refugee & Protection **Claims** by Nationality 2018/19



Top 5 Refugee & Protection **Approvals** by Nationality 2018/19

1. China
2. Iran
3. Saudi Arabia
4. Afghanistan
5. Egypt

Focus of the Plan

1. **Capability and capacity building:** Granular data monitoring to level 4.

2. **Access:** Equity of access and utilisation of healthcare services:
- Awareness of the New Zealand Health & Disability System
- PHO enrolment (eligible new migrants, (**equity of access)** to former refugees, and babies at 3months) and lower access to primary health services
- Better management of long term conditions (**equity of access**) to cardiovascular disease – Indian and South Asian; diabetes – Chinese and South East Asian (Filipino)
- Mental health and addictions (youth, (**equity of access)** to perinatal maternal mental health)
- Sexual and reproductive health
- Immunisations (HPV, 5 year event, Influenza over 65 years), and
- Preschool oral health (Chinese, Filipino and Middle Eastern).

3. **Health promotion/prevention** including culturally tailored and/or targeted preventive healthy lifestyle activities.

4. Adopting a **partnerships approach** to engage under-served segments of the population.

To know more about the **Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023** and list of references please visit (insert weblink)

4.1 Planning Funding and Outcomes Update

Recommendation:

That the Community and Public Health Advisory Committee notes the key activities within the Planning, Funding and Outcomes Unit.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Kate Sladden (Funding and Development Manager Health of Older People), Ruth Bijl (Funding & Development Manager Women, Children & Youth), Meenal Duggal (Funding & Development Manager, Mental Health and Addiction Services), Faimafili Tupu (Portfolio Manager, Pacific Health Gain), Samantha Bennett (Manager, Asian, Migrant and Former Refugee Health Gain), Jean McQueen (Acting Funding and Development Manager, Primary Care), Shayne Wijohn (Māori Health Gain Manager)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

AAA	-	Abdominal Aortic Aneurysm
ALT	-	Alliance Leadership Team
AOD	-	Alcohol and Drug
ARC	-	Aged Residential Care
ASH	-	Ambulatory Sensitive Hospitalisation
ARRC	-	Aged Related Residential Care
B4SC		B4 School Check
CADS	-	Community Alcohol and Drug Services
CALD	-	Culturally and Linguistically Diverse Communities
CASA	-	Clinical Advisory Services Aotearoa
CBACs	-	Community Based Assessment Centres
CPHAC	-	Community and Public Health Advisory Committee
CVD	-	Cardiovascular Disease
CWF	-	Child, Women and Family
CTC		Community Testing Centre
DCNZ		Dental Council of New Zealand
DHB	-	District Health Board
ESBHS	-	Enhanced School Based Health Services
GP	-	General Practitioner
HCSS	-	Home and Community Support Services
HEEADSSS	-	Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety
HPV	-	Human papillomavirus
IPMHAS	-	Integrated Primary Mental Health and Addiction Services
IMT	-	Incident Management Team
LAS	-	Language Assistance Services
MADS	-	Metro Auckland Data Sharing
MADSG	-	Metro Auckland Data Stewardship Group
MACGF		Metro Auckland Clinical Governance Forum
MELAA	-	Asian & Middle Eastern Latin American and African
MMR	-	Mumps, Measles and Rubella
MoH		Ministry of Health
MRRC	-	Mangere Refugee Resettlement Centre
MSD	-	Ministry of Social Development
NAHH		Noho Āhuru – Healthy Homes

NCHIP	-	National Child Health Information Platform
NCSP	-	National Cervical Screening Programme
NGO	-	Non-Governmental Organisation
NHI	-	National Health Index
NIR	-	National Immunisation Register
NRHCC	-	Northern Region Health Coordination Centre
OIS	-	Outreach Immunisation Service
PCV	-	Pneumococcal Vaccine
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
PPE		Personal Protective Equipment
SMILE	-	Smoke and Alcohol Free, Mental wellbeing Matters, Immunise, Lie on Your Side and Eat Healthily
SPPGG		Suicide Prevention and Postvention Governance Group
UR-CHCC	-	Uri Ririki - Child Health Connection Centre
WCTO	-	Well Child Tamariki Ora

1. Purpose

This report updates the Waitematā DHB's Community and Public Health Advisory Committee (CPHAC) on Planning and Funding and Outcomes (PFO) activities and areas of priority.

2. Planning

2.1 Annual Plans

The final draft of the 2020/21 Annual Plan was submitted to the Ministry of Health (MoH) on 18 August 2020. To date, no further feedback has been received. However, the MoH have indicated that they do not have a final estimate for when the plan will be approved and that the Ministry is still in discussion with the DHB.

As per the modification to the Crown Entities Act (149CA), Waitematā DHB published a final, signed 2020/21 Statement of Performance Expectations (including the financial position at that time) to the DHB's website on 14 August 2020 (final due date was 15 August). Notice to take up this extension, in line with the modification to the legislation, was also published to the DHB's website, and will also be published in the 2019/20 Annual Report, as required.

2.2 2019/20 Annual Reports

The 2019/20 audit continues and we have been working with the auditors to complete requirements. As per our prior agreement with Audit New Zealand, the MoH and the Chair, the Annual Report will be a 'scaled-down' version, due to COVID-19 response activities, which have impacted on service delivery. Many indicators have also been impacted and to ensure this is transparent, performance for the first three quarters of the year is presented separately for many indicators alongside quarter four performance. As per Audit NZ recommendations, we are including a whole section on the COVID-19 response work and impacts, including:

- Participation in the regional response to the COVID-19 pandemic through the Northern Region Health Coordination Centre (NRHCC), which included:
    - COVID-19 testing strategy and model of delivery

- responsibility for the entire health component of the Managed Isolation and Quarantine (MIQ) system in the Northern Region and the development of robust procedures to ensure the safety of workers, their families and our communities
- contingency planning for future outbreaks in ARC facilities
- Support for our employee's health, safety and wellbeing
- social welfare and cultural support services

- New services that were developed as part of the response work

The recently updated population estimates (from StatsNZ and the MoH) have also impacted some indicators and some targets have needed to be revised.

3. Primary Care

3.1 Response to COVID-19

The metro Auckland response continues to be supported by the primary care team, with staff working within both the DHB and the NRHCC.

Semi-permanent capacity for fixed site Community Testing Centres (CTCs) and mobile testing units was established prior to the August COVID-19 outbreak. This was designed to supplement the COVID-19 testing that is routinely available through general practices and urgent care clinics. In response to the surge outbreak, an additional 18 short term CTCs were established across metro Auckland, and over 70 'pop-up' clinics (ie operated one to three days duration) in a range of locations chosen for easy access.

Since the August COVID-19 outbreak (between 12 August 2020 and 8 October 2020), CTCs and mobile clinics have completed 160,000 swabs, while another 97,000 swabs were taken through general practice and urgent care clinics across metropolitan Auckland. The volume of tests completed since the August outbreak (between 12 August 2020 and 8 October 2020) accounts for around 50% of the total swabs taken since March this year.

Table 1. Proportion of tests taken at CTCs and mobile testing clinics by ethnicity (Source: e-notifications) between 12 August 2020 and 8 October 2020.

Māori	12%
Pacific	26%
European	36%
Asian	19%
MELAA*	2%
Other	5%

* Middle Eastern Latin American and African

Mobile Outreach Health clinics

During COVID-19 Alert Level 4, approximately 500 rough sleepers were accommodated in motel units ("managed accommodation") across metropolitan Auckland. Auckland and Waitematā DHBs successfully implemented mobile Outreach Health clinics to provide health services to those living in managed accommodation from 1 July 2020 to 30 September 2020. The services supported people not enrolled with a primary care provider and have untreated or unmet health need. 41% of these people are Māori and 15% are Pacific.

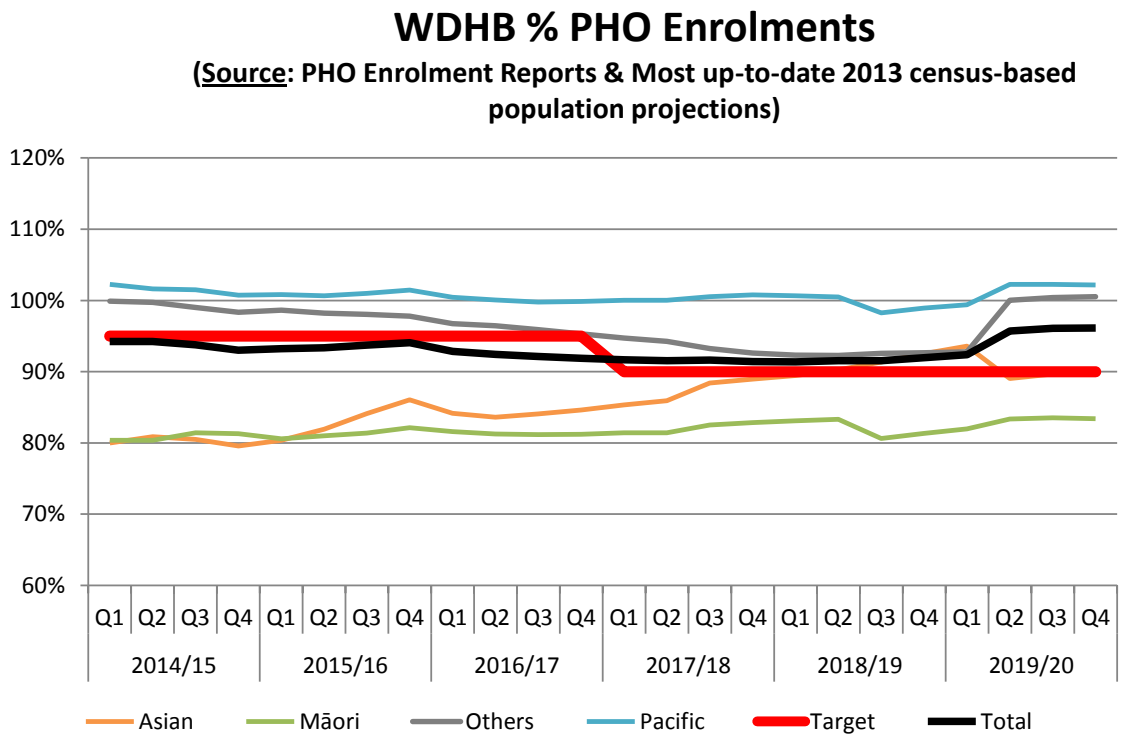
The mobile Outreach Health clinics are nurse-led and have access to general practitioners or nurse practitioners and social workers. Services include comprehensive health assessments, triaging, limited range of treatments and supply of medicines, screening/prevention activities and COVID-19 testing if required. The services are being extended for a further six months to 31 March 2021 to continue providing services to people in managed accommodation.

3.2 Diabetes

Due to the impact of COVID-19 on the Primary Health Organisation's (PHO) ability to release staff and for the programme Data Analyst supporting the NRHCC data for quarter four 2019/20 is not available. The most up to date MACGF diabetes and CVD clinical indicators data is from March 2020, which was reported at the August 2020 meeting. It is expected that an update on the PHOs and DHBs performance against the MACGF diabetes and CVD clinical indicators can be provided after November 2020.

3.3 PHO Enrolment

The most recent PHO enrolment data is provided below. The data has been impacted by the changes to population projections and to changing to the National Enrolment System.



Note: 2018/19 Q3 new data source (National Enrolment System) decreased numerator and new population projections for 2019 calendar year increased denominators across all ethnicities resulting in decreased enrolment %. 2019/20 Q2 2019 update of 2013 census population projections decreased population resulting in increased enrolment rates.

4. Health of Older People

4.1 Aged Residential Care

It is over five months since aged residential care (ARC) facilities were assessed by the DHB on their COVID-19 preparedness. It is now important that facilities maintain their vigilance even when the risk of community transmission is thought to be low. To this end, a five week programme has been developed focusing on key areas of COVID-19 preparedness for ARC; the sessions are facilitated through Zoom. Each week the same session is offered over a range of days and times (six sessions per week) providing options for ARC facilities to attend. The sessions provide a forum for information sharing, discussion and questions, and with a view to ensuring facilities feel supported. The five week programme covers the following topics:

- COVID-19 preparedness – roles and responsibilities
- Preventing introduction of infection into an ARC facility
- Preventing transmission of infection within an ARC facility
- Care Planning
- Business continuity.

As the programme is focused on maintaining COVID-19 preparedness in ARC facilities in the long term, the topics and frequency of sessions may change over time. A Steering Group across metro Auckland Planning and Funding teams has been set up to oversee the programme.

4.2 Home and Community Support Services

The national framework and service specification for Home and Community Support Services (HCSS) have been published. The approach is a restorative HCSS model using a casemix methodology to group people with similar levels of assessed needs together and enables services to be flexed up and down to respond to real time client needs. This is a significantly different model from the current fee for service, task based HCSS model in place at Waitematā DHB. The intention was that all DHBs would be required to transfer to the new model by 1 July 2022, but with the impact of COVID-19, it is likely that this timeframe will change.

5. Child, Youth and Women's Health – WDHB CPAHC Update October 2020

5.1 Immunisation

5.1.1 Childhood Immunisation Schedule Vaccinations

Provisional data for quarter 1 2020/21 indicates that at 92% coverage Waitematā DHB has not achieved the 95% target for the MoH's Immunisation focus area. There remains an unacceptable equity gap for tamariki Māori – with provisional coverage at 82% which is a decrease on coverage achieved last quarter and for the same quarter in the 2019/20 financial year. There has been an improvement for Pacific children, with a provisional 92%, an improvement from 87% last quarter.

As previously indicated, COVID-19 will have an impact on immunisation coverage, particularly in the first two quarters of this financial year. The PFO continues to monitor the impact on "on-time" immunisation. The most recent lockdown has seen on-time coverage stabilise at 80%, with the more "real-time" one-month rolling coverage dropping below 80% (although this is prone to fluctuation due to small numbers).

Tamariki Māori continue to be the most affected by the drop in on-time coverage and work with PHOs and Well Child Tamariki Ora (WCTO) colleagues on catch-up initiatives for these children is underway. There are discussions with the Māori Health Gain team on opportunities for the Māori Mobile health units to support childhood immunisations. Referrals to the Outreach Immunisation

Service (OIS) have also increased following the lock-down with around 1,300 active referrals currently sitting with the service.

WDHB Māori Immunisation Coverage (1 month rolling) as at	6m	8m	18m	24m
11/05/2020	53%	84%	67%	86%
08/06/2020 (L1)	43%	83%	63%	92%
06/07/2020	69%	87%	69%	84%
03/08/2020	60%	84%	69%	88%
31/08/2020	57%	81%	79%	82%
28/09/2020	56%	82%	62%	84%

From 1 October 2020, a new 12-month immunisation event was introduced, for the first dose of Measles, Mumps and Rubella (MMR) and a PCV vaccine. The 15-month event remains but will be three immunisations (Haemophillus influenzae b, Varicella and the second dose of MMR). The four years of age event will only be DTap-Polio. Auckland PHO led a PHO-DHB-IMAC webinar about the changes which was well received. The changes have been signalled to primary care through Medinz.

5.1.2 Measles

In February 2020, the MoH announced funding for a national measles campaign, with a focus on 15-30 year olds, particularly Māori and Pacific. The primary strategies for Waitematā DHB are increasing awareness of the need to be immunised and increasing access to the vaccine. The plan includes utilising the relationships with schools through the Enhanced School Based Health Service (as per the successful MMR catch up during the mumps outbreak), tertiary institutes, workplaces (alongside 'flu vaccination in 2021), sexual health and Family Planning clinics, community pharmacies and other community settings such as marae and Pacific churches.

The Ministry has confirmed the visual concept of the national communications suite for this programme, as below.

The PFO is developing a targeted communication strategy for the resource suite and expect it will include static media, social media (TradeMe), Dating aps, Spotify and radio advertising (Flava and Mai FM, including sponsored messages on their social media). The strategy will be informed by focus groups with rangatahi Māori and Pacific people aged 15-30, supported by the Māori Health Gains and Pacific Health Gains teams.

5.2 Uri Ririki – Child Health Connection Centre

The Uri Ririki - Child Health Connection Centre (UR-CHCC) is now established. UR-CHCC comprises teams of administrators tasked with management of the National Immunisation Register (NIR), National Child Health Information Platform (NCHIP) and Noho Āhuru – Healthy Homes (NAHH) (formerly called Kāinga Ora).

NCHIP enables the identification of children who have missed out on universal services, and work with child health providers to engage or re-engage with families. An equity focused methodology is applied by the coordination centre starting with babies in the first three months of life. A total of 72 Waitematā and Auckland babies previously missing from the NIR were identified via NCHIP and

linked in with GPs or outreach for immunisation follow up in Q4 2020. Pathways-to-care scoping work has started with WCTO providers, lead maternity carers and the newborn enrolment coordinator. NCHIP data is now actively being used to investigate which babies are missing their first WCTO core check (4-6 weeks). Following a data quality check, priority is given to Māori, Pacific or Q5 babies for direct whānau contact to link them with an appropriate WCTO provider of their choice.

As at 30 September 2020, Waitematā DHB received 1,431 referrals to NAHH. This included 5,545 family members getting access to healthier home interventions. Of the referrals received, 577 (40%) were for families with a newborn baby or hapu woman.

Referrals to the service did not slow as significantly over the second COVID- 19 Alert Level 3 lockdown and impact on assessment timeframes was limited. Planning for a summer student to support the completion of audit activities for the service is being undertaken. While the audit protocol is still under development, it will help identify opportunities to strengthen on-referral and support in a number of domains.

5.3 Well Child Tamariki Ora and B4 School Check

All providers resumed face to face WCTO services under COVID-19 Alert Level 1 and were focusing on catching up tamariki who missed core visits during lock down. The change to Alert Level 3 and then Alert Level 2 has again disrupted some services. Most contacts were provided by phone though some high-needs whānau still received face-to-face visits. Phone screening is undertaken before undertaking home visits. The Ministry advice was to prioritise core checks for those with high needs and the youngest babies.

Recent data shows that two providers never managed to catch up those tamariki that had missed their core checks during the lock downs. For the two quarters, data was unavailable from one provider . In quarter one (July – September) of 2019, the Waitematā DHB WCTO services delivered a total of 754 core checks compared to 458 for quarter one of 2020.

WCTO Core checks Q1 2019 and Q1 2020

	Asian	European	Māori	Pacific	Other	Unknown	Total
Q1 2019	16	95	461	124	1	57	754*
Q1 2020	5	77	268	59	4	45	458*

*There is missing data for one of the providers.

COVID-19 Alert levels have also impacted B4 School Check services. Unlike the WCTO checks for younger babies, a valid B4 School Check (B4SC) check requires all components to be completed, only some of which can be undertaken virtually (ie the B4SC wellbeing assessment and health education, developmental screening and the child health questionnaire). Priority for virtual B4SC was given to tamariki who are close to their 5th birthday, Māori, Pacific and Q5. In person contacts for B4SC (Oral health assessment (Lift the Lip) and growth assessment were arranged to resume during Alert Levels 2 and 1. The table below shows that the target was not achieved for Q1 2020. All providers have been asked to develop appropriate catch-up plans as the alert levels allow.

B4SC Comparison Waitematā DHB Q1 2019 and Q1 2020

Percentage of eligible population checked (target = 22.5% in Q1)	High deprivation	Māori coverage	Pacific coverage	Overall coverage
Q1 2019	20.6	20.2	18.9	22.8
Q1 2020	13.2	12.1	15.6	14.3

5.4 Rheumatic Fever

Work has commenced on the short-term/high impact initiatives in the Auckland and Waitematā DHB regions in support of managing Rheumatic Fever (RhF):

- Identification of culturally safe ways to increase referrals to the Healthy Homes initiative. A closed RFQ will be run shortly to recruit a kaupapa Māori researcher and Pacific researcher to use guidance from families to develop resources.
- Piloting of whānau support worker programme. The model of care is in development.
- Piloting dental health services for adults with Acute RhF / Rheumatic Heart Disease. Early costings are being developed for hospital based clinics and community based clinics.
- Finalisation, evaluation and release of 'fight the fever' mobile app. The app has been launched and young people on monthly bicillin injections are now being recruited to the evaluation.

The project manager is reviewing opportunities for increasing awareness, which may include schools and pharmacy settings. Work is underway to establish a nursing service which will partner with the social workers in NAHH, to undertake whānau health and well-being assessment, identify unmet health needs and facilitate whānau engagement with acceptable health services. A service specification is in development.

5.5 Oral Health

5.5.1 Child Oral Health

The Auckland Regional Dental Service (ARDS) is the provider of universal oral health services for pre-school and school age children across metropolitan Auckland. There are approximately 280,000 children enrolled with the service. Services are delivered from 83 clinics, which are primarily located in schools. The majority of children are seen while they are at school, without a parent or caregiver present.

The onset of COVID-19 has had a significant and enduring impact on the delivery of services. During COVID-19 alert levels 4 and 3, all oral health providers were directed by the MoH and Dental Council of New Zealand (DCNZ) to postpone all routine dental treatment. Therefore, ARDS was only able to provide urgent and emergency dental care to children, once the child's condition had been assessed by a dental clinician over the phone. Schools were also closed over the lockdown periods.

Timeliness (Arrears)

Well over half the children engaged in the service are now overdue dental services. The table below outlines the percentage of children for whom their dental check is overdue (in arrears) by ethnicity and DHB of domicile as of 31 August 2020.

DHB	Māori	Pacific	Asian	Other	Total
Auckland	59%	61%	54%	54%	56%
Counties Manukau	64%	65%	58%	59%	62%
Waitematā	60%	62%	57%	57%	58%
Not yet allocated*	69%	69%	62%	57%	62%
ARDS Total	**62%**	**64%**	**57%**	**57%**	**59%**

*There are about 7,000 children who do not have a DHB of domicile recorded and ARDS is manually reviewing their records to ensure they have an allocated DHB of domicile by end of 2020.

The current level of arrears has been significantly impacted by the COVID-19 lockdown periods. With the move to Alert Levels 2.5, 2 and 1 the service has recommenced the provision of routine appointments, however there are on-going Dental Council requirements that continue impacting service productivity and access (pre-screening of all children prior to their appointment). Given these

requirements are on-going, it is anticipated that arrears will further deteriorate over the coming months.

Children under 2 years of age
Only 13%of children aged under 2 years have been seen by ARDS. The table below shows the percentage of children, by ethnicity, who are under 2 years and have attended an appointment with the service.

DHB	Māori	Pacific	Asian	Other	Total
Auckland	13%	14%	17%	18%	17%
Counties Manukau	7%	9%	14%	12%	11%
Waitematā	10%	8%	13%	13%	12%
Not yet allocated	7%	14%	29%	23%	20%
ARDS Total	9%	10%	14%	14%	13%

The majority of enrolled children who are under 2 years have not been seen by the service. However, there has been an increase of 2% of children 'seen' over the past month. This is due to the implementation of the Telehealth Oral Health Promotion Pēpi programme, a new initiative where a therapist telephones whānau and offers a virtual appointment. During the appointment the therapist introduces the service, ensures that the child's correct contact details are recorded, delivers key oral health messages and talks with whānau about any concerns they may have about their child's teeth.

The provision of telehealth was prioritised during August (while clinics were closed) and the service delivered approximately 2,000 appointments. The service found it more challenging to contact Māori and Pacific whānau. Strategies to address this are currently being explored, using the Centralised Booking Team to ensure an equitable access for these pēpi.

School Year 8 children
Only a quarter of Year 8 children have been seen during 2020. The table below details the percentage of school year 8 students, by ethnicity, seen by the service as at 31 August 2020.

DHB	Māori	Pacific	Asian	Other	Total
Auckland	25%	28%	27%	22%	25%
Counties Manukau	24%	26%	29%	29%	27%
Waitematā	21%	21%	22%	20%	21%
Not yet allocated	30%	26%	37%	17%	25%
ARDS Total	**23%**	**26%**	**26%**	**23%**	**24%**

The plan to examine all school year 8 students by mid-2020 has been significantly impacted by COVID-19. At present, given the level of disruption across the service and the current number of children overdue their appointment, prioritisation is based on clinical need rather than age alone. Given this, discussions are underway between ARDS and the Auckland, Waitematā and Counties Manukau funders to identify alternative service provision options for these children who will be leaving ARDS at the end of this calendar year.

5.5.2 Adolescent Oral Health

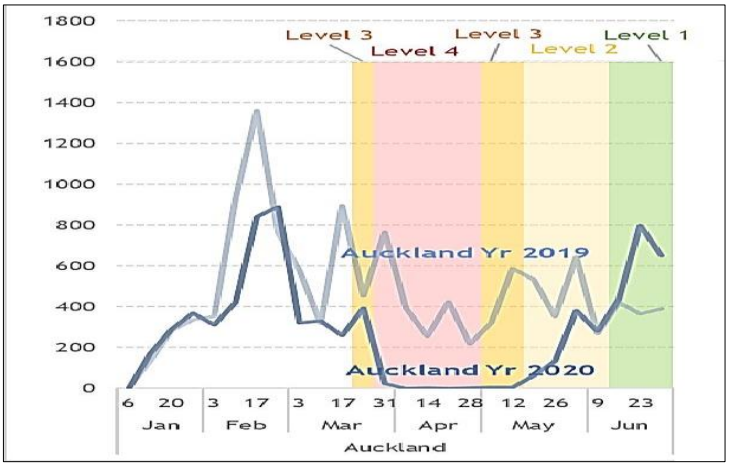
Oral Health Services for Adolescents are provided by private oral health providers (dentists) that have a contract, known as the Combined Dental Agreement (CDA), with DHBs. There are 321 dental providers across three metro Auckland DHBs - ADHB 104, CMH 92 and WDHB 125.

The onset of COVID-19 has also had a significant and enduring impact on the delivery of adolescent oral health service. During COVID-19 Alert Levels 4 and 3, all oral health providers were directed by

the MoH and DCNZ to postpone all routine dental treatment. Dental providers were only able to provide urgent and emergency dental care to all age groups including adolescents.

Between January and June 2020, based on MoH interim claims data for DHB of contract, about 4,855 adolescents have accessed funded dental care in Auckland DHB. This is around 20% of the adolescent population eligible for funded dental care in Auckland. As some dental claims are made a few months after completion of treatment, the number of adolescents utilising the service may increase slightly. Based on current claims data, the projected utilisation for adolescents' dental service for 2020 is expected to be somewhere between 40 to 50%. The yearly utilisation target set by MoH for adolescents oral health service is 85%.

The below graph shows weekly claims volume for ADHB: Jan-Jun 2019 vs. Jan-Jun 2020.



5.6 Youth Health - Enhanced School Based Health Services

The Enhanced School Based Health Services (ESBHS) programme offers youth friendly, confidential, and easy to access health services – the nurse is available at school every day, supported by a visiting general practitioner. About 9,330 secondary school students have improved access to primary healthcare in Waitematā DHB through the ESBHS programme.

5.7 Contraception

Service agreements are now in place across a network of community locations as well as and Auckland Regional Sexual Health Clinics. Uptake of the service in primary care and NGO services shows a marked improvement in the last quarter.

The MoH has commissioned the preparation of National Contraception Guidelines, these have now been shared to professional colleges for endorsement. Once the guidelines are complete, a training package will be released by Family Planning Association. This training, which has been commissioned by MOH, will provide some free training for health practitioners to access Long Acting Reversible Contraception (LARC) training. Training has been a gap to date and remains an issue in achieving a robust network of providers who can offer all types of contraceptive options. We are working with Family Planning to confirm the offering for our DHB and prioritise recipients of training as well as work towards a sustainable training programme going forward.

5.8 Fertility

Fertility services are seeing patients as per usual with a process in place to address both delays and disadvantages that may have been experienced due to COVID-19 closures. Catch up in response to

the immediate delays and cancellations associated with the COVID-19 Alert Level 4 disruption have been completed. Demand outstrips capacity in this service and work is ongoing to address this.

5.9 Cervical Screening

Cervical Screening coverage for WDHB remains in significantly below the coverage target 80%. The coverage rate is more concerning amongst Māori for whom coverage is 59% and total population 69%. Cervical Screening coverage has been declining over the past three years nationally and locally. The recent COVID-19 restrictions had a significant impact on completion of cervical screens which are largely provided in primary care. Of greatest concern however are the women who have never been screened, or have not been screened for five years or more. The National Screening Unit is moving toward implementation of the HPV Primary Screening Programme, which offers some significant advantages for improving equity and coverage. One of these is the implementation of HPV self-testing which the National Screening Unit (NSU) have recently confirmed will be included in the HPV Primary Screening Programme. An implementation timeline remains unclear however it is now assumed that the previously published 2021 implementation date is not achievable. Funding for a new NCSP register is a dependency.

There remains significant interest in HPV self-testing to address the ongoing inequity in both cervical screening coverage and cervical cancer outcomes. Several research proposals are in development nationally which consider aspects of HPV self-testing implementation in anticipation of informing the national programme in due course.

A number of guidelines changes have been implemented, some of which came into effect during the April-May COVID-19 Alert Level lockdown period. We have worked to update the Health Pathways guidance to reflect these and this is going live in October.

A Cervical Screening update was held on 2 September. This was the first time the update has been virtual, (hosted via Zoom) with a recording made for use as an e-learning on Ko Awatea. The update and the e-learning can be accessed for free by primary care practitioners or others interested in cervical screening. Over 50 people attended the virtual update and over 100 have watched online subsequently. The update included an explanation of HPV self-testing research, the recent guidelines changes and the evidence supporting them and a number of practice points. The update was received very positively.

5.10 Breast screening

Breast screening coverage for Waitematā DHB is not currently reaching the coverage target of 70% and is currently around 66%. Coverage of Māori women has been consistently below the target and is currently 60%. Pacific women's coverage has been over the 70% target until the most recent coverage reporting in June 2020. Coverage has been impacted by COVID restrictions, there has been a significant step down in coverage in the most recent period.

6. Mental Health and Addictions

6.1 Opening of the New Kaupapa Māori Community Forensic Step-Down House:

Waitematā DHB provides the Regional Forensic Psychiatry Service for the Northern Region. A component of the forensic service is the provision of 20 step down rehabilitation beds in the community, contracted by the Funder with Non-Government Organisations. These services comprise a mainstream service, a Pacific service and a Kaupapa Māori service. The Regional Forensic Community team based at the Mason clinic access manage these services for people leaving the Mason Clinic and the team provide the community clinical follow-up for this group of people.

The Waitematā DHB endorsed a recommendation in 2017, that the contract for provision of five Kaupapa Māori forensic step down beds be exited, due to on-going concerns about the quality and safety of that service. PFO conducted an open competitive process for the replacement of these beds. The contract was awarded to Kāhui Tū Kaha , and the service became operational in September 2020. A mini launch was held in the first week of September with numbers limited to ten due to COVID-19 restrictions, with three Kaumatua and two Kaikaranga, Mason Clinic Clinical Director, Forensic Community Team Manager and the CEO of Kāhui Tū Kaha. Subsequently, there was a tour for a small group of Mason clinic staff together with the Kāhui Tū Kaha Service Manager. This was followed by a tour for tangata whaiora, who were brought into the house gradually over the week.

The service is named Te Kotiu and is currently located in Pt. Chevalier. In the longer term, the provider intends to purchase a suitable piece of land and purpose build a house. The name Te Kotiu is not limited to the current house and so will transfer to the new building.

6.2 Suicide Prevention

The review process for the Suicide Prevention and Postvention Action Plan 2020/2023 has been completed and agreed by the Suicide Prevention and Postvention Governance Group (SPPGG). The action plan will be presented to members of Waitematā CPHAC at the next meeting.

In late August, the chief coroner Judge Deborah Marshall released the annual provisional suicide data, which showed the provisional suicide rate is at its lowest in three years. In the year to 30 June 2020, 654 people died by suicide, compared to 685 the year before – a decrease of 31 deaths, and a drop in the suicide rate from 13.93 deaths per 100,000 to 13.01 nationally. In the Waitematā district, the number of deaths from suicide decreased from 87 in the previous financial year (2018/19) to 54 for 2019/20 financial year.

As part of the national Suicide Prevention Action Plan 2019-2024, the MoH have funded a role for a Whānau Support Coordinator for those bereaved by suicide for an 18-month period. The purpose of the role is to facilitate recovery / healing for whānau and prevent adverse health outcomes for those bereaved by suicide. The appointment for this position has been completed and there are plans underway, to develop support services for whānau bereaved by suicide, once the staff member has started their employment.

7. Pacific Health Gain

7.1 MMR Vaccination plan

Plan is underway for Pacific focus groups to be held in the next two weeks. Two pacific focus groups will be conducted, one for age group 18-24 years and for age group 25-30 years. A meeting was held with Sister's United who are happy to partner, support and champion the messages of the MMR Campaign to the target audience with particular focus on Māori and Pacific 15-30 years. The Pacific Health Gain Team is supporting by coordinating the focus groups and connecting with pacific providers.

7.2 Pacific Regional response to COVID-19 Mobile service

The Pacific team has continued to work collaboratively with Primary care, Pacific providers, Pacific church and community leaders to increase COVID-19 testing amongst Pacific communities. Considerable work and effort has been invested in setting up a number of pop up mobile testing units across many Auckland communities. The change from Alert Level 2 to Level 1 has resulted in a reduction in the number of people seeking a COVID-19 tests, however, ensuring Pacific communities

continue to have opportunities to access testing has remained and the team has continued to ensure mobiles are available in the community.

Work is underway to plan for possible future outbreaks in collaboration with various NRHCC teams.

7.3 Pacific mobile service

The Pacific mobile service run by The Fono Health and Social Services is supporting Pacific populations in the Waitematā DHB region. The service is providing focused mobile capacity to ensure any COVID-19 cases are rapidly identified and managed appropriately to reduce the risk of community transmission. It is also providing surveillance swabbing if requested by the DHB, primary care assessment and care and social service support as needed.

Monthly meetings are in place for DHB and The Fono to share learnings, feedback and agree on way forward in reaching targeted populations.

8. Māori Heath Gain

8.1 COVID-19 specific responses and service

The Māori Health Gain Team has supported the Māori Response to COVID-19 Programme (the Programme). This Programme is broken down into five key areas that cover immediate responses to longer term system redesign. The five *pou* are:

1. Leadership and oversight
2. Engagement and communication
3. Māori health services (existing and redeployment)
4. Protecting Māori whānau and communities (testing strategy)
5. Welfare and wellbeing (welfare response and Pae Ora public health response)

Overall, the Māori health response focused on three key programmes of work. The first was communication and engagement. As reported at our last CPHAC meeting, the communication strategy employed by the Māori team within the NRHCC centred on social media engagement through DHB sites and was mirrored on our partners' sites. The Whānau Guide to COVID-19, a show hosted by Māori that asked questions of health experts posted on DHB and Māori TV Facebook pages, received over 25,000 unique views this time around. This ensured that whānau had access to up to date information about COVID-19 and the local/regional health system response.

Second, the Māori team focused on implementing a COVID-19 testing response that ensured Māori had access to testing sites. This included the CTC at Whānau House and a number of Māori-led mobile testing stations set up around metro-Auckland where coverage was low. The use of Māori-led mobile units also ensured that targeted sub cluster testing was able to be carried out as required. A paper is being supported through the NRHCC for executives to maintain these mobile units between community outbreaks of COVID-19 to ensure a trained workforce is available when required. Between outbreaks, these teams will support recovery efforts to clear backlogs of patients needing, for example, child immunisations that drop significantly during lock downs.

The final programme of work consisted of welfare support for whānau who were self-isolating in their homes as close or casual contacts. The Auckland Regional Public Health Service (ARPHS) teams identified whānau needs through their regular contact with them. These needs were referred into the Māori team and care was coordinated from that point. This included access to food parcels while whānau were confined to their homes, or care for their pets, for example, when they were moved

into managed facilities. Partnerships with whānau ora providers and other community providers were vital for this programme of work.

A permanent Māori team within the NRHCC is being established, as well as a Māori public health team (Pae Ora Team) within ARPHS. Both of these teams will support preparedness planning for the Māori health sector and lead future Māori health responses to COVID-19 outbreaks.

Kaimanaaki programme
In the midst of our region's COVID-19 response, the NRHCC supported the implementation of Ngā Kaimanaaki services (non-clinical welfare and care navigation support services) across the Northern Region. In phase 1 of this programme, five lead providers were identified to support whānau in Auckland and Waitematā DHBs' catchment areas – Orakei Health Services, Kotuku ki te Rangi (a kaupapa Māori mental health provider), Ngāti Whātua, Te Whānau o Waipareira and Piritahi Hauora (on Waiheke Island). In phase 2, we supported the northern iwi collective, Te Kahu o Taonui, to roll out the Kaimanaaki programme amongst their providers and services.

In the first wave of the outbreak, Māori community responses were successful in reaching vulnerable whānau across metro Auckland and Northland. Kaimanaaki in Waitematā DHB engaged over 3,784 whānau as a part of larger whānau ora response teams. They delivered a total of 4,196 food packs, and completed 1,904 wellness plans and check-ups with whānau that will be used to coordinate their care on an on-going basis.

Te Kahu o Taonui, the northern iwi collective who led the northern iwi response, has had similar success in engaging high numbers of whānau. Their programme, which is funded through several sources as well as health, is designed to get essential resources to isolated communities. Since 1 June, they have delivered over 27,919 food parcels and hygiene packs to over 25,553 homes primarily across Northland and to some whānau in metro Auckland. Their funding comprised the following components:

- Funding to set up an Iwi Coordination centre and hub. This centre houses response teams, a call centre, logistics support teams who oversee 4 distribution centres, housing support programmes, data support and analytics, training support and their leadership team to coordinate this response on behalf of the eleven northern iwi groups.
- Over 90 FTE for Iwi Kaimanaaki roles throughout Te Tai Tokerau. To date, Iwi Kaimanaaki have completed 5,128 wellbeing assessments with 5,002 whānau (86% Māori). They also provided 243 whānau transports to appointments/medication deliveries.
- A Whānau Support Fund for immediate financial assistance to purchase essential items for vulnerable whānau.
    - 491 winter warmth packs were given to whānau
    - 40 basic clothing packs were provided
    - 32 tanks were filled
    - 98m3 of firewood was provided
    - 59 whānau were accommodated in temporary housing units/motels
    - 62 whānau were accommodated in mobile homes

In addition to this data, multiple referrals were made to health and social support services across Northland and Auckland. The Kaimanaaki were non-clinical roles, and comprised largely whānau members from within high needs communities. With the support of clinical leaders from iwi health providers, they carried out brief wellbeing assessments in their own communities. Any immediate wellbeing needs were addressed through the programme (including access to food, water and items for their home), while escalation policies allowed for longer term needs to be referred on to the appropriate healthcare or social support provider.

Māori mobile units

Three Māori mobile units started delivering care to whānau in high needs communities during July and August. These services are focused on flu vaccinations for eligible Māori in homes, or other community settings via pop-up clinics. They are also designed to offer additional complimentary care while in homes through nurses, social workers and mental health clinicians. Also supporting these units are PHO based coordination centres that are referring Māori patients into these units.

The recent COVID-19 Alert Level 3 lock down has significantly impacted this project just as it began in July. During the lock down period, many of these mobile units were re-deployed to COVID-19 testing. Some early data captured prior to lock down has shown that 54 flu vaccinations were completed in July by these units. However, these completed vaccinations represent a small number of contacts and home visits that were carried out by the Māori mobile units. For example, Orakei Health Services found that only 13% of home visits, although pre-booked, actually resulted in a flu vaccination. Despite this low rate of flu vaccination uptake, they were able to complete a range of other primary healthcare for whānau including medication checks, health education, screens and assessments.

This programme of work is on-going and the end date of October has been extended to account for the time lost during the redeployment of these services to COVID-19 testing.

8.2 Māori Pipeline Projects

A summary of recent Māori Health Pipeline activity is below:

- Lung cancer screening – the inaugural Consumer Advisory Group met in mid-October, comprised of participants from the earlier focus groups and surveys, their whānau, and DHB kaumatua. The group has agreed to walk alongside the project team to develop the programme to ensure benefit for Māori, initially focusing on the communications materials and invitation pathways. A communication approach is underdevelopment. A readiness assessment process with hospital services is being established to map potential impacts on the range of hospital services and to develop the processes models of care to support screening. A screening pilot is planned to begin early in 2021. Further funding grants are under development.
- Alternative community cardiac rehabilitation model – work on the business case remains on hold as staff were deployed in the COVID-19 response.
- Alternative community pulmonary rehabilitation model – on hold over COVID-19, work is underway to establish a group with kapa haka and pulmonary rehab expertise in anticipation of the restarting of the programme.
- Northern region breast screening datamatch (‘500 Māori women campaign’) – this project is now complete and the results are being developed into a report.
- Māori provider and PHO datamatch – due to COVID-19 not all providers were able to contribute data. Counties Manukau DHB providers did not contribute any data. For those providers who did contribute there was sufficient evidence of whānau engaged with a Maori provider but not enrolled in a PHO to warrant proceeding to Phase 2. The Steering Group recommended re-offering to those ADHB and WDHB providers with missing data to see whether a complete dataset could be confirmed, and to take the findings to the Māori provider forum to discuss the next steps.
- Facilitated PHO enrolment – on hold with the second COVID-19 outbreak.
- High grade cervical screening project – a progress report has been developed and will be presented to the steering group with a proposal to change the direction of the project to incorporate it into a larger HPV self-testing proposal.

The Māori Health Pipeline of work is currently being reviewed, proposals for consideration will be presented to Kōtui Hauora (Iwi-DHB Partnership Board).

9. Asian, Migrant and Former Refugee Health Gain

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

The Asian, new migrant, former refugee and current asylum seeker health plan 2020-2023 (and Annex 1 –summary infographic) is included in this agenda.

The Asian, new migrant and former refugee health gain team have contributed significant resource to provide culturally appropriate support in the COVID-19 Outbreak#2 response for the Botany Cluster, and South Asian welfare cases on behalf of the NRHCC, as well as Communications to CALD communities.

9.2 Increase access and utilisation to Health Services

Indicators:

- Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 90% by 30 June, 2021

The Waitematā DHB, Asian PHO enrolment rate for Quarter 3 2020 remains at 90%. There were 1,709 new enrolees between Quarter 2 and Quarter 3, 2020.

A suite of activities have been rolled out to increase awareness and access to health services including:

1. English NZ Health and Disability System video aimed at new migrants, former refugees and international students has been refreshed with subtitles added, https://vimeo.com/158429915
2. Mandarin video version in process of being refreshed
3. Korean (with support of Waitematā's Asian Health Services) and Arabic language videos are in the process of development.

The team are coordinating the Metro Auckland Interpreting and Translation Service Steering Group to oversee regional planning and coordinate management of the RFP application (Phase 2 of the national Language Assistance Services Programme (LAS)) to bid as a supplier of Face to Face Interpreting services for health and non-health specialities in the metro Auckland region.

9.3 Indicator: Increase opportunities for participation of eligible former refugees enrolled in participating general practices as part of the *'Improving access to general practice services for former refugees and current asylum seekers' agreement'* (formerly known as Former Refugee Primary Care Wrap Around Service funding)

A *Former Refugee & Asylum Seeker Health & Wellbeing* Zoom webinar ran on 8 September with over 30 people attending virtually on the topic 'Response and reflections of COVID-19 in accessing and utilising primary health services'.

An interim UNHCR Emergency Cases - Metro Auckland Community General Practice Model has been developed (in the absence of a primary care service at Mangere Refugee Resettlement Centre (MRRC)) in partnership with MBIE's Refugee Health Liaison Team and MoH. The intention is to support the emergency case families access the DHBs' *Improving access to general practice services for former refugees and current asylum seekers' agreement'* funding to support their primary care needs.

5.1 Oral Health in the Auckland Region

Recommendation:

That the Community and Public Health Advisory Committee:

a) **Notes that oral health is a vital component of general health and there are persistent inequities for Pacific and Māori children.**
b) **Notes that some good progress had been made against the equity focused 2017 Preschool Oral Health Action Plan, but gains have been lost due to COVID-19 outbreaks and ongoing requirements placed by the Dental Council of New Zealand.**
c) **Notes that there are significant delays in time to treatment for hospital-based (secondary) dental care which has led this to be identified as a vulnerable service in the regional services plan.**
d) **Notes that Waitematā DHB has allocated $821k of the Ministry of Health Planned Care COVID-19 catch up activity funding to fund additional secondary dental capacity to address these delays in c) above.**
e) **Notes the need for urgent, additional targeted approaches to improve access to oral health services for Māori and Pacific children and adolescents. Further work needs to be undertaken, cognisant of the ongoing risk of COVID-19 and Dental Council of New Zealand requirements and is currently being considered within the Regional Vulnerable Services Framework.**

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Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

ARDS	-	Auckland Regional Dental Service
ARHSD	-	Auckland Regional Hospital and Specialist Dentistry
CDA	-	Combined Dental Agreement
CMH	-	Counties Manukau Health
DCNZ	-	Dental Council of New Zealand
DHB	-	District Health Board
dmft	-	decayed, missing or filled teeth (a measure of severity of dental disease) in deciduous teeth
DMFT	-	Decayed, Missing or Filled Teeth in permanent teeth
ECE	-	Early Childhood Education Centre
EDS	-	Emergency Dental Service
FSA	-	First Specialist Appointment
GA	-	General Anaesthesia
HSD	-	Auckland Regional Hospital and Specialist Dentistry
MoH	-	Ministry of Health
WCTO	-	Well Child Tamariki Ora

1. Executive Summary

This information paper describes the current state of oral health and funded dental services for children, adolescents and adults. There are significant and persisting inequities in access and outcomes most noticeably for Pacific children and for Māori tamariki. Effects are enduring and life-long. While gains were being made in oral health following the development of the 2017 Oral Health Action Plan and service improvement initiatives at the Auckland Regional Dental Service (ARDS), the impact of COVID-19 and the new ongoing requirements of the Dental Council of New Zealand (DCNZ) on the delivery of dental services has substantially impacted the sector, reversed many of these gains and set services back to concerning levels.

Auckland Regional Dental Service (ARDS) had implemented a number of equity focused strategies over the last few years to address known issues, however, the onset of COVID-19 has had a significant and will have an enduring impact on the delivery of oral health service. There is also currently an urgent need to address the large number of children awaiting dental treatment at the Auckland DHB-led Hospital and Specialist Dental service. Planned Care COVID-19 catch up activity funding has been applied to purchasing additional capacity to address these unacceptable waits by June 30, 2021.

Good oral health is everyone's business, not just that of dental services. Achieving better oral health outcomes requires a concerted effort at the environmental and policy level (eg. Fluoridation of water; poverty) and across health provider groups from health promoters, primary care, and primary and secondary dental services. Services had been taking steps to improve oral health overall, and address longstanding inequities in oral health, however, the situation is now urgent. In light of the ongoing COVID-19 risk and restrictions placed by the DCNZ, there is a need for urgent, additional, targeted approaches to improve access to oral health services particularly for Māori and Pacific children. The inclusion of the Auckland Regional School Dental Services within the Regional Vulnerable Services framework is currently being considered, in addition to what sources of funding are available to be applied to this. The Committee will be provided regular updates as this works is progressed.

2. Introduction

Good oral health is vital to general health and wellbeing across all ages. Poor oral health affects general health by causing considerable pain and suffering, limiting what people can eat, and affecting overall quality of life and well-being. There is also a growing body of evidence linking poor oral health to specific medical conditions, including heart disease, diabetes, and pre-term and low birth-weight babies. Poor oral health can be particularly devastating for children, significantly affecting their physical, psychological and social development. Dental decay in infants and children can lead to pain and infection in teeth and gums, poor nutrition, difficulty sleeping, speech impairments and delayed language development, and low self-esteem and confidence.

Dental caries is one of the most prevalent health issues that affect both children and adults in New Zealand. There are marked ethnic inequities in the oral health of children in the Auckland region. Māori children, Pacific children and those living in most deprived areas have significantly higher levels of dental caries. Treatment alone cannot achieve good oral health in the long term. Adoption of preventive practices and early interventions are necessary from a young age to achieve good oral health over the course of life.

Oral health is a complex issue that reflects the impacts associated with the social determinants of health, with marked inequities in outcomes seen across all age group. These are most marked for Pacific peoples and for Māori. To address these known and longstanding inequities the Preschool Oral Health Action Plan was developed in 2017, focused on prevention, promotion and intervening early. The main service provider, the Auckland Regional Dental Service (ARDS), also undertook a significant change programme. Unfortunately, what progress had been made has been largely reversed by the impact on services of COVID-19 lockdowns and service disruptions. There are now serious delivery issues which are outside of the service's control.

The Auckland Regional Hospital and Specialist Dentistry (HSD) provides secondary and tertiary (inpatient services) oral health care services to the metro Auckland region. Work is being progressed to reduce the significant wait to treatment time, under the auspices of the vulnerable services programme. In 20/21, Waitematā DHB plans to invest $821k of the Ministry of Health Planned Care COVID-19 catch up activity funding to fund additional secondary dental capacity to address these delays.

Private dental providers in the community who hold a contract, (the Combined Dental Agreement (CDA)), with the DHB, provide oral Health Services for Adolescents. In 2019 Waitematā DHB coverage for adolescents was 71%. There is also a significant disparity in dental coverage for Māori teenagers with only 54% coverage for the same time period. In 2020, estimates are that, in total, less than half of the adolescents will be seen by a dentist and even lower numbers of Māori rangatahi will be seen.

Emergency dental services required for the immediate relief of pain and infections are provided for low-income adults aged 18 years and older who hold a valid community services card. Untreated infections can result in hospital admissions for sepsis and may contribute to heart disease and other medical conditions. Treatment is restricted to the current problem and does not include any preventative or maintenance treatment. Treatment under this service commonly comprises dental extractions and provision of painkillers and antibiotics. Patients are also required to pay a $40 co-pay.

Dental disease is one of the leading causes of potentially preventable admissions to hospital for young children, as well as a significant source of inequity for Māori and Pacific populations. These admissions also come at a significant cost. In the 2019/20 financial year, 1,609 children under the age of 15 years received dental extraction or restoration under general anaesthesia (GA) in metro Auckland.

3. Oral Health Outcomes

A number of health outcomes are highlighted below, with a full description provided in Appendix 1. All oral health services have been significantly disrupted throughout 2020. Consequently, the available outcome data from 2019 can be expected to show a very much more positive picture than will be seen in the 2020 data. Based on the 2019 data, there are access issues across all oral health services, and persistent inequity. This is demonstrated across all age groups. While oral health is not solely influenced by access to oral healthcare, low access contributes to the poor outcomes seen.

3.1. Children under 2 years of age – 2020 data

Only 12% of Waitematā DHB children aged under two years have been seen by ARDS this year, including through virtual consultations. The table below shows the percentage of children, by ethnicity, who are under two years of age and have attended an appointment with the service.

DHB	Māori	Pacific	Asian	Other	Total
Auckland	13%	14%	17%	18%	17%
Counties Manukau	7%	9%	14%	12%	11%
Waitematā	10%	8%	13%	13%	12%
Not yet allocated	7%	14%	29%	23%	20%
ARDS Total	9%	10%	14%	14%	13%

The preventative strategy, applying fluoride varnish as measured at 2 years of age, shows very low uptake with only 2.2% of those *attending* in Waitematā DHB receiving fluoride varnish according to ARDS records, resulting in only 0.49% of Waitematā DHB children in 2020.

Ethnicity	Auckland DHB 2020			Waitematā DHB 2020		
	Of the population	***Of those enrolled***	***Of those who have attended***	***Of the population***	***Of those enrolled***	***Of those who have attended***
Māori	2.71%	3.80%	15.10%	0.49%	0.70%	3.30%
Pacific	4.90%	5.40%	18.50%	0.83%	0.90%	5.10%
Total ARDS	2.95%	3.60%	10.70%	0.49%	0.50%	2.20%

3.2. Children aged 5 – 12 years – 2019 data

Oral health status for children is measured at age 5 years through two outcomes:

(i) Caries-free rates measures the proportion of children with no evidence of dental decay (higher caries-free rates are better).

(ii) Mean number of decayed, missing or filled teeth (dmft) measures the severity of disease (lower mean dmft is better).

In 2019, the Auckland Regional Dental Service (ARDS):

- Examined approximately 53% (11,554) of 5-year-old children. Among those 5-year-old children examined by ARDS:
  - 57% of Māori and 70% of Pacific children have dental decay, compared to 38% of non-Māori non-Pacific children.
  - Māori and Pacific children have more severe dental disease at examination, with an average of 2.6 to 3.7 decayed, missing or filled teeth by the age of five, compared to 1.6 for non-Māori non-Pacific children.
- These inequities are still evident at school Year 8. ARDS examined 71% (15,073) of School Year 8 (ages 12 – 13) children. Among those Year 8 students examined by ARDS:
  - 39% of Māori and 45% Pacific children had dental decay in their teeth at examination, compared to 27% of non-Māori non-Pacific children.

These statistics are likely to underestimate the true prevalence of dental disease and the extent of inequities in our population, as they do not include children not examined by ARDS.

Other access and outcome disparities seen in the 2019 data include:

- Caries-free rates at age five has not changed significantly since 2010, though it appears that there was a decline in the number of children who were caries-free among Pacific and Other ethnic group in 2019. There appears to be a slight increase in caries-free rates for Māori children at age five (Figure 1).
- The rates of dmft appear to show an increase in severity of dental disease among Pacific and for Other ethnic groups, but some improvements for Māori children (figure 2).

- Dental admission rates for children aged 0-4 years are highest in Pacific children with the childhood dental admission rate for Pacific increasing in 2019. Dental admission rates for Māori children are higher than for other children.

Figure 1: Caries-free rates at age five for the Auckland Region, by ethnicity

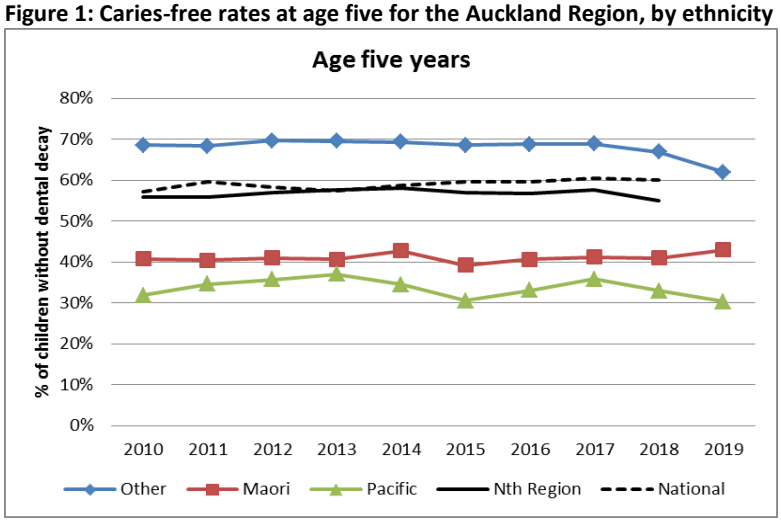
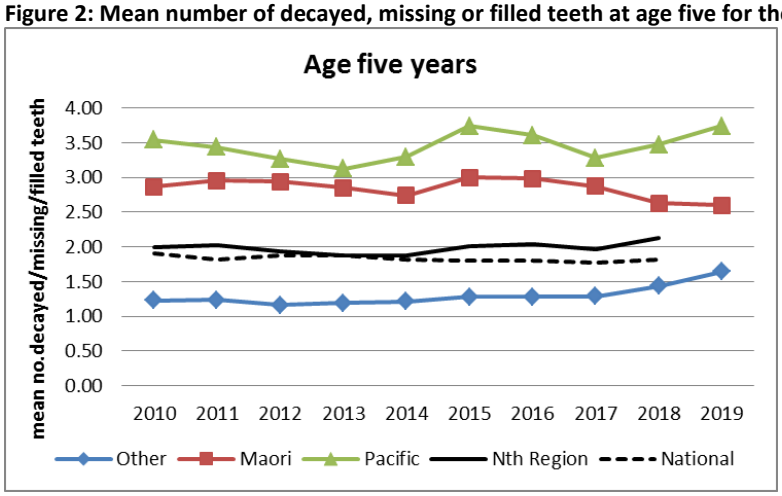


Figure 2: Mean number of decayed, missing or filled teeth at age five for the Auckland Region, by ethnicity



4. Dental Services in the Auckland Region

In New Zealand, dental services are publicly funded for children from birth until their 18th birthday. Until School Year 8, children primarily receive dental care from dental therapists and some dentists within the Community Oral Health Service. In Auckland, this service is referred to as the Auckland Regional Dental Service (ARDS). From School Year 9 until a person's 18th birthday, dental care is provided by private dental practices contracted under the Combined Dental Agreement (CDA). Once a person turns 18, there is a very limited range of publicly funded dental services available for adults. These services include dental treatment due to an accident or injury and specialist oral health care for people with needs that prevent them from accessing community-based dental care. In the Auckland region, the regional Hospital and Specialist Dentistry provide these services. All metro Auckland DHBs also fund limited emergency dental care for low-income adults, which provide treatment for the immediate relief of pain and infection but no preventative or basic dental care.

4.1. Auckland Regional Dental Service (ARDS)

A description of ARDS is provided in Appendix 2. Following the 2016 review, ARDS developed a service improvement programme to guide the achievement of improved patient experience, improved oral health outcomes and improved service performance. In response to marked ethnic inequities in preschool oral health outcomes the Preschool Oral Health Action Plan for the Auckland Region was also developed. The Plan's actions were broadly divided into

i. oral health promotion, and
ii. the prevention, early detection and treatment of caries.

Oral health promotion activities include the delivery of oral health promotion messages in the community and primary care. These activities are the responsibility of multiple organisations and providers, including ARDS, primary care and Well Child Tamariki Ora (WCTO) providers. Preventive and treatment activities are mostly within the scope of ARDS.

Since 2018, ARDS has driven several key initiatives to address ethnic inequities and improve oral health outcomes. This is further detailed in Appendix 2. Some key activities included:

- Automatic enrolment of infants at birth and working collaboratively to locate children not attending appointments.
- A centralised whānau focused booking and scheduling process.
- Introduction of a supportive treatment pathway, resulting in a reduction of non-attendance.
- Increasing productivity with improvement in utilisation of dental chairs and focusing on reducing arrears and wait times.

As part of its focus on prevention, ARDS introduced a policy in 2018 to apply topical fluoride to all children at their recall appointment. A programme of topical fluoride application to pre-schoolers in high-needs ECEs was being systematically rolled out across the metro Auckland region. In 2019, the service was being provided in 39 early childhood centres across metro Auckland (eight in Waitematā DHB, 16 in Auckland DHB and 15 in Counties Manukau DHB). The programme was prioritised for delivery in Te Kohanga Reo, Pacific language nests and centres with a high number of Māori and Pacific children enrolled. All children received a toothbrush and oral health promotion pack. This programme was suspended in March 2020 due to COVID-19.

ARDS was the only Community Oral Health Service in the country offering Saturday clinics for families unable to access services during the working week. After an intitial trial, Saturday clinics were offered in Browns Road (Manukau), Puinuhi Road (Papatoetoe), Botany, Point England, Glenfield and Glen Eden. They were well attended although preliminary data from these clinics show that only one-third of those who attended were Māori or Pacific. These Saturday clinics have partly re-opened.

4.2. Dental Care for Adolescents: The Combined Dental Agreement

Dental care services for adolescents are described in detail in Appendix 3. Dental care for adolescents is funded via a nationally standardised CDA. The agreement also covers special dental services for children in Year 8 and younger who have been referred from ARDS due to treatment requirements beyond the scope of a dental therapist. There are 321 dental providers across three metro Auckland DHBs. As well as fixed dental practices in the community, three large private mobile providers take mobile dental clinics into some secondary schools to provide adolescent dental care.

Feedback received by dental providers at the hui organized by combined Auckland DHBs in 2019 highlighted the need to increase the awareness of the availability of free oral health service and effective collaboration with schools, and other key stakeholders.

4.3. The Auckland Regional Hospital and Specialist Dentistry

The Auckland Regional Hospital and Specialist Dentistry (HSD) is the metro Auckland hospital dental service, providing secondary and tertiary oral health care services. The service is managed by Auckland DHB. HSD provide clinical services to a large and growing group of medically complex and special care patients; children requiring care under GA, and; patients who require dental or oral health services as an essential part of in- and out-patient hospital medical and surgical treatment.

The HSD service currently has 2,157 children on the waiting list for a first specialist appointment (FSA) or dental treatment under General Anaesthetic (GA). The demand for dental treatment for children at hospital currently exceeds capacity. The HSD service receives approximately 200 new referrals per month for specialist paediatric assessment and a significant proportion of these children are subsequently placed on the waiting list for dental treatment under GA. Approximately 150 children can receive dental treatment under GA per month. Many children with severe dental problems wait more than eight months, from the time of referral to completion of definitive treatment. Work is being progressed under the Vulnerable Services work stream to assist HSD to reduce waiting times and ensure children's needs are met in a timely manner. More detail about HSD is provided in Appendix 4. The significant health burden and the impacts of COVID-19 have made oral health the primary focus for the regional Vulnerable Services in the Equity Planned Care work programme.

4.4. Emergency Dental Services for Low income adults

Emergency dental services (EDS) are services for the immediate relief of pain and infections for low-income adults. The HSD and a limited number of dentists in the community who hold a 'Relief of Pain' contract with the DHB provide these services. To access this service, adults need a Community Service Card and to pay a $40 co-payment for this service. More detail about EDS is provided in Appendix 5.

5. Impacts of COVID-19

The onset of COVID-19 has had a significant impact on the delivery of dental services for all ages. During Alert Levels 4 and 3, routine oral health services were suspended in line with the Dental Council of New Zealand (DCNZ) and Ministry of Health (MOH) directives. Dental care providers are at high risk due to the nature of their profession, which necessitates close proximity to the patient's oropharyngeal region and the use of droplet and aerosol-generating procedures.

Between 23 March and 14 May 2020 all oral health providers were directed to postpone all routine dental treatment and only provide essential dental services (urgent and emergency treatment).

Essential dental services were defined as:

- Severe pain that cannot be controlled by medication;
- Fractured teeth or pulpal exposure, if pain not able to be managed;
- Oro-facial swelling that is serious and worsening despite taking antibiotics;
- Post-extraction bleeding that the patient is not able to control with local measures;
- Dental conditions that have resulted in acute systemic illness or raised temperature as a result of dental infection; or
- Acute infections that is likely to exacerbate systemic medical conditions such as diabetes.

In addition, DCNZ also issued guidelines for enhanced infection prevention and control, and additional PPE requirements. PPE was supplied to 50 dental practices in the community that have a Combined Dental Agreement.

For patients who were high risk (eg. COVID-19-positive, suspected to be COVID-19 positive and awaiting results or a close contact) the DHBs were expected to provide emergency dental treatment in a hospital or tertiary care facility with a negative pressure room and full PPE.

As part of regional response, the Buckland Road Community Dental facility was made ready to see patients with high-risk profile needing emergency treatment. This facility was also used to provide relief of pain services for low income adults.

5.1. Impacts on the Auckland Regional Dental Service

COVID-19 has had a significant and enduring impact on the service delivery of ARDS. Only 24 children met the DCNZ essential care criteria for an appointment in the March and April COVID-19 Alert Level 4 and 3 lockdown, and only three children met the emergency essential care criteria in the August Level 3 lockdown.

With the move to Alert Level 2 and 1, the service has re-started routine appointments, however, there are on-going DCNZ requirements that are impacting service productivity and access (eg. enhanced Infection controls and pre-screening). This reduced productivity from around eleven children per day per chair to seven. This has significantly affected the current level of arrears for ARDS. Some of the other contributing factors reported by ARDS are:

- Increased time taken to complete documentation about pre-screening), as well as apply PPE measures (e.g. wiping surfaces, wearing gowns for every appointment).
- Many schools have been reluctant to have additional staff (including ARDS staff) on site and have imposed other restrictions such as to after-school appointments, bringing in other children, and not allowing parents on-site.
- Reduced school hours as school trips, examinations, essential learning have been condensed into a shorter period of time, due to the lockdown.
- Reduced school attendance post lock-downs, with some schools reporting only 45% attendance.
- Workforce impacts from leave to care for sick children unable to attend school with COVID -19 restrictions.

Arrears

Arrears is a timeliness indicator that measures the proportion of children who are overdue for their scheduled examination. The national target is that 10% or less children are in arrears. While the national target for arrears has not been met for any ethnic group in recent years, COVID-19 has significantly increased the percentage of children in arrears across metro Auckland. The table below outlines the percentage of children in arrears by ethnicity and DHB of domicile as of 31 August 2020.

Table 4: Children in Arrears – 2020 data

DHB	Māori	Pacific	Asian	Other	Total
Auckland	59%	61%	54%	54%	56%
Counties Manukau	64%	65%	58%	59%	62%
Waitematā	60%	62%	57%	57%	58%
Not yet allocated*	69%	69%	62%	57%	62%
TOTAL	**62%**	**64%**	**57%**	**57%**	**59%**

*There are about 7,000 children who do not have a DHB of domicile recorded and ARDS is manually reviewing their records to ensure they have an allocated DHB of domicile by end of 2020.

Significantly overdue

While there has been a reduction of 453 significantly overdue children over the last month, there are a further 17,332 children in the Auckland region who last attended an appointment prior to 2018. ARDS is monitoring the progress reducing the number of significantly overdue children weekly and is using a supportive treatment pathway to ensure all avenues are being explored to locate and support children to attend an appointment.

The table below outlines the number of significantly overdue children (last attended prior to 2018) by ethnicity and DHB of domicile as of 31 August 2020.

Table 5: Long waiting Children – 2020 data

DHB	Māori	Pacific	Asian	Other	Total
Auckland	307	570	659	1,198	2,734
Counties Manukau	2,179	2,768	1,414	2,192	8,553
Waitematā	787	630	1,203	3,074	5,694
Not yet allocated	48	73	72	158	351
TOTAL	**3,321**	**4,041**	**3,348**	**6,622**	**17,332**

Utilisation by Children under age 2 years – 2020 data

Only 13%of children aged under 2 years have been seen by ARDS. The table below shows the percentage of children, by ethnicity, who are under 2 years and have attended an appointment with the service.

DHB	Māori	Pacific	Asian	Other	Total
Auckland	13%	14%	17%	18%	17%
Counties Manukau	7%	9%	14%	12%	11%
Waitematā	10%	8%	13%	13%	12%
Not yet allocated	7%	14%	29%	23%	20%
ARDS Total	9%	10%	14%	14%	13%

The majority of children under age two have not been seen by the service due to COVID-19. Due to the implementation of the Telehealth Oral Health Promotion Pēpi Programme in August 2020, the service delivered approximately 2,000 appointments. During the appointment the therapist introduces the service, ensures that the child's correct contact details are recorded, delivers key oral health messages and talks with whānau about any concerns they may have about their child's teeth. However, the service has found it more challenging to contact Māori and Pacific whānau. Strategies to address this are currently being explored.

School Year 8 Students

ARDS provides care to all children from birth to the end of School Year 8. Following this, young people are transferred to private contracting providers, where they continue to receive free dental care up until their 18th birthday under the CDA. Before transferring these children, ARDS is required to examine all Year 8 students and complete their treatment. Prior to the onset of COVID-19, ARDS were tracking to achieve the completions of Year 8 students. However, the restrictions instituted by DCNZ on service provision under alert levels 3 and 4 have greatly impacted the service's ability to meet its requirements to examine all Year 8 children before the end of the year. Only 24% of Year 8 children have been seen by ARDS this year.

At present, given the level of disruption across the service and the current number of children with overdue appointments, prioritisation is based on clinical need rather than age alone. This means ARDS will no longer be able to complete examination and transfer of all Year 8 students. Only 24% of Year 8 children have been seen by ARDS this year.

The table below details the percentage of school year 8 students seen by the service as at 31 August 2020.

Table 6: percentage of School Year 8 Students Seen by ARDS – 2020 data

DHB	Māori	Pacific	Asian	Other	Total
Auckland	25%	28%	27%	22%	25%
Counties Manukau	24%	26%	29%	29%	27%
Waitemata	21%	21%	22%	20%	21%
Not yet allocated	30%	26%	37%	17%	25%
TOTAL	**23%**	**26%**	**26%**	**23%**	**24%**

5.2. ARDS Recovery Plan

ARDS is currently prioritising appointments for children who are currently under treatment and those waiting the longest for their routine examination. In addition, there is a focus on children living in the highest need communities by focusing on schools that are low decile (1-4) and/or rural locations, and have:

- high Māori and Pacific enrolments
- high number of children under treatment
- most delayed service.

For those schools that meet the above criteria and have on-site clinics, these clinics are open. For schools that meet the above criteria and do not have on-site clinics, mobile facilities are provided in order of highest need. The majority of ARDS sites are now open with at least one chair operating.

Three Saturday clinics (Browns Road, Point England and Glenfield) have re-started. Other facilities that previously offered Saturday clinics (Puhinuhi Road in Papatoetoe, Botany, Wesley, and Glen Eden) will re-open in Term 4. High needs children continue to be the priority group offered appointments at the Saturday clinics.

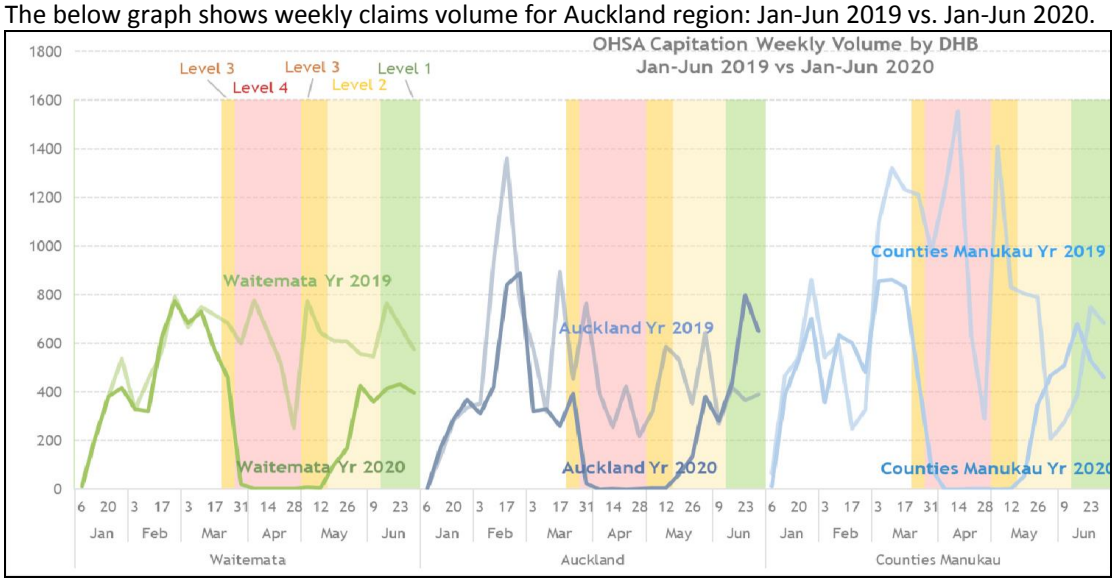
During COVID-19 Alert Levels 3 and 2, kohanga reo, language nests and early childhood centres were reluctant to have ARDS staff into their centres to complete oral health assessments and fluoride varnish applications on children's teeth. However, during Level 2, some centres in Waitematā and Counties Manukau DHBs invited ARDS to attend, so the service re-commenced in these areas. Centres in Auckland DHB have asked to wait until Alert Level 1, so ARDS Community Engagement Coordinators will re-engage with these centres to re-commence the service during Term 4.

5.3. Impacts on the Adolescents Oral Health Service

The onset of COVID-19 has also had a significant impact on the delivery of adolescent oral health service. During COVID-19 Alert Level 4 and 3, dental providers were only able to provide urgent and emergency dental care to all age groups including adolescents.

Between January to June 2020, based on Ministry of Health interim claims data for DHB of contract, about 20% adolescents have utilised funded dental care in Auckland DHB and 17% in Waitematā DHB. As some dental claims are made a few months after completion of treatment, the number of claims for this period may increase slightly. There has been a 29% decrease in payments made to CDA providers in Waitematā DHB and 22% decrease for Auckland DHB providers due to COVID-19. Based on claims and payments data, the projected utilisation for adolescents' dental service for 2020 is expected to be somewhere between 40 to 50%. This will result in a reduction of 30 to 40% coverage for adolescents in this calendar year, compared to 2019.

The below graph shows weekly claims volume for Auckland region: Jan-Jun 2019 vs. Jan-Jun 2020.



Work is currently underway to look at the development of a regional Adolescent Oral Health Coordination Service Plan. The plan will outline a range of actions to improve the uptake and on-going participation of adolescents in publically funded oral health services. The plan will be developed with input from range of stakeholders particularly for Māori.

6. Conclusion

There are persistent inequities in oral health across all ages. In metro Auckland, Māori and Pacific children experience poorer oral health outcomes than non-Māori and non-Pacific children. Over 60% of Māori and Pacific children enrolled with ARDS are now overdue for their examination. Very few young children have received a preventative therapy (fluoride varnish). In addition, ARDS also has high numbers of children that are very overdue. Dental admission rates for children at hospitals are highest in Pacific children followed by Māori children. The demand for dental treatment for children at Hospital and Specialist Dentistry currently exceeds capacity. The HSD service currently has 2,157 children on the waiting list for a first specialist appointment (FSA) or dental treatment under GA. The Planned Care COVID-19 catch up activity funded has provided the opportunity for Waitematā DHB to allocate $812k which will fund sufficient capacity to address the current waiting times.

There is also a significant disparity in dental coverage for Māori teenagers in the Auckland region. There is a high prevalence of dental disease, particularly for Māori and Pacific adolescents and adults and those living in more deprived neighbourhoods. For low-income adults treatment is restricted to relief of pain and does not include any preventative or maintenance treatment.

Across metro Auckland, several actions were taken to eliminate long-standing inequities particularly for preschool children under the equity focused Preschool Oral Health Strategy. However, with the impacts of COVID-19, including total cessation of the majority of ARDS services and the ongoing DCNZ requirements, there now needs to be concerted, additional efforts to address service disruption and the persistent inequity for all funded services, particularly for Māori and Pacific children and adolescents. Given these restrictions are likely to be longstanding, there are current discussions about the opportunity to include the ARDS service within the Regional Vulnerable Services Framework and utilisation of the DHB sustainability funding.

Appendix 1: Oral Health Outcomes

Oral Health Outcomes for Children

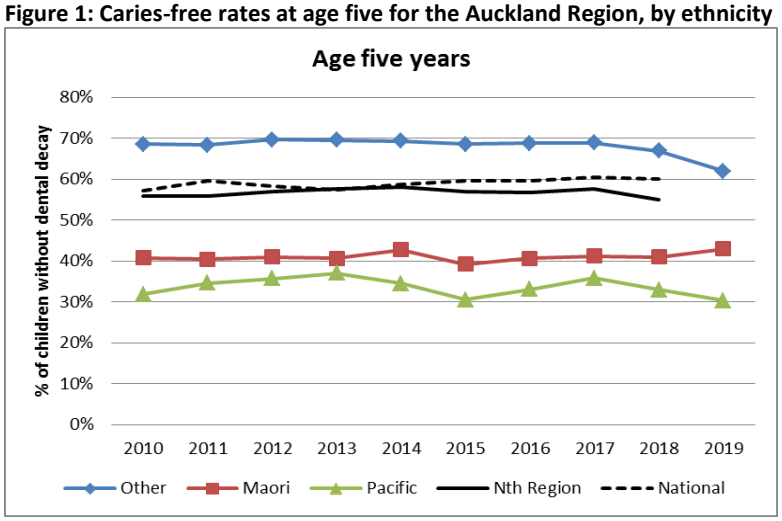
Results for 2020 will see a significant decline across all access and outcome measures, with poor quality outcome data available due to the small number of children actually examined.

The Auckland Regional Dental Service (ARDS) is the provider of universal oral health services for pre-school and primary school age children across the metro Auckland. Oral health status for children is measured through two: (i) caries-free rates (i.e. the proportion of children with no evidence of dental decay) and (ii) mean number of decayed, missing or filled teeth (dmft).

Caries-free rates reflect the prevalence of dental decay in the community (higher caries-free rates are better) and mean dmft the severity of disease (lower mean dmft is better). However, these rates are likely to underestimate the true prevalence of dental disease and the extent of inequities in our population, as they do not include children not examined by ARDS. In 2019 (our most recent data), approximately 53% (11,554) of 5-year-old children and 71% (15,073) of School Year 8 (ages 12 – 13) children were examined. Children who have been unable to access this free dental service are likely to have poorer health outcomes than those who have been examined and/or received treatment (although the numbers accessing private dentists is unknown).

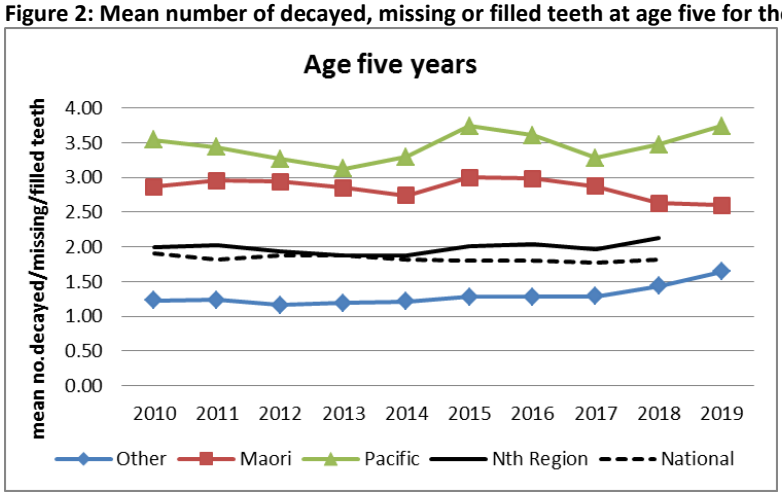
Figures 1 and 2 show caries-free rates and the mean dmft at the age of five years in the Auckland region, by ethnicity from 2010-2019. These figures also include data up to 2018, for the Northern Region (including Northland DHB) and National rates for comparison. Caries-free rates at age five years has not changed significantly since 2010, though it appears that there is a decline in the number of children who are caries-free among Pacific and Other ethnic group in 2019. There does however, appear to be a slight increase in caries-free rates for Māori children at age five.

Figure 1: Caries-free rates at age five for the Auckland Region, by ethnicity



The rates of dmft appear to show an increase in severity of dental disease among Pacific and for Other ethnic groups, but some improvements for Māori children.

Figure 2: Mean number of decayed, missing or filled teeth at age five for the Auckland Region, by ethnicity



Figures 3 and 4 below show caries-free rates and the mean dmft at school Year 8 for children in the Auckland region by ethnicity from 2010-2019. Caries-free and mean dmft rates for children at School Year 8 continue to improve suggesting that school dental services in general have made progress in improving the oral health outcomes of school-aged children, but more work needs to be done to reduce persistent inequities seen at all ages for Māori and Pacific children.

Figure 3: Caries-free rates at age school Year 8 for the Auckland Region, by ethnicity

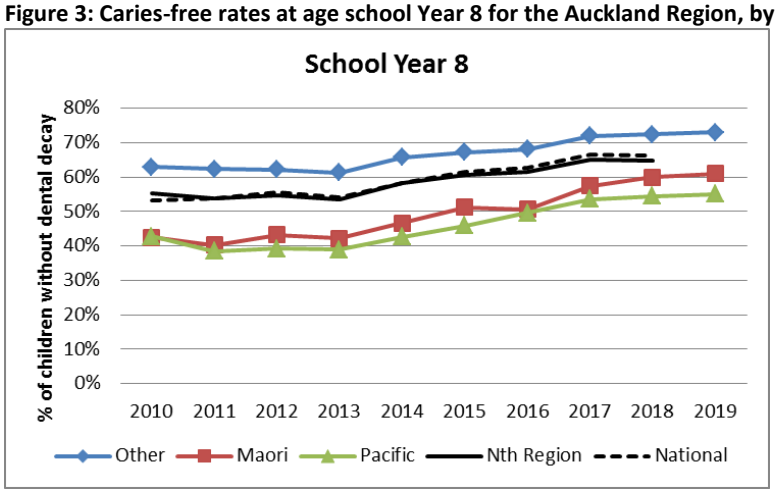
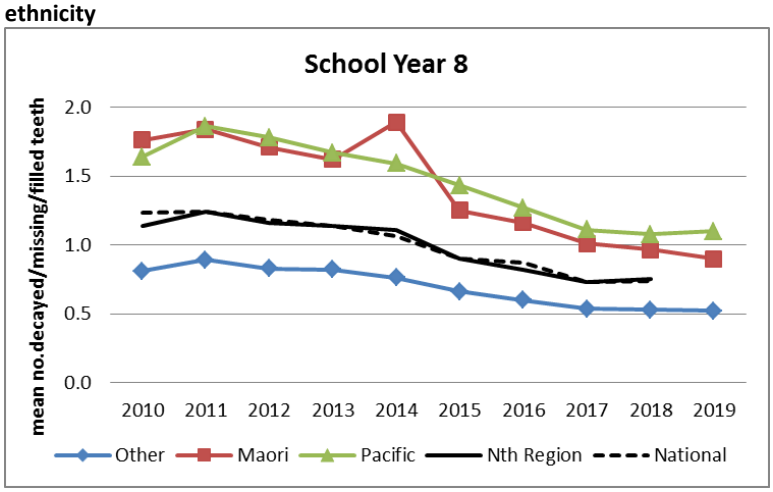


Figure 4: Mean number of decayed, missing or filled teeth at school Year 8 for the Auckland Region, by ethnicity



Dental admission rates for children aged 0-4 years are highest and also above the national average in Pacific children in the Auckland region. Dental admissions, mainly for dental extractions under GA are an important cause of ambulatory sensitive hospitalisations (i.e. hospitalisations considered potentially reducible through preventive or treatment strategies deliverable in a primary care setting), and the childhood dental admission rate for Pacific has increased further in 2019 for Auckland and Waitemata DHB. Dental admission rates for Māori children are higher than for other children, but not as high as expected, given caries-free and mean dmft rates, suggesting that there may be issues with access to secondary care.

Figure 5: Dental admission rates for children aged <5 years in Auckland DHB, 2015-19

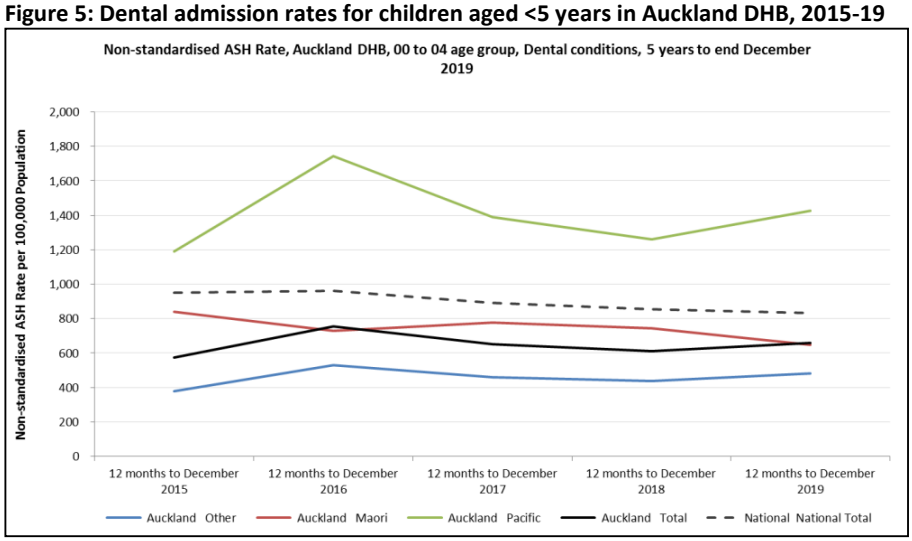
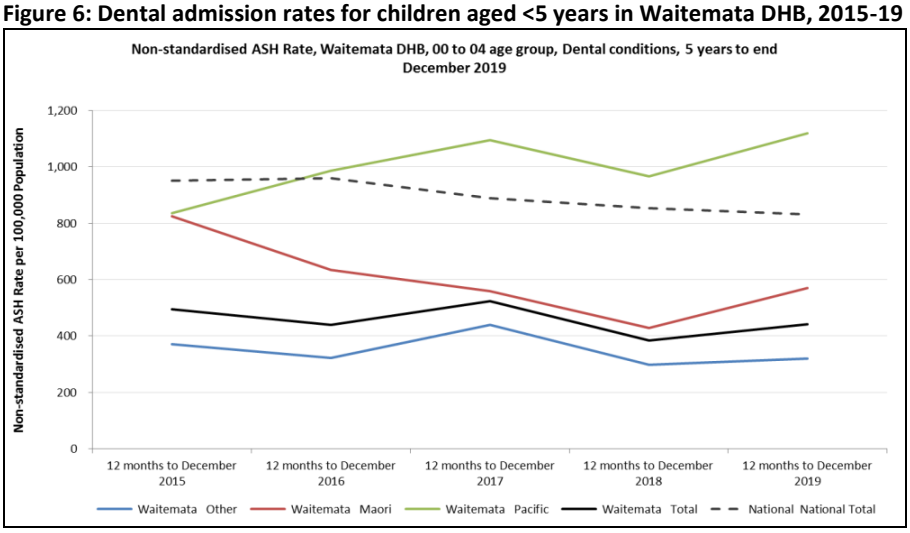
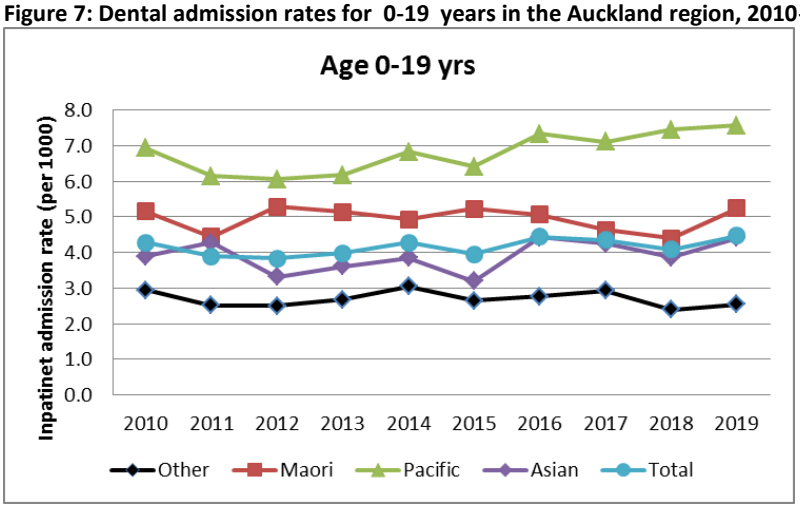


Figure 6: Dental admission rates for children aged <5 years in Waitemata DHB, 2015-19



Dental admission rates for those aged under 19 years and younger are also highest in Pacific children follwed by Māori children demonstrating that the inequities from childhood persist into adulthood.

Figure 7: Dental admission rates for 0-19 years in the Auckland region, 2010-2019



Oral Health Outcomes for Adolescents

Oral health services for Adolescents are provided by private oral health providers with a Combined Dental Agreement (CDA) with the DHB. As well as fixed dental practices in the community, three large private mobile providers take mobile dental clinics into some secondary schools to provide adolescent dental care. In Auckland DHB, these providers provide services to three quarters of adolescents seen (within the publicly funded system). In Waitemata DHB, two providers see nearly half (46%) of the adolescents. Students are eligible for services regardless of whether they are attending a school, training institute or working.

Unlike children, there are no standardised outcome indicators (such as caries-free or dmft) available for adolescents. The Ministry of Health has set an utilisation target of 85% of adolescents from school year 9 – 17 years to receive annual dental care. This is measured by identifying unique individuals using the claims data from contracting dentists and adding a small number of high risk adolescents seen by seen by Community Oral Health Services (ARDS in the Auckland region).

Auckland DHB coverage for adolescents' oral health in 2019, was 69% and in Waitematā DHB 71%. Both DHBs utilisation rates for adolescents' oral health are below the national target of 85%. While there is an increase in overall utilisation rates over the years, there is also a significant disparity in dental coverage for Māori teenagers with only 52% and 54% coverage for Auckland and Waitematā DHBs respectively. While Māori teenagers utilisation rate is above the national average of 48%, more work is needed to increase the uptake of dental service by Māori teenagers.

Figure 8: Adolescents dental utilisation in Auckland DHB, 2017-2019

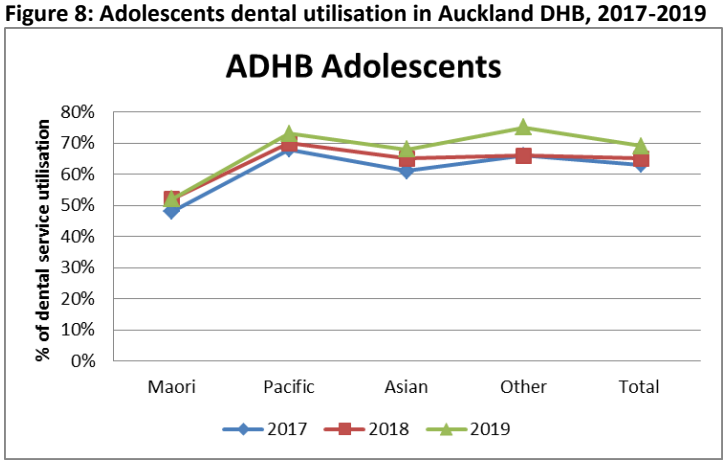
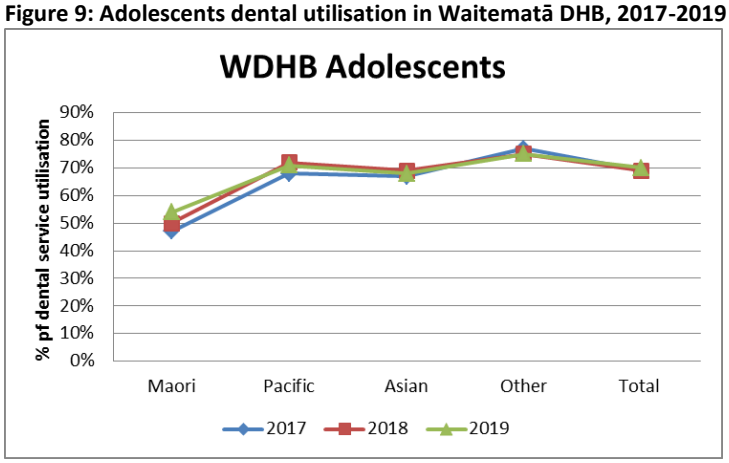


Figure 9: Adolescents dental utilisation in Waitematā DHB, 2017-2019



Oral Health Outcomes for Adults

Dental care for adults is mostly not covered by the publicly funded health system. Adult oral health care makes up a small portion of the Government's health spending, less than 0.5% of Vote Health in 2018/19, of which more than half is spent on secondary services and ACC.[1]

Data from national surveys indicates that ethnic and socioeconomic inequities in oral health outcomes persist into adulthood. Data from recent New Zealand Health Survey (2019) show that there is a high prevalence of dental disease, particularly for Māori and Pacific adults and those living in more deprived neighbourhoods. In that dataset, 11% of Pacific, 10% of Māori and 9% of adults living in quintile 5 reported having one or more teeth removed due to decay, infection or gum

[1] Access to Oral Health Services for Low Income Adults (2020). New Zealand Dental association. URL: https://www.nzda.org.nz/assets/files/Access_To_Oral_Health_Services_For_Low_Income_Adults.pdf

disease in the previous 12 months, compared to 5% of quintile 1 adults and 6% of adults overall.[2] In addition, about 348,000 (51.5%) people in quintile 5 had avoided dental care in the previous year due to cost, compared to about 0ne-third of adults living in quintile 1.

There is also evidence of significant unmet need for dental care in adults, with more than half of adults reporting that they have never visited a dental health worker or only visited for toothache or problems. Māori and Pacific adults are significantly more likely to report unmet need for dental care than other adults, as are those living in the most deprived neighbourhoods. Even after adjusting for age, sex and ethnicity, those living in quintile 5 neighbourhoods are twice as likely as those living in quintile 1 neighbourhoods to have not visited a dentist. In the New Zealand Oral Health Survey, conducted in 2009, nearly half of adults reported that they felt they currently needed dental care, but had avoided it due to cost.[3]

[2] Ministry of Health (2019). Annual Data Explorer 2019: New Zealand Health Survey [Data File]. URL: https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/_w_deeee4aa/#!/home

[3] Ministry of Health (2010). Our Oral Health: key findings of the 2009 New Zealand Oral Health Survey. Wellington: Ministry of Health.

Appendix 2: The Auckland Regional Dental Service (ARDS)

ARDS provides screening, early detection, preventive and restorative dental services for preschool and school-aged children. Children requiring treatment outside the scope of ARDS clinicians are referred to either HSD (if treatment is required by a paediatric specialist including the use of GA) or a private dentist with a Combined Dental Agreement.

ARDS is managed by Waitemata DHB on behalf of all three metro Auckland DHBs. There are approximately 280,000 children enrolled with the service. Service provision extends from Wellsford to the Bombay Hills and is delivered in 83 facilities, including fixed, mobile and transportable dental units across all three DHBs with 188 patient chair capacity.

Table 1: Dental facilities owned by metro Auckland DHBs

Auckland DHB	Waitematā DHB	CMH
No TDU's	15 TDU's	6 TDU's (CMH are using 2 x TDU's owned by Waitematā DHB)
6 vans	8 vans	5 vans Plus 1 sponsored mobile vehicle
14 Fixed clinics	11 Fixed Clinics	17 Fixed Clinics

ARDS has undergone a significant upgrade in facilities and equipment since 2008 as part of a national reconfiguration of Community Oral Health Services across New Zealand. Prior to this time, the free children's dental service was based in schools and primarily focused on dental treatment in school-aged children. The new vision required services to be re-oriented to focus on prevention and the promotion of good oral health. Addressing oral health inequities, particularly in relation to Māori and Pacific children, was a priority for the new model of care. To improve access, the new model of service delivery used a hub and spoke model, in which services were provided for preschool and school-aged children from a range of fixed and mobile clinical units. However, a formal evaluation of the national dental service reorientation by ESR in 2014 reported that equity was still an issue. Many dental therapists had concerns that those with the most need (including Māori and Pacific children) were still less likely to access clinical services due to the unavailability of transport or parents being unable to take time off work to bring their children.[4]

In 2016, a service review of ARDS was undertaken by Waitematā DHB to better understand whether the service was meeting Ministry of Health and District Annual Plan targets and deliverables, and to identify areas of improvement, particularly in terms of equity.[5] The review reported examination rates of 64-78% of the enrolled population, but treatment completion rates of 54-70% and non-attendance rates consistently above 20%, particularly for Māori and Pacific children and those living in Counties Manukau DHB. Furthermore, chair utilisation was found to be lower than that recommended by the Ministry of Health (eight appointments per day per chair, compared to the recommended eleven appointments per day per chair).

Pre-school Enrolment

Ensuring that all children are enrolled in ARDS is a crucial first step in ensuring that all children are able to access the service. Figure 8 show the percentage of children in the metro Auckland region enrolled in ARDS by the age of four. Percentages for Asian and Other ethnic groups exceed 100% at

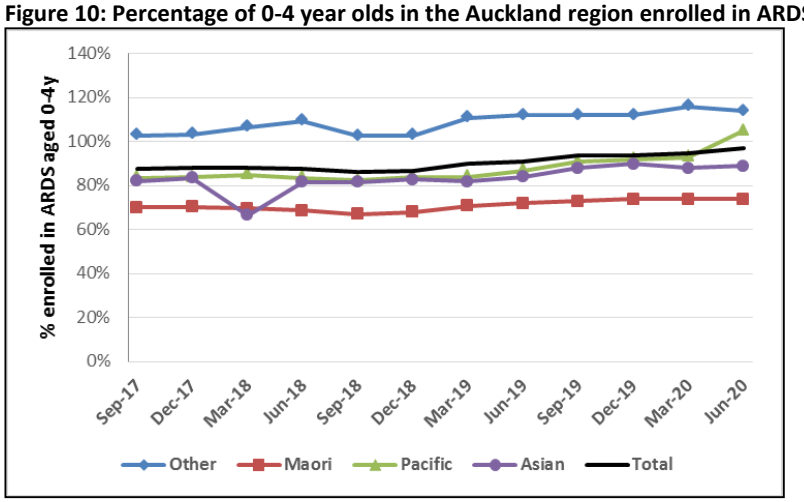
[4] Institute of Environmental Science and Research Limited (ESR). *An Evaluation of the Reorientation of Child and Adolescent Oral Health Services*. Wellington: Ministry of Health; 2014.
[5] Harun L. *Auckland Regional Dental Service Review Report.* ARDS; October 2016.

some points because of a mismatch in ethnicity data between the Census (used for the denominator) and health data (used for the numerator). Work is being done to ensure ethnicity is being reported correctly within the Titanium system that is used by ARDS.

The number of Pacific 0-4 year old children enrolled with ARDS has increased in the last two years due to the introduction of automatic enrolments from birth lists. A data matching process has occurred with the Auckland and Waitematā Well Child Tamariki Ora providers. This has supported ARDS to identify many high needs children who were not enrolled with the service. It has also allowed the services to work together to identify current contact details and improve oral health service utilisation. ARDS are also working closely with the newly established National Child Health Information Platform to ensure they will receive the information to help ensure all children are enrolled with ARDS.

Māori children continue to have lower enrolment rates than children of other ethnicities. Approximatley 26% of 0-4 year old Māori children are not enrolled in the Auckland region. The reasons for these lower enrolment rates are unclear, and work is currently underway to ensure ethnicity data in the ARDS system is accurate. Community Engagement Co-ordinators are working closely with Māori providers to conduct a data-matching process to identify children enrolled with a Māori health provider not currently enrolled in ARDS and/or have not received an examination. ARDS datasets are reconciled against school lists to ensure children who were previously discharged due to non-attendance and/or no contact are identified and re-enrolled.

Figure 10: Percentage of 0-4 year olds in the Auckland region enrolled in ARDS



Further breakdown of the percentage of children enrolled in ARDS by the age of two show similar results with approximatley 27% of Māori children not enrolled in ARDS.

Figure 11: Percentage of children in Auckland DHB enrolled in ARDS by the age of 2 years

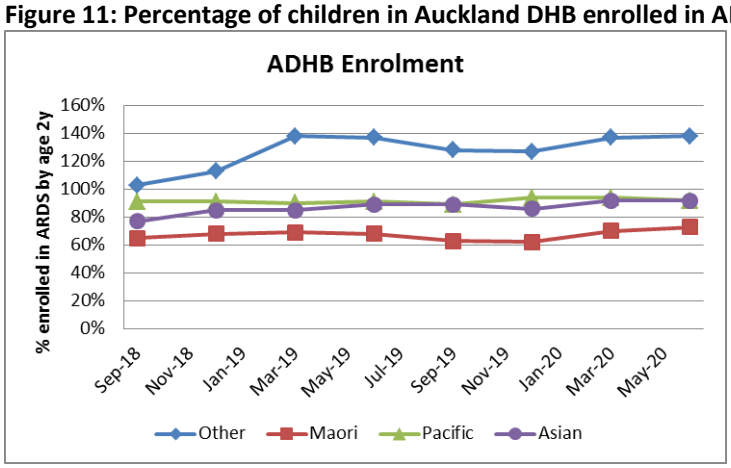
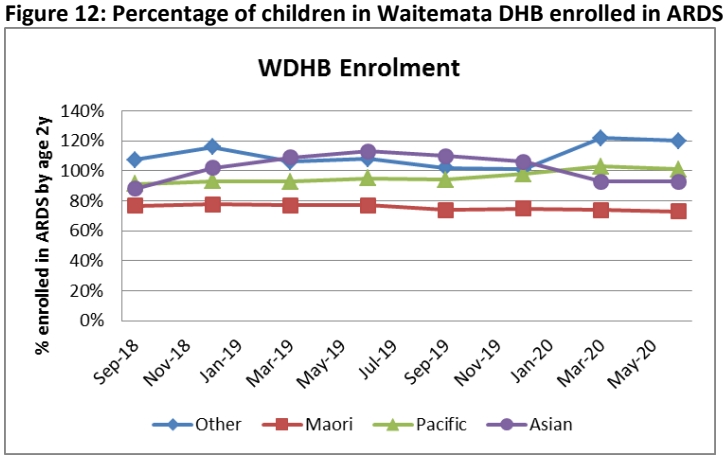


Figure 12: Percentage of children in Waitemata DHB enrolled in ARDS by the age of 2 years



Access to care

Improving access to care has been a particular focus for ARDS, particularly for Māori and Pacific families. While the percentage of children seen by age two remained steady in Auckland DHB in 2019, there was a marked decrease in utilisation of the service for all ethnic groups in Waitematā DHB in 2019. Access plumeted in 2020 with service cessation and disruption caused by COVID-19.

The utilisation rates in 2019 continue to remain lower in Māori and Pacific children across both DHBs when compared to other children. An ongoing focus on increasing access for these children is necessary to close the equity gap.

Workforce

Though overall vacancies across ARDS were reduced, the recruitment and retention of dental and oral health therapists remains a challenge for the service. Activities undertaken to support staff recruitment and retention include:

- A review of the new graduate programme was completed and the recommendations identified have been implemented. The revised programme commenced in January 2019.

- Two new clinical coach roles have been implemented. These roles are primarily focused on supporting new graduates transition to practice, but also provide support to therapists with identified learning needs.
- Dental assistants were supported to complete CareerForce training.
- Staff are actively engaged in service improvement initiatives and changes in models of care
- The service continues to support flexible working conditions including flexibility in location, hours of work and working part time across private practices and ARDS. The service recruited 24 new graduate therapists for 2020.

Appendix 3: Dental Care for Adolescents: The Combined Dental Agreement

Dental care for adolescents is funded via a nationally standardised CDA. The agreement also covers special dental services for children in Year 8 and younger who have been referred from ARDS due to treatment requirements beyond the scope of a dental therapist (for example, some treatments of oral disease, the restoration of dental tissue, or extractions). There are 321 dental providers across three metro Auckland DHBs - Auckland DHB 104, CMH 92 and WAITEMATĀ DHB 125. As well as fixed dental practices in the community, three large private mobile providers take mobile dental clinics into some secondary schools to provide adolescent dental care. A small number of high-risk adolescents continue to receive services from ARDS.

There are two components of service for adolescents:

- A standard (capitated) package of care for all adolescents which covers an annual examination and all other necessary consultations, diagnostic services, single surface restorations and preventative treatment within the 12-month period.
- Services outside of the capitated package are paid on a fee for service basis.

A small review of the agreement occurs annually focusing on small amendments and price increases. A major review occurs every three years allowing more significant changes to the agreement. A broader national landscape review scheduled by the National Oral Health Group and the Ministry of Health is proposed to establish how well the CDA provides equitable access to dental care and recommend improvements to future contracting years.

Locally the three Metro Auckland DHBs are working together to track adolescent use of the service from transfer from ARDS after school year 8, to where adolescents are being seen each year. Some key activities include;

- Data matching the children who have been transferred out of ARDS to locate the school the children are attending and requesting the mobile dental service to offer an appointment for them.
- Trialling data matching the children transferred to private dental providers and working with them to find out why students have not attended.
- Alternative Education students dental visit history is checked by the adolescent coordination service and a list of local providers are sent to the centres for the staff to book an appointment for them if they are due to be seen.
- Gateway Adolescents given dental background check and retained in ARDS if deemed necessary or enrolled directly with an adolescent provider.

In addition, about 15,000 adolescents who were not receiving care in the past two years have been identified. The plan to use the Ministry of Health's NHI level data to match their NHI with their current contact details to re-engage with these adolescents was delayed due to COVID-19. Individual follow up at provider level has proven unsuccessful for these adolescents due to incorrect addresses and disconnected phone numbers obtained at the time of transfer from ARDS in Year 8.

Adolescent Oral Health Coordination Service

More work is required to increase utilisation for our young people most at risk of poor oral health outcomes. This requires district and regional approaches. The adolescent oral health coordination service is one of the key mechanisms currently available for increasing utilisation. This is a community based, population targeted service that is intended to coordinate the various groups that influence the delivery of adolescent oral health services (e.g. dentist, community oral health services, Māori health service providers).

The purpose of the service is “to improve the health and wellbeing of all adolescents, particularly those in at risk groups, by providing coordinated services that will enhance the uptake and on-going participation rates of adolescents in oral health care services”. The intention is that the service plans, implements and maintains a population-based service to improve the uptake and on-going participation of adolescents in publically funded oral health services. The service does not directly deliver oral health assessment or treatment services. Currently, the service consists of one coordinator across Metro Auckland (1FTE) who is based within ARDS. The focus of this long standing position is to support the transition of adolescents in year 8 between ARDS and private contracted dental providers. The coordinator also supports a limited amount of communications activity.

There is a strong need for health promotion and education focused on young people including creating awareness of the availability of free publically funded oral health service. Effective collaboration with high schools, alternative education providers, Teen Parent Units, Māori and Pacific providers, youth groups and other key stakeholders is needed to promote the availability of free service. Regular liaison and communications with contracted dental providers is also needed to strengthen recall systems and follow up appointments.

Work is currently underway to look at the development of a regional Adolescent Oral Health Coordination Service Plan. The plan will outline a range of actions to improve the uptake and on-going participation of adolescents in publically funded oral health services. Given the marked inequity in accessing the service, particularly by Māori adolescents, the plan need to be developed with input from range of stakeholders.

Feedback received by dental providers at hui organized by combined Auckland DHBs in 2019 also highlight the need for support and coordinated efforts to increase the awareness of the availability of free oral health service and effective collaboration with schools, and other key stakeholders

Appendix 4: The Auckland Regional Hospital and Specialist Dentistry

The Auckland Regional Hospital and Specialist Dentistry (HSD) is the regional hospital dental service, providing secondary and tertiary oral health care services to people living in Auckland, Waitematā and Counties Manukau DHBs. It is funded by the three metro Auckland DHBs, and is managed by Auckland DHB.

HSD provide clinical services to a large and growing group of medically complex and special care patients, children requiring care under General Anaesthetic (GA), and patients who require dental or oral health services as an essential part of in- and out-patient hospital medical and surgical treatment. HSD also provide very limited emergency dental care for low-income adults service, as do dentists in the community who hold a contract with the DHB.

HSD provide outpatient services from clinics at Greenlane Clinical Centre, Auckland City Hospital, Starship Children's Hospital, Buckland Road Community Clinic (relief of pain service) and Middlemore Hospital. No outpatient oral health services are provided from North Shore or Waitakere Hospitals.

Day-stay and inpatient operating sessions are provided from Greenlane, Starship, Auckland and Middlemore Hospitals, Quay Park Surgical Centre and, at times Waitakere Hospital.

Children requiring care under GA are treated mainly at Greenlane and Quay Park. Medically complex children requiring GA are treated as inpatients or via daystay at Starship Hospital

The demand for dental treatment for children at hospital currently exceeds capacity. The HSD service receives approximately 200 new referrals per month for specialist paediatric assessment and a significant proportion of these children are subsequently placed on the waiting list for dental treatment under GA. With operating theatres working under full capacity, approximately 140 -150 children can receive dental treatment under GA per month. The demand for children requiring dental treatment under GA has caused significant challenge for the service in achieving compliance with ESPI requirements that specifies all children receive their first specialist appointment within four months of referral and treatment within four months after FSA. This means that many children with severe dental problems wait more than eight months, from the time of referral to completion of definitive treatment in Auckland region. Work is currently being done under Vulnerable Services work stream to assist HSD to reduce waiting times and ensure these children are managed in a timely manner.

Appendix 5: Emergency Dental Services for Low income adults

Emergency dental services are services that are required for the immediate relief of pain and infections for low-income adults. Under the service coverage schedule, DHBs are required to provide emergency dental services where funding and capacity allows. Both Auckland and Waitematā DHB have historically allocated funding for emergency dental treatment. The HSD and a limited number of dentists in the community who hold a 'Relief of Pain' contract with the DHB provide these services. In order to access this service, adults must hold a valid Community Service Card. There is a $40 co-payment for this service. Treatment is restricted to the current problem and does not include any preventative or maintenance treatment.

5.2 System Level Measures – Quarter 4 Report

Recommendation:

That the Community and Public Health Advisory Committee note the Quarter four[1] results for the fourth SLM Improvement Plan.

Prepared by: Wendy Bennett (Planning & Health Intelligence Manager) and Tim Wood (Acting Director of Funding – Auckland and Waitematā DHBs)
Endorsed by: Dr Debbie Holdsworth (Director of Funding) and Karen Bartholomew (Director Health Outcomes)

Glossary

ACP	-	Advance Care Plan
ALT	-	Alliance Leadership Team
ARPHS	-	Auckland Regional Public Health Service
ASH	-	Ambulatory sensitive hospitalisations
CEO	-	Chief Executive Officer
CVD	-	Cardiovascular disease
DHB	-	District Health Board
ED	-	Emergency Department
HT	-	Health Target
HQSC	-	Health Quality and Safety Commission
PES	-	Patient Experience survey
PHC	-	Primary health care
PHO	-	Primary Health Organisation
POAC	-	Primary Options for Acute Care
SLM	-	System level measure
WCTO	-	Well Child/Tamariki Ora

1. Introduction

Please note that due to COVID-19, some data has been delayed and also activities and actions have had to be paused. A number of indicators are likely to be heavily impacted by COVID-19 response work and this will make understanding of the latest date more difficult. It will be sometime before we are able to return to normal business.

The System Level Measures (SLMs) Framework was developed by the Ministry of Health with the aim of improving health outcomes for people by supporting DHBs to work in collaboration with health system partners (primary, community and hospital) using specific quality improvement measures. This provides a framework for continuous quality improvement and system integration.

System Level Measures are set nationally and designed to be outcomes focused, requiring all of the health system to work together to achieve. They are focused primarily on children, youth and those parts of the population who experience poorer health outcomes than others. DHBs are able to choose from a suite of 'contributory' measures or devise their own – which they have identified as having the biggest impact on achievement of each system level measure. These in turn are connected to local clinically led quality improvement activities.

[1] Latest available data currently

System Level Measures recognises that good health outcomes require health system partners to work together. Therefore the district alliances are responsible for implementing SLMs in their districts.

The Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (the Alliances) jointly developed the 2019/20 System Level Measures Improvement Plan and are firmly committed to achieving the SLM milestones over the medium to longer term. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement. Contributory measures were added where data collection processes have been developed in response to identified clinical priorities.

The steering group continues to meet in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs. Steering group membership includes senior clinicians and leaders from the seven PHOs and the three DHBs. The steering group is accountable to the two Alliance Leadership Teams (ALTs) and provides oversight of the overall process. PHO Implementation Groups also meet to support and enable implementation of SLM improvement activities.

This paper provides quarter four results on the current (fourth) improvement plan: 2019/20. The six System Level Measures are:

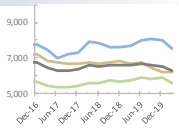
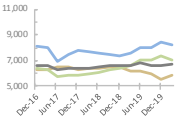
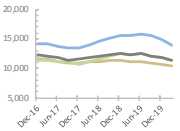
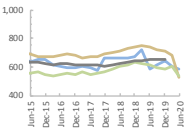
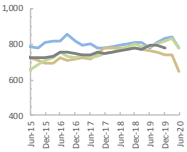
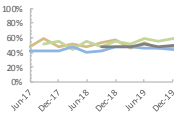
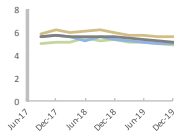
1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates
5. Babies living in smokefree households at six weeks
6. Youth are healthy, safe and supported.

For each SLM, there is an improvement milestone to be achieved in 2019/20. The milestone must be a number that improves performance from the district baseline, reduces variation to achieve equity, or for the developmental SLMs, improves data quality. In 2019/20, the Auckland Metro Region has continued focusing on cross–system activities which have application to multiple milestones. Activities with a prevention focus may show collective impact across the life course over time. It seems pragmatic for each milestone to benefit equally from activities which add value in multiple areas. The work is the foundation for quality improvement activities, and illustrates enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples. In planning, each contributor has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those with the poorest health outcomes.

This report includes the most up-to-date data available at quarter four for each DHB for both the SLMs and contributory measures. It also outlines progress against the improvement activities identified for each SLM in the SLM Improvement Plan.

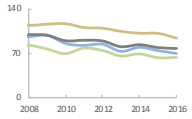
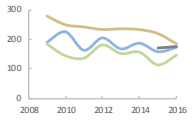
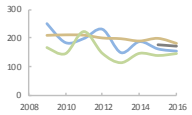
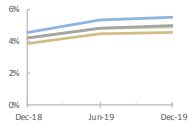
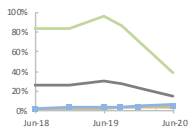
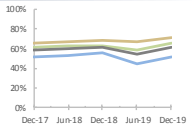
Scorecard – Part 1

		DHB / Region	Target		Performance: Actual	Data Period	Trend
1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds							
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Total Population	Auckland	7,381 (max.)	●	**7,558**	12-monthly	
		Counties Manukau	6,605	●	**6,223**	to	
Target 2019/20:	3% reduction	Waitemata	5,502	●	**5,577**	Mar-20	
		Metro Auckland	6,343	●	**6,302**		
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Maori	Auckland	7,109 (max.)	●	**8,260**	12-monthly	
		Counties Manukau	6,355	●	**5,895**	to	
Target 2019/20:	3% reduction	Waitemata	6,181	●	**7,031**	Mar-20	
		Metro Auckland	6,365	●	**6,668**		
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Pacific	Auckland	15,184 (max.)	●	**13,925**	12-monthly	
		Counties Manukau	11,051	●	**10,395**	to	
Target 2019/20:	3% reduction	Waitemata	12,045	●	**11,269**	Mar-20	
		Metro Auckland	12,405	●	**11,328**		
2. Acute Hospital Bed Days							
Measure:	Age-standardised rate per 1,000 domiciled population - Maori	Auckland	648 (max.)	●	**587**	12-monthly	
		Counties Manukau	717	●	**525**	to	
Target 2019/20:	3% reduction	Waitemata	616	●	**540**	Jun-20	
		Metro Auckland	667	●	**unavail**		
Measure:	Age-standardised rate per 1,000 domiciled population - Pacific	Auckland	780 (max.)	●	**781**	12-monthly	
		Counties Manukau	755	●	**648**	to	
Target 2019/20:	3% reduction	Waitemata	774	●	**774**	Jun-20	
		Metro Auckland	763	●	**unavail**		
3. Patient Experience of Care							
Measure:	DHB Adult Inpatient Experience Survey: medication side effects question answered "yes completely"	Auckland	55%	●	**47%**	Quarterly	
		Counties Manukau	53%	●	**59%**	to	
		Waitemata	49%	●	**45%**	Dec-19	
Target 2019/20:	5% improvement	Metro Auckland	51%	●	**49%**		
Target 2019/20:	Primary Care Survey - time to get GP appointment Weighted response: 10 = same	Auckland	6.70	●	**5.70**	Quarterly	
		Counties Manukau	5.90	●	**4.90**	to	
		Waitemata	6.00	●	**5.00**	Dec-19	
Target 2019/20:	10% improvement	Metro Auckland	6.20	●	**5.20**		

A note about the population:

Stats New Zealand and the Ministry of Health recently released updated population estimates and projections using new methodology (and there are likely to be further updates to these figures). This had a significant impact on the population figures for Auckland DHB, with substantially fewer people living within the DHB boundaries, according to these new figures, compared with previous estimates and projections. This will in turn have a substantial impact on performance against those measures that use DHB population as denominator. Going forward, there may be marked changes in both current results and trend information. Note: that some of the target data has had to be reworked within this dashboard and therefore, may not match the target presented in the 2019/20 SLM Plan or previous dashboards/reporting.

Scorecard – Part 2

		DHB / Region	Target		Performance Actual	Data Period	Trend
4. Amenable Mortality							
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds.	Auckland	70.4 (max.)	●	**69.6**	12 monthly	
		Counties Manukau	99.2	●	**93.7**	to	
Target 2019/20:	6% reduction by 2021	Waitemata	62.1	●	**63.3**	Dec-16	
		Metro Auckland	75.4	●	**77.4**		
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds - Maori	Auckland	154.8 (max.)	●	**173.0**	12 monthly	
		Counties Manukau	215.2	●	**184.6**	to	
Target 2019/20:	2% reduction by June 2020	Waitemata	110.8	●	**146.8**	Dec-16	
		Metro Auckland	167.2	●	**175.6**		
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds - Pacific	Auckland	159.3 (max.)	●	**154.9**	12 monthly	
		Counties Manukau	195.2	●	**181.7**	to	
Target 2019/20:	2% reduction by June 2020	Waitemata	136.8	●	**146.4**	Dec-16	
		Metro Auckland	173.5	●	**172.1**		
5. Youth Health							
Measure:	Chlamydia testing coverage for 15-24 year-old males.	Auckland	6%	●	**5.4%**	12 monthly	
		Counties Manukau	6%	●	**4.6%**	to	
Target 2019/20:	6% coverage rate by June 2020	Waitemata	6%	●	**4.9%**	Dec-19	
		Metro Auckland	6%	●	**5.0%**		
Measure:	Alcohol-related ED presentations	Auckland	10% (max.)	●	**4.3%**	12 monthly	
		Counties Manukau	10%	●	**6.5%**	to	
Target 2019/20:	Reduce 'unknown' alcohol related ED presentation status to less than 10%	Waitemata	10%	●	**38.0%**	Jun-20	
		Metro Auckland	10%	●	**15.0%**		
6. Babies Living in Smokefree Households							
Measure:	Proportion of babies living in smokefree homes at 6 weeks postnatal	Auckland	68.1%	●	**71.30%**	12 monthly	
		Counties Manukau	53.9%	●	**51.10%**	to	
Target 2019/20:	2% increase on baseline	Waitemata	63.1%	●	**64.94%**	Dec-19	
		Metro Auckland	61%	●	**61.22%**		

Legend

- ● Target met / on track
- ● Improvement needed
- ● Significant improvement needed
- ● Data or target unavailable

- Metro Auckland Region
- Auckland DHB
- Counties Manukau DHB
- Waitematā DHB

Overall Progress Report

Overarching activities for Q4:

- Implementation of the 2019/20 SLM Improvement Plan is on-going and has become business as usual for many of the stakeholders involved.
- Reporting is released quarterly or more frequently where available to PHOs via Citrix Sharefile or from Healthsafe, which allows safe and secure sharing of confidential information.
- The 2020/21 SLM Improvement Plan has been developed, submitted to the Ministry of Health and approved.

3. System Level Measures Report

Keeping children out of hospital

ASH rates per 100,000 for 0–4 year olds

Improvement Milestone: 3% reduction (on Dec-18 baseline) (by ethnicity) by 30 June 2020

	Milestone Target[2]			**Actual – 12 months to March 2020**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Total pop.	7,381	6,605	5,672	7,558	6,223	5,577
Māori	7,109	6,355	6,372	8,260	5,895	7,031
Pacific	15,184	11,051	12,417	13,925	10,395	11,269

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prevention or therapeutic interventions deliverable in a primary care setting.

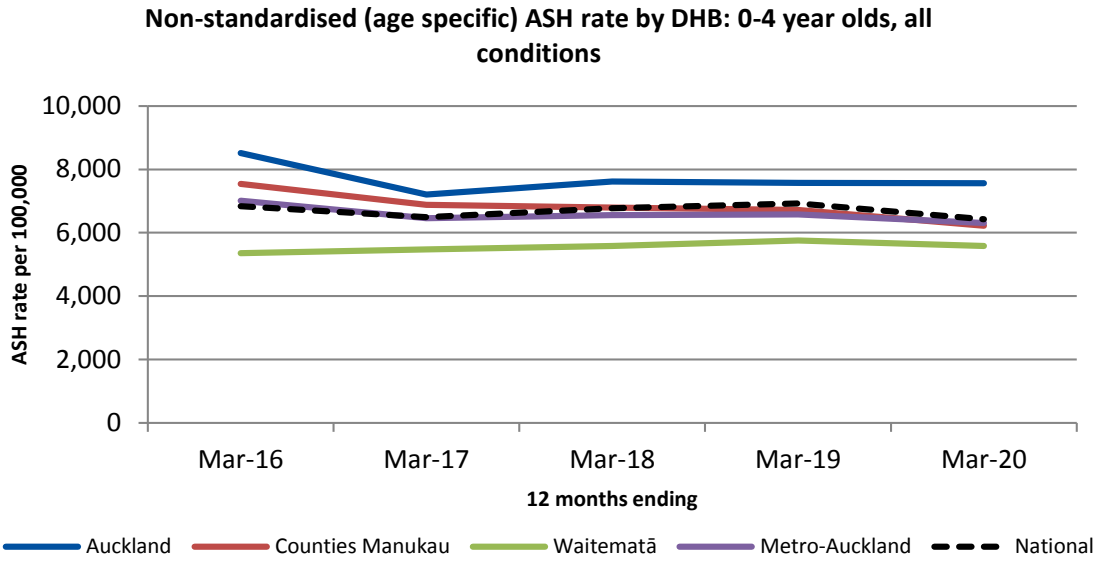
Determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure.

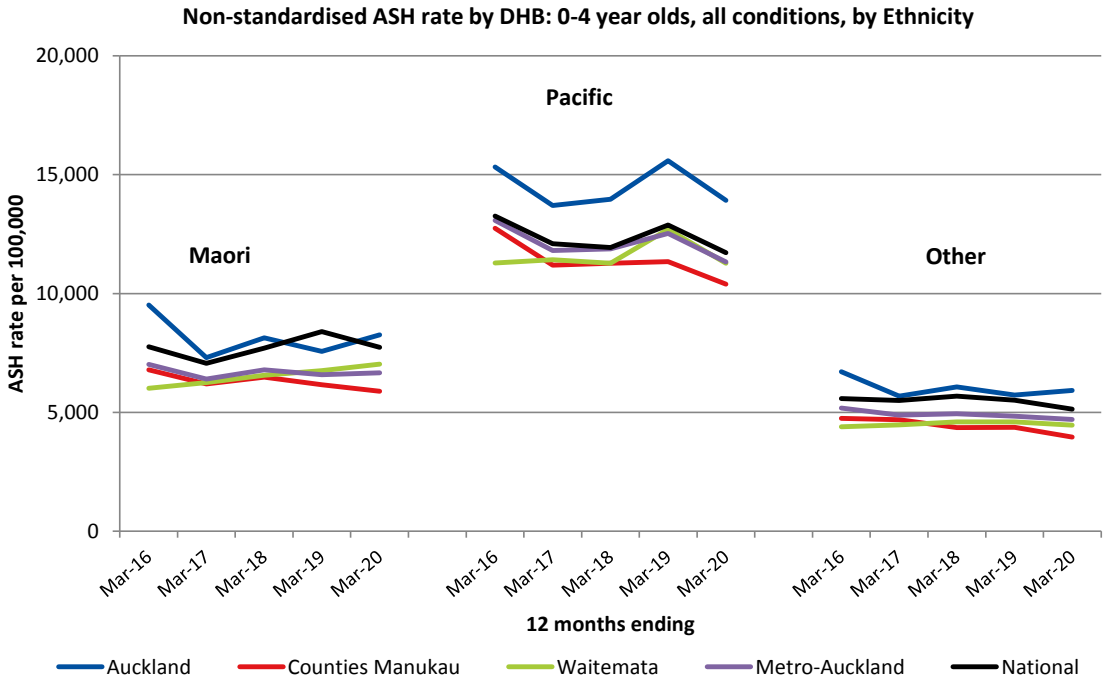
It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and strongly, by the overall social determinants of health, particularly housing. This measure can also highlight variation between different population groups that will assist with DHB planning to reduce disparities.

In 2019/20, the overall improvement milestone and the milestone for both Māori and Pacific ASH rates are to achieve a reduction of 3% for 0-4 year olds by June 2020. Ethnic specific targets are important to ensure that interventions reduce, not worsen inequity. Metro Auckland's rate is 6,302 per 100,000 for the 12 months to March 2020 for the total population. This is a 4.5% decrease (improvement) on the results to December 2018 (baseline) of 6,587[2] per 100,000 population. At an ethnic-specific level, the Māori and particularly Pacific rates also improved (by 1.4% and 10.7%) from baseline.

[2] These have been updated, see Note about the population on page 3





The higher (non-standardised) rates for Auckland DHB Pacific children persist, though they are declining compared to the same time last year.

When compared, rates for Pacific are nearly six times that of 'Other' ethnicities across metro-Auckland for dermatitis and eczema, four times the rate for cellulitis and nearly twice the rate for pneumonia. Though numbers are much smaller, Pacific and Māori children are much more likely to be admitted for vaccine preventable MMR (measles, mumps, rubella).

Using health resources effectively

Total acute hospital bed days

Improvement Milestone: 3% reduction (on December 2018 baseline) for Māori and Pacific population by 30 June 2020 (standardised)

	Milestone Target[2]			**Actual – 12 months to March 2020 (latest available)**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Māori	647.7	716.7	615.9	606	681	600
Pacific	780.0	754.5	773.9	843	737	829

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between the community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. Good access to primary and community care and diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed days per capita rates will be illustrated using the number of bed days for acute hospital stays per 1000 population domiciled within a DHB with age standardisation.

Certain conditions are more likely to result in unplanned hospitalisation alongside other contributory factors such as the referral process to ED (self, provider variation, ambulance etc.). The social determinants of health are a key driver of acute demand.

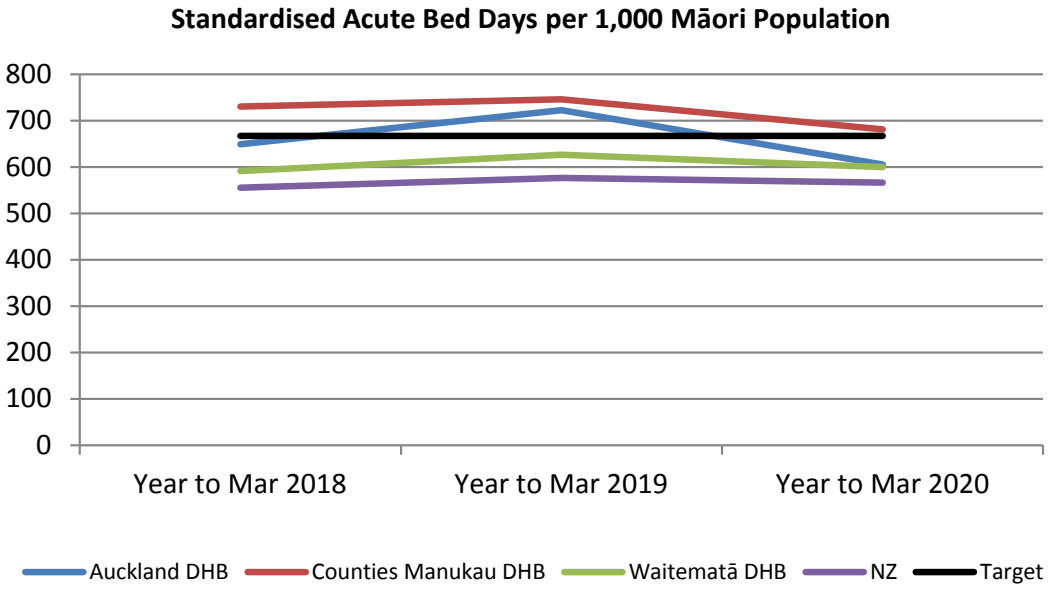
The Auckland Metro age standardised acute bed day rate per thousand population has been re-calculated and targets re-set to reduce the rate by:

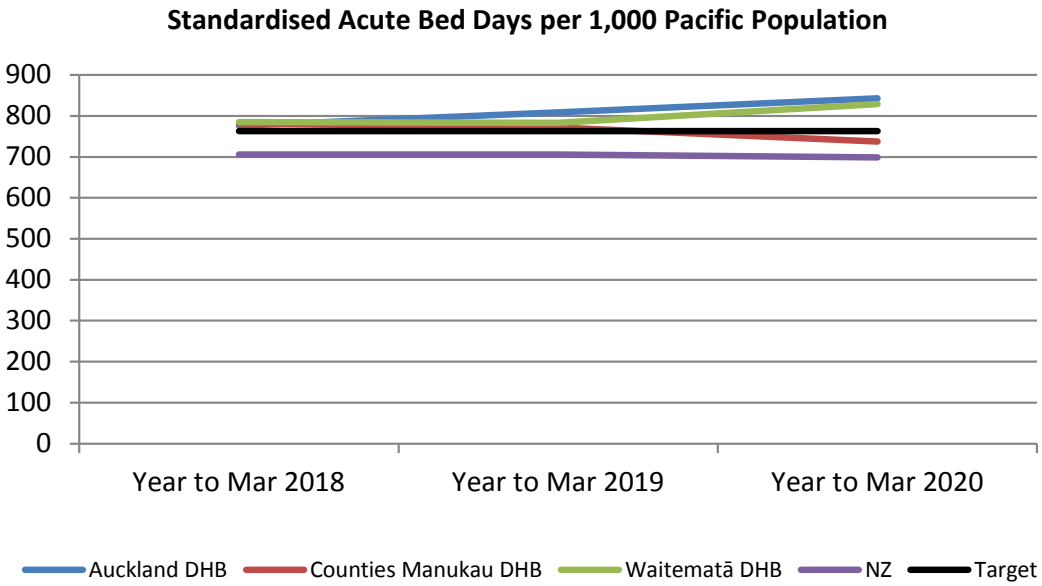
- 3% for the Māori population – target 667.0 standardised acute bed days/1000 by June 2020
- 3% for the Pacific population – target 762.6 standardised acute bed days/1000 by June 2020

It must be noted that the opening of new beds within the region will impact on this indicator.

While overall standardised rates have been generally declining over time, the metro-Auckland ethnic specific rates to March 2020 are mixed. Pacific rates are not meeting target for either Auckland or Waitematā DHBs, rates for Māori are better than target for both these DHBs. For Counties Manukau, performance is the opposite – better for Pacific and worse for Māori.

Note that only three time periods are presented in the trend graphs below, as recalculation of rates has not been done on retrospective datasets prior to this.


Standardised Acute Bed Days per 1,000 Māori Population
800
700
600
500
400
300
200
100
0
Year to Mar 2018
Year to Mar 2019
Year to Mar 2020
Auckland DHB
Counties Manukau DHB
Waitematā DHB
NZ
Target


Standardised Acute Bed Days per 1,000 Pacific Population
900
800
700
600
500
400
300
200
100
0
Year to Mar 2018
Year to Mar 2019
Year to Mar 2020
Auckland DHB
Counties Manukau DHB
Waitematā DHB
NZ
Target

Patient Experience

'Person-centred care' or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through enhanced patient safety and experience of care.

Hospital inpatient survey

The nationally applied DHB Adult Inpatient Survey was conducted quarterly from 2014. However, with the move to another reporting provider, the HQSC has taken the opportunity to redevelop both the inpatient and outpatient surveys. Therefore, the survey went into hiatus for most of 2020 and data is only available up until December 2019 (as previously reported). The redeveloped survey was conducted for the first time in August 2020 and results from this are still pending.

The previous Adult Inpatient Experience Survey captured four measured domains - communications, partnership, coordination, and physical and emotional needs. The 2019/20 target was to achieve a 5% improvement on the inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' by 30 June 2020.

Interventions take a multidisciplinary approach, focusing on culturally appropriate patient-centred information, co-design of patient experience initiatives with a focus on Māori and Pacific people, developing an integrated approach to feedback so patient stories can be heard outside of traditional survey collection mechanisms and developing a Māori Patient Experience plan endorsed by the Māori Health Equity Committee.

Learnings are to be shared with primary care through established networks and forums. There is also a focus on improving response rates, especially for Māori and Pacific, and monitoring this through regular reporting.

Waitematā DHB convened a Consumer Council in 2019 to advise on DHB priorities, strategy, health literacy and patient experience.

Improvement milestone: 5% improvement on the inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' by 30 June 2020.

Hospital Inpatient survey – percentage of respondents who answered 'yes, completely', to the inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?'

Targets				% of 'yes, completely' result for Q2 2019/20			
ADHB	CMDHB	WDHB	Metro-Auckland	ADHB	CMDHB	WDHB	Metro-Auckland
55.2%	52.5%	47.0%	51.4%	47.4%	58.8%	44.8%	49.4%

With the exception of Counties Manukau DHB, the improvement target was not achieved for this measure in Q2 2019/20. The Metro-Auckland results improved slightly against the 2018 calendar year baseline (49.0%), the Waitematā DHB result did not change from baseline (44.8%), and Auckland DHB's performance is lower than the baseline (52.6%).

Primary health care patient experience survey (PHC PES)

Primary care survey: 10% relative improvement on PES question: 'When you ring to make an appointment how quickly do you usually get to see your current GP?' by 30 June 2020

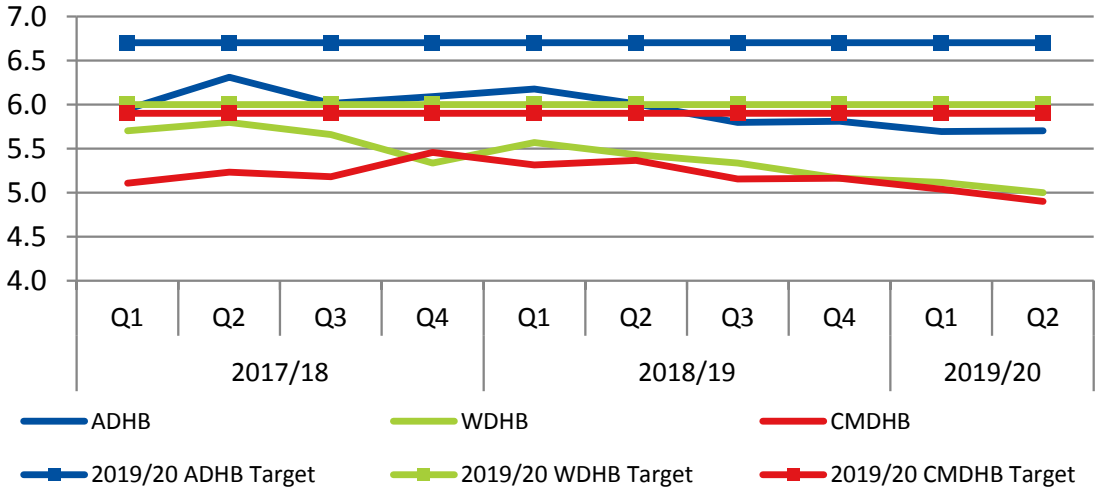
The PHC PES was implemented in practices over the 2017/18 year. Since then, practice participation has steadily increased. The focus this year has been on improving practice response to patient feedback.

Primary health care patient experience survey – percentage of respondents who answered 'same day' or 'next day', to the survey question: 'When you ring to make an appointment how quickly do you usually get to see your current GP?'

Targets (by practice location)				% of 'same day/next day' result for Q2 2019/20			
ADHB	CMDHB	WDHB	Metro-Auckland	ADHB	CMDHB	WDHB	Metro-Auckland
6.7	5.9	6.0	6.2	5.7	4.9	5.0	5.2

None of the three DHBs are meeting target in Q2 2019/20. While Auckland DHB's results are fairly stable, Waitemata and Counties Manukau DHB results are declining.

Percentage of PHC PES respondents who report being able to make an appointment to see their current GP on the same day or the next day (by DHB of practice)



Preventing and detecting disease early

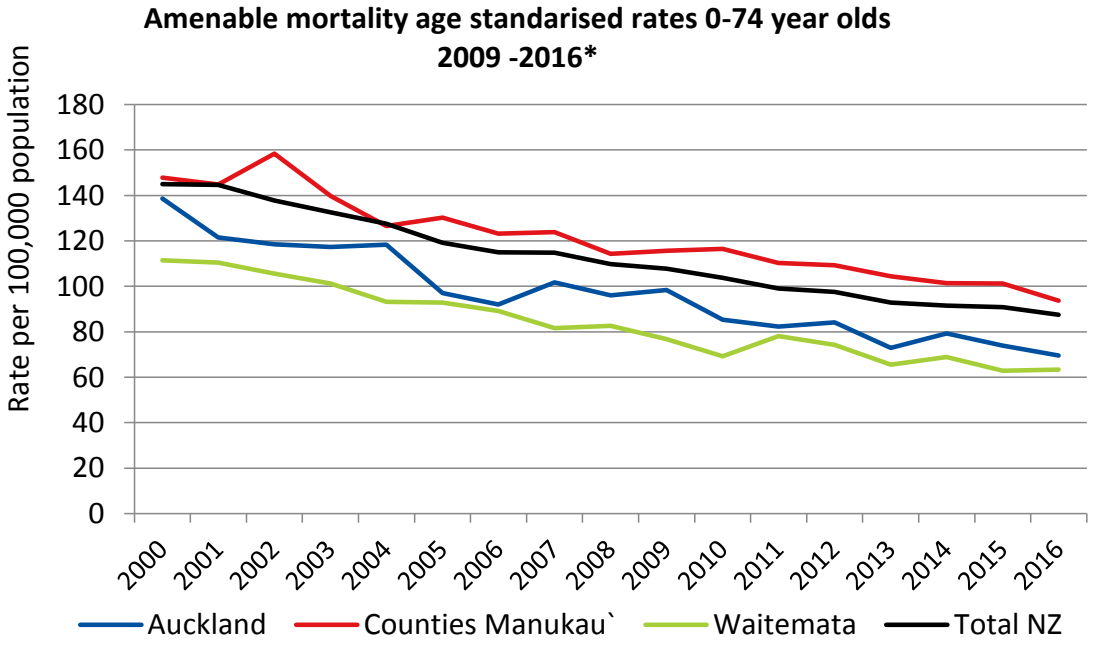
Amenable mortality

Improvement milestone 6% reduction for each DHB (on 2013 baseline) by 30 June 2021.
2% reduction for Māori and Pacific by 30 June 2020.

Note: no new data is currently available

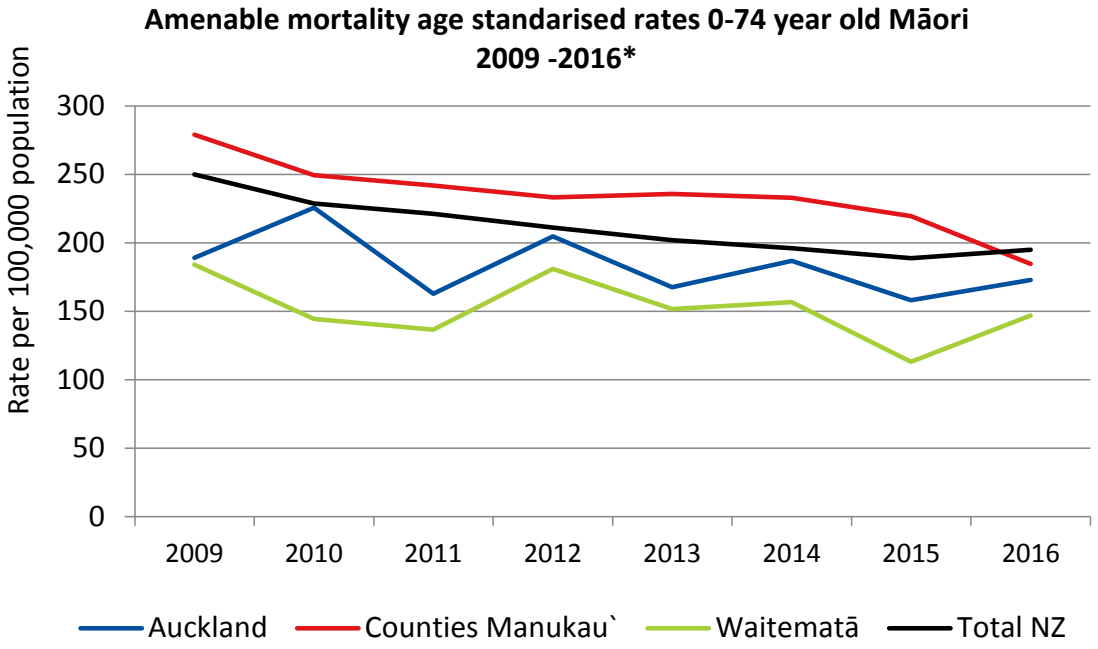
	Milestone Target			Actual – 2016 deaths (* draft data)		
	Auckland	Counties	Waitematā	Auckland	Counties Manukau	Waitematā
Total Pop	70.4	99.2	62.1	69.6	93.7	63.3
Māori	154.8	215.2	110.8	173.0	184.6	146.8
Pacific	159.3	195.2	136.8	154.9	181.7	146.4

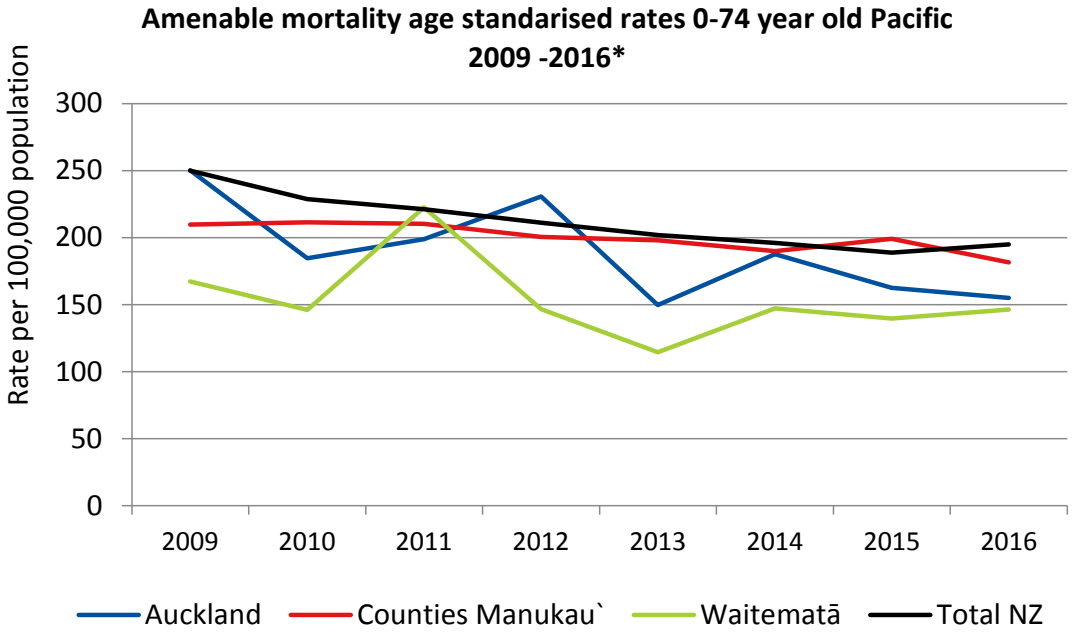
Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before 75 years of age. This indicator considers all deaths for those aged 0-74, in the relevant year with an underlying cause of death included in the defined list of amenable causes. It takes several years for some coronial cases to return verdicts, therefore results for this indicator are approximately 2-3 years delayed. The 2016 coded mortality data has been delayed, so we are unable to provide updated results currently.



Based on trends over time, all three Metro Auckland DHBs show consistently declining rates as illustrated in the graph above, despite some fluctuation. Comparing current (2016) rates with baseline (2015) rates, there is a 2% decline in rates for metro-Auckland, or 1% when comparing the 5 year rates. Given that there will always be some annual fluctuation and that the target extends to 2021, we should be on track to meet the 6% reduction by 2021.

While rates for Māori are also declining, the sharp, consistent decline seen for overall rates is not evident. This is even more so for Pacific rates, however smaller numbers will mean greater year on year variation.


Amenable mortality age standarised rates 0-74 year old Māori
2009 -2016*
Rate per 100,000 population
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
2016
Auckland
Counties Manukau`
Waitematā
Total NZ


Amenable mortality age standarised rates 0-74 year old Pacific
2009 -2016*
Rate per 100,000 population
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
2016
Auckland
Counties Manukau`
Waitematā
Total NZ

Youth access to and utilisation of youth-appropriate health services

Chlamydia testing coverage in 15-24 year old males

Improvement milestone: increase coverage of chlamydia testing for males to 6% for 15-24 year olds by June 2020.

Results for the six-month period to December 2019: males only.

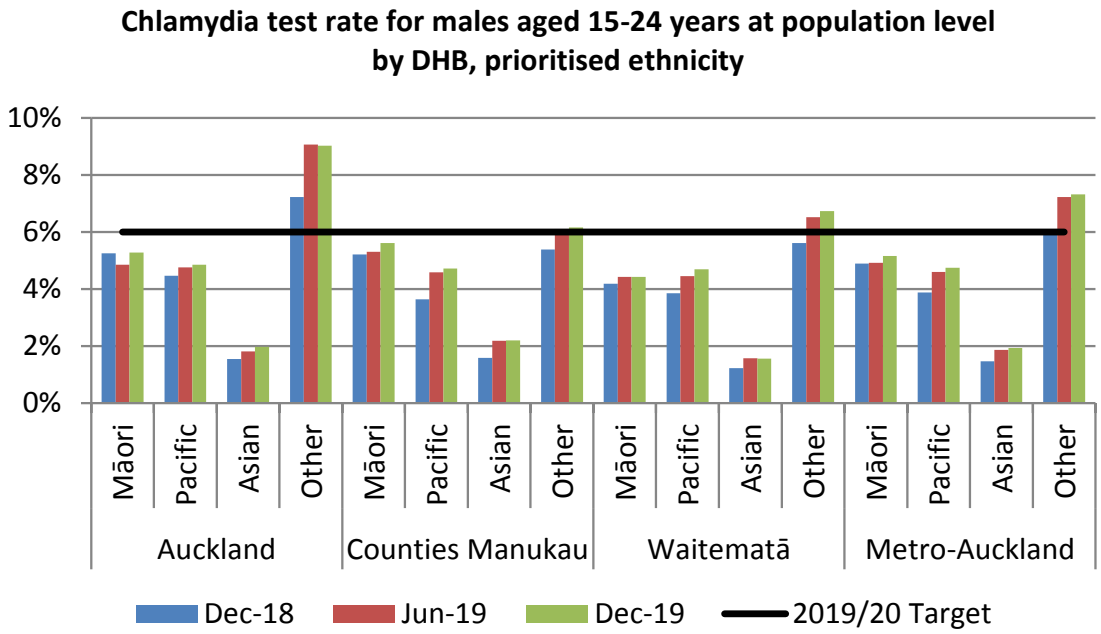
DHB	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	Chlamydia test rate (%)
Auckland	Māori	200	3,790	**5.3%**
	Pacific	249	5,130	**4.9%**
	Asian	280	14,210	**2.0%**
	Other	1,338	14,820	**9.0%**
Counties Manukau	Māori	481	8,570	**5.6%**
	Pacific	569	12,050	**4.7%**
	Asian	264	12,000	**2.2%**
	Other	670	10,870	**6.2%**
Waitematā	Māori	263	5,950	**4.4%**
	Pacific	200	4,270	**4.7%**
	Asian	159	10,270	**1.5%**
	Other	1,432	21,280	**6.7%**
Metro-Auckland	Māori	944	18,310	**5.2%**
	Pacific	1,018	21,450	**4.7%**
	Asian	703	36,480	**1.9%**
	Other	3,440	46,970	**7.3%**

* 6 with unknown gender excluded

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet can lead to increased risk of poor adult health and overall poor life outcomes.

The focus for 2019/20 has been on sexual and reproductive health – specifically on Chlamydia Screening for 15-24 year old males for whom testing coverage has been very low. Chlamydia is the most commonly reported sexually transmitted infection in Auckland, usually diagnosed in females aged 15-19 years and in males aged 20–24 years. However, in the context of SLMs, chlamydia screening is being used as a proxy for access to sexual health services.

At a population level, screening coverage rates for men have improved when comparing the six months to December 2018 and the six months to June 2019. This will need further monitoring to understand if these rates continue to trend upwards. Overall, the target of 6% coverage for males is not being reached, despite the upward trend.



At a population level, screening coverage rates for men have improved overall, when comparing the six months to December 2019 and the six months to December 2018. However, the rates for Māori, Pacific and Asian males have not increased as markedly as they have for other ethnicities, effectively widening the gap between each of these ethnicities and 'Other' ethnicities' screening coverage. The only exception at DHB level is for Counties domiciled Pacific males, where there is a small decrease in gap between Pacific and other ethnicities screening coverage.

Current results – at PHO enrolled population level:

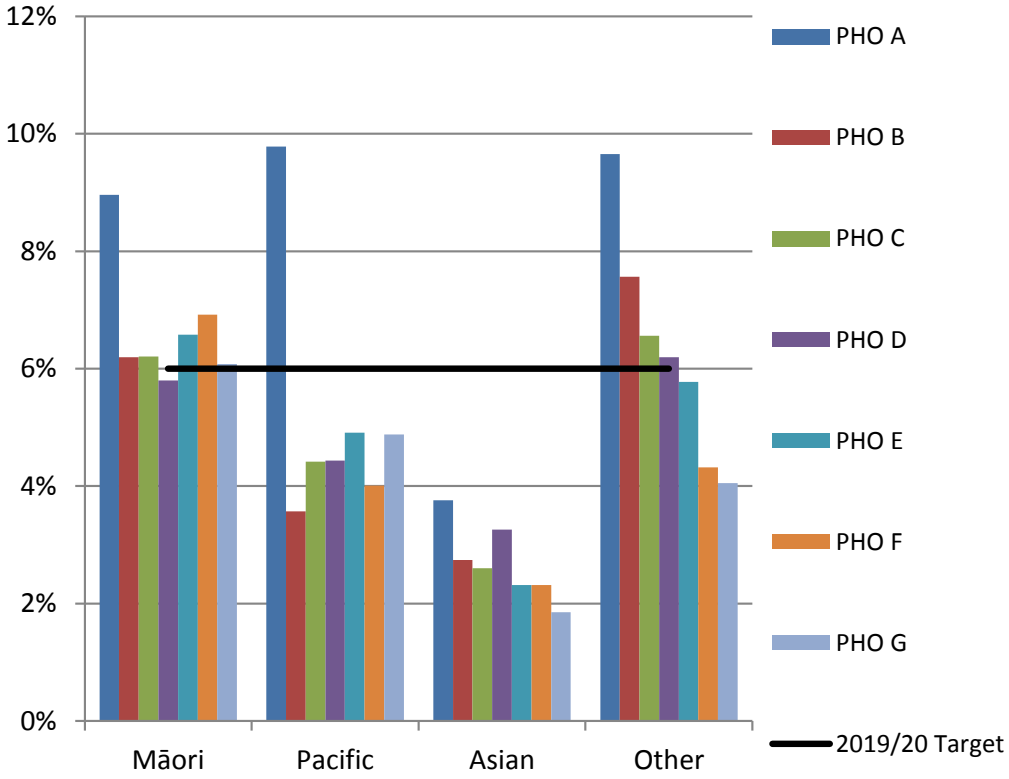
Results at this level are much better and improving over time – the enrolled Māori population appears to have the best overall coverage. The differences between this level and population level coverage rates suggests that there is under-enrolment for this cohort of the population.

Results at December 2019 (target 6%):

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	Chlamydia test rate (%)
PHO A	Māori	25	279	9.0%
	Pacific	36	368	9.8%
	Asian	41	1,091	3.8%
	Other	122	1,264	9.7%
PHO B	Māori	64	1,033	6.2%
	Pacific	36	1,008	3.6%
	Asian	42	1,533	2.7%
	Other	70	925	7.6%
PHO C	Māori	433	6,977	6.2%
	Pacific	371	8,394	4.4%
	Asian	253	9,719	2.6%
	Other	1,670	25,454	6.6%
PHO D	Māori	78	1,345	5.8%

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	Chlamydia test rate (%)
	Pacific	150	3,381	4.4%
	Asian	52	1,596	3.3%
	Other	110	1,775	6.2%
PHO E	Māori	103	1,565	6.6%
	Pacific	52	1,059	4.9%
	Asian	57	2,464	2.3%
	Other	533	9,234	5.8%
PHO F	Māori	169	2,442	6.9%
	Pacific	256	6,387	4.0%
	Asian	74	3,196	2.3%
	Other	57	1,320	4.3%
PHO G	Māori	20	329	6.1%
	Pacific	8	164	4.9%
	Asian	27	1,456	1.9%
	Other	133	3,282	4.1%

Chlamydia test rate for males aged 15-24 years at PHO enrolled population level by ethnicity

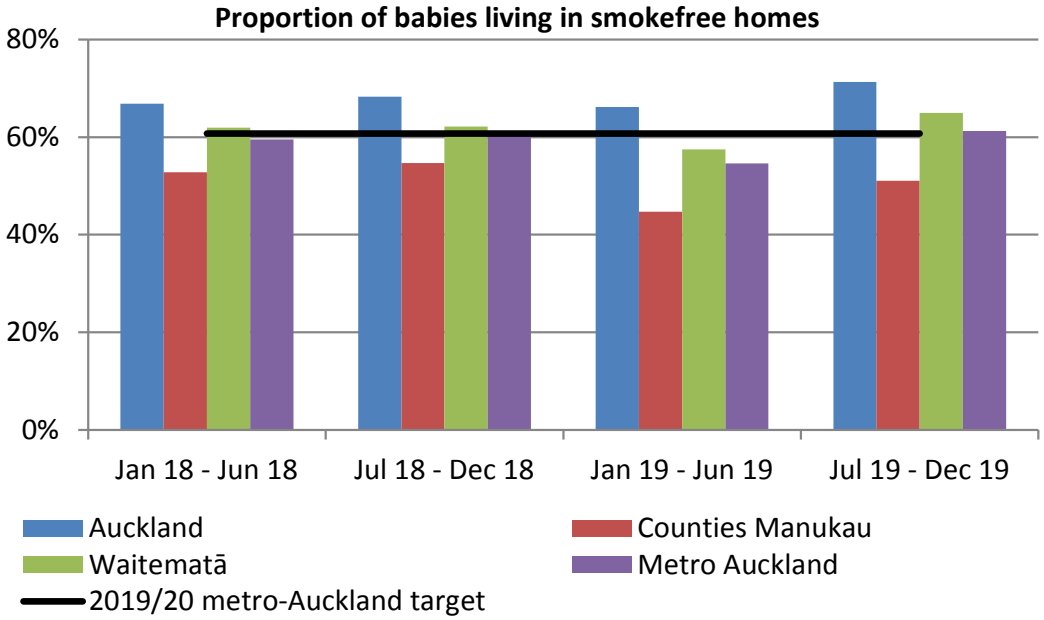


Healthy start

Proportion of babies who live in a smoke-free household at six weeks post-natal

Improvement milestone: Increase the proportion of babies living in smokefree homes by 2% (January 2018 – June 2018 baseline)

Reporting period	DHB of domicile			
	Metro-Auckland	Auckland	Counties Manukau	Waitematā
Jan 18 - Jun 18	59.5%	66.8%	52.8%	61.9%
Jul 18 – Dec 18	60.9%	68.3%	54.7%	62.2%
Jan 19 - Jun 19	54.6%	66.2%	44.7%	57.5%
Jul 19 – Dec 19	61.2%	71.3%	51.1%	64.9%
2019/20 Targets	**60.7%**	**68.2%**	**53.9%**	**63.2%**



The methodology for calculating measures on previous Ministry of Health releases has been changing, therefore, the data presented uses only the latest methodology. Results show that only Counties Manukau DHB is not reaching the DHB's individual target although performance has improved since the last reporting period.

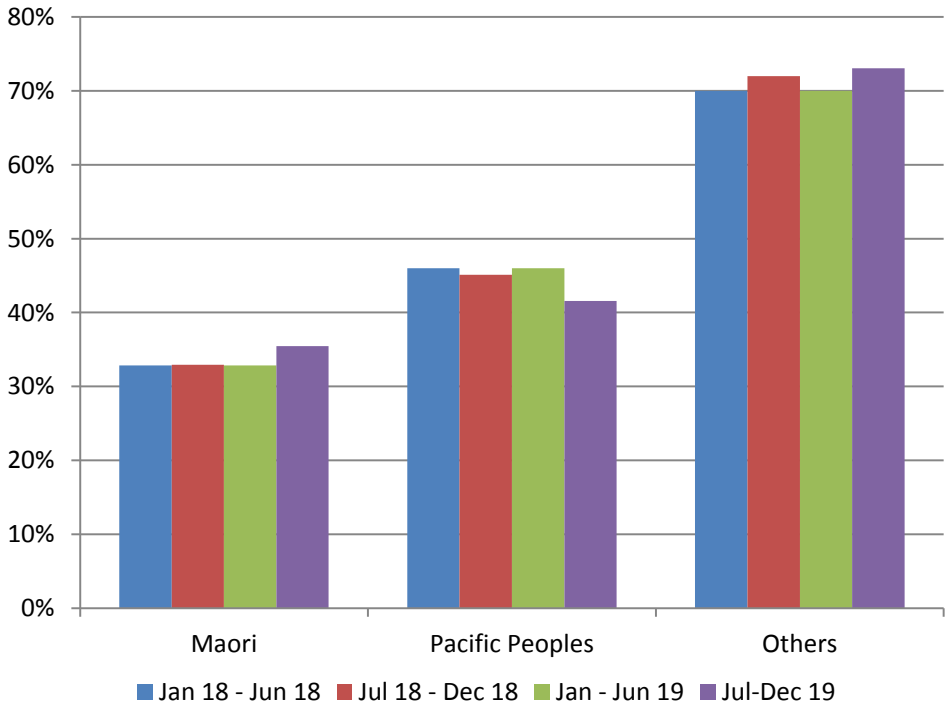
This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy to birth and the home environment within which they will initially be raised.

Data is sourced from Well Child Tamariki Ora providers and shows that around 61% of metro-Auckland babies live in a smokefree household at six weeks post-partum with a small improvement since the January-June 2018 reporting period.

The percentage of Māori babies living in smokefree homes is much lower than other ethnicities - 29% in Counties Manukau DHB, 38% in Waitematā DHB and 48% in Auckland DHB. Rates for Pacific are

also lower than other ethnicities. This correlates with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations.

Proportion of babies aged <56 days living in a smokefree household at six weeks post-natal: Metro-Auckland



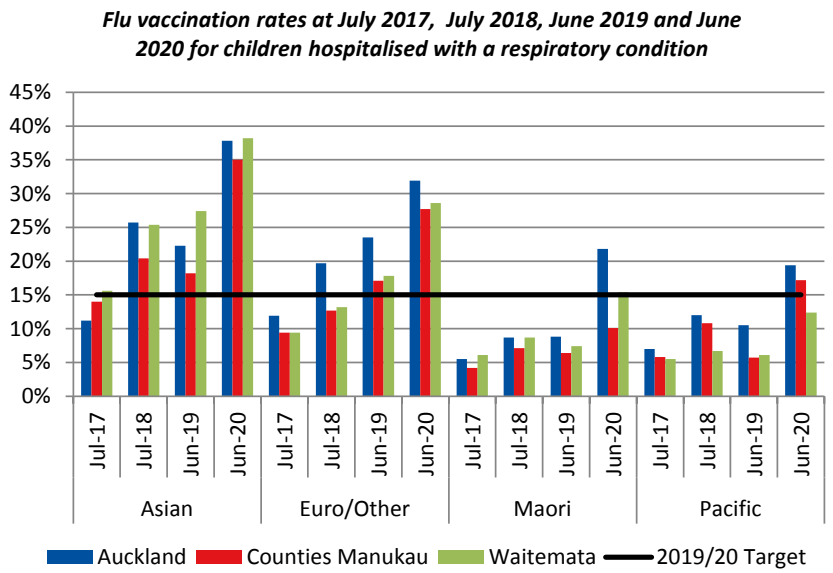
4. Improvement Activities and Contributory Measures

Improvement activities create change and contribute towards improved outcomes in the various SLM milestones. These activities are measured locally by contributory measures which support a continued focus in each area. Activities support the improvement of the system as a whole. For 2019/20, Auckland Metro region focused on choosing activities which relate to multiple milestones where possible for best collective impact.

Respiratory Admissions in 0-4 year olds

SLM Milestones impacted: Ambulatory Sensitive Hospitalisation (ASH) Rates per 100,000 for 0 – 4 Year Olds
Amenable mortality
Babies in Smokefree Homes
Acute hospital bed days

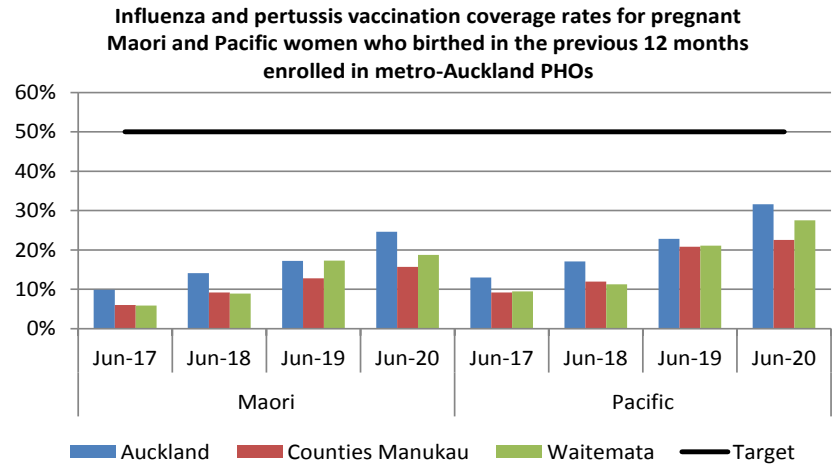
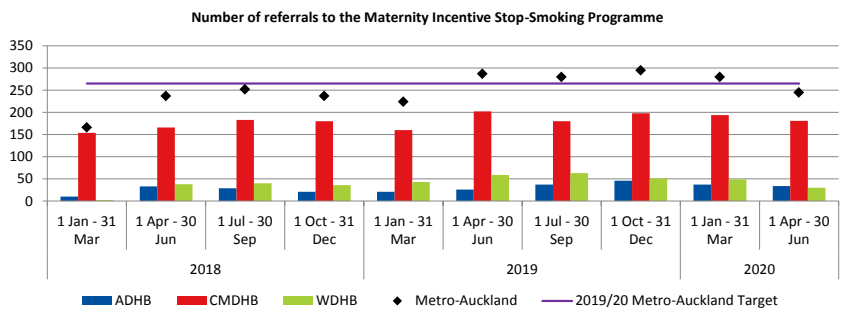
Respiratory conditions are the largest contributor to ASH rates in Metro Auckland. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants and young children, and can lead to further respiratory complications; both of these are vaccine preventable. Social factors like housing and smoking also contribute to poor respiratory health. We are working to increase referrals to healthy housing programmes and help more pregnant women quit smoking. eReferrals for smoking and healthy housing went live in early 2019, supporting a reduction in ASH admissions. We are working with healthAlliance to develop a process for matching e-referral data to PHO registers with a view to driving increased referrals from practices.

Indicator	Target	Results
Influenza vaccination rates for eligible Māori and Pacific children	15%	

Commentary

- Overall coverage has increased from 7.4% in July 2017 to 22.8% in June 2020. Coverage rates have consistently increased since monitoring and improvement activities began.
- Auckland DHB domiciled children have the highest coverage at 27.5%, closely followed by Waitematā at 24.5%
- While a coverage rate of nearly 23% has been achieved for the total population, rates for Māori and Pacific children continue to be much lower, though these are also increasing and for the first year, the 15% target has been exceeded for Māori children in Waitematā DHB
- Four of the seven PHOs have surpassed the 15% target for their eligible Māori children, and all but one have surpassed this target for their Pacific children.

Implementation of the special immunisation programme had wide support by PHOs, although national supply chain logistics challenges related to influenza vaccine may have adversely affected these results. The data matching process conducted by DHBs produced valuable lists for action supported by PHOs. Concerns about COVID-19 in the community and coordinated efforts to vaccinate vulnerable populations as part of winter planning likely impacted the increase in uptake in quarter 4. Further integration of processes in practice PMS and workflow will likely see greater gains. Vaccination rates should continue to improve – particularly for Māori and Pacific children – with integration into wider systems such as inpatient services – where the first vaccination is given in hospital, socialisation of the importance of flu vaccination for children can occur alongside more effective use of discharge summaries.

Indicator	Target	Results
Increase influenza and pertussis vaccine coverage rates for pregnant Māori and Pacific women	50%	 **Commentary** Combined antenatal influenza and pertussis vaccination rates have improved markedly since June 2017. Results for Māori have more than doubled for both Counties Manukau and Auckland DHBs and more than trebled for Waitematā DHB. Improvements for Pacific are also obvious. Despite this, coverage for both Māori and Pacific pregnant women is still well below the target of 50% and below that of 'Other' ethnicities. Antenatal pertussis vaccination rates for Māori and Pacific were below 10% for all the metro-Auckland DHBs in 2016 and are now over 27% for Māori and over 37% for Pacific. Across 2018 and 2019 there has been a significant uplift across multiple ethnicities. To June 2020, the highest vaccination coverage rates (12 month period) are seen among women domiciled in Auckland DHB (61.5%), followed by Waitematā DHB (54.4%) and Counties Manukau DHB (42.2%). By ethnicity, Auckland and Waitemata DHBs have the best results for Māori at 37.5% and 31.6% respectively, with Counties Manukau at 22.3%.
Increase referrals to maternal incentives smoking cessation programmes, for pregnant women	ADHB = 27 WDHB = 58 CMH = 180 = 265 per quarter	 **Commentary** Overall performance for the region met the 2019/20 target, with all but Waitematā DHB meeting quarterly targets., Referral numbers have continued to grow - overall a 48% increase since March 2018. Note that the differences in referral numbers between DHBs reflect the size of the programme operating at each DHB – the Counties programme being much larger than the others. A system whereby pregnant women are required to opt out of referral to smoking cessation was successfully trialled in one DHB and has been adopted by the other two and is being considered by PHOs. Implementation has been incomplete and will be further supported over the next year. Better integration with Maternity Services is also needed.

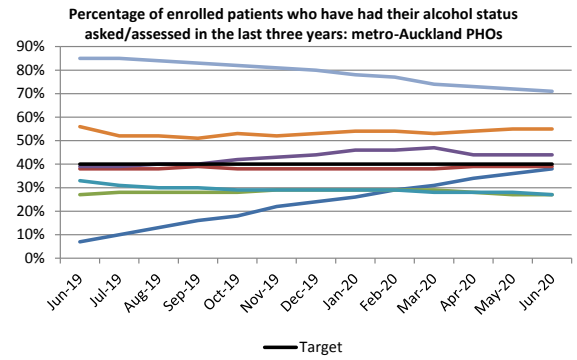
Alcohol Harm Reduction

SLM Milestones impacted: ***Youth access to and utilisation of youth-appropriate health services***
Acute bed days
Amenable mortality

Identifying and monitoring alcohol-related ED presentations will enable better understanding of alcohol harm and the populations and communities most affected. From July 2017, a mandatory data item was added to the National Non-admitted Patient Collection. In some DHBs, full implementation and reporting to the Ministry has taken some time to implement. The mandatory question is "Is alcohol associated with this event?" Possible answers are: yes, no, unknown and secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved). It should be noted that the response recorded may be a subjective assessment by healthcare staff and not confirmed by alcohol testing. Data quality has been an issue, particularly for Waitematā DHB, with missing data in some areas. Quality improvement work undertaken during 2018/19 resulted in the question becoming mandatory. This has achieved some improvement, however, work is ongoing.

Alcohol ABC in primary care has been rolled out in some areas, led by a Counties Manukau programme. A SLM Implementation group specifically for Alcohol ABC has been established and will consider the resource required to offer practice support and quality improvement. The 2020/21 SLM Plan has included Alcohol ABC within the Counties Manukau catchment, and these will be evaluated and lessons shared.

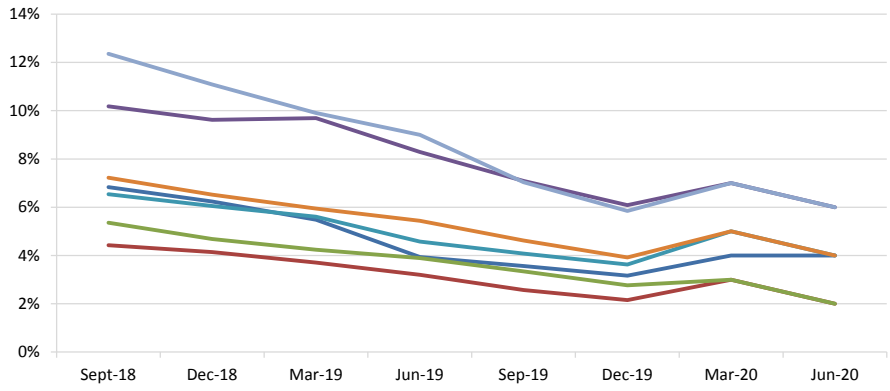
Indicator	Target	Results	Commentary
Percentage of ED presentations where alcohol involved	Baseline	Data quality at Waitematā DHB remains insufficient to be able to baseline metro-Auckland results correctly.	Data capture is now mandatory at Waitematā DHB resulting in improved quality for 2019/20 reporting, but still with some issues to resolve.
Reduce 'unknown' alcohol related ED presentation status	<10%	Results (latest available) to March 2020 (DHB of service): Auckland DHB = 4.1% Counties Manukau DHB = 5.6% Waitematā = 55.2%	See above.

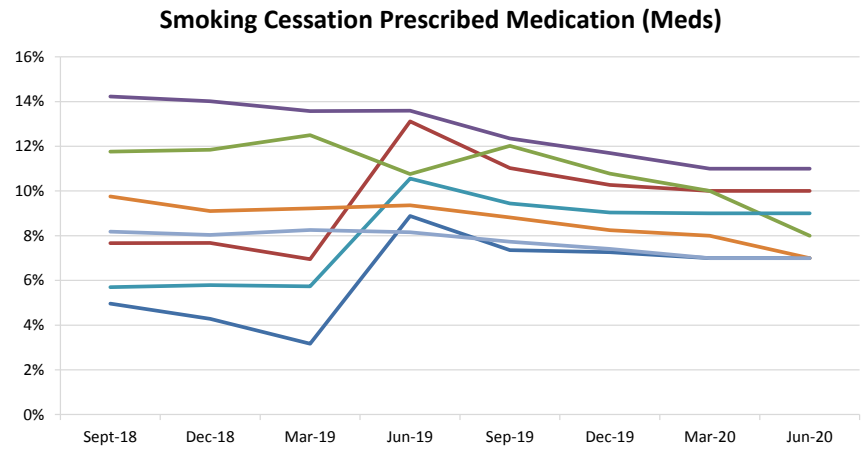
Indicator	Target	Results	Commentary
Percentage of the enrolled population aged over 14 years with alcohol status documented *Note: PHOs de-identified*	40%		The data is only available from practices with Medtech PMS and represents 73% of the enrolled population aged over 14 years. Currently three of the seven PHOs are meeting or exceeding the target of 40%, with another two very close. We are working with PMS vendors to reduce the amount of missing data. A quality improvement approach across all DHBs is in development, but has been delayed due to the increased requirements in the sector for COVID-19 response.

Smoking Cessation

SLM Milestones impacted: ***Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds***
Acute bed days
Amenable mortality
Babies in smokefree homes

Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. Using the 2018 usually resident population, 13% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (28%) and Pacific people (21%), although reduced since 2013. Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

Indicator	Target	Commentary
Rate of referral to smoking cessation providers by PHO *Note: PHOs de-identified*	N/A – new indicator developed	Referral rates have previously been measured using Read codes in the practice PMS. This has been found to be inaccurate – thus performance cannot be measured against the target set. A new definition has been developed for an alternative performance indicator that measures referrals received by Ready Steady Quit and CMH Living Smokefree. **Smoking Cessation Referrals to Ready Steady Quit and Living Smokefree services** 

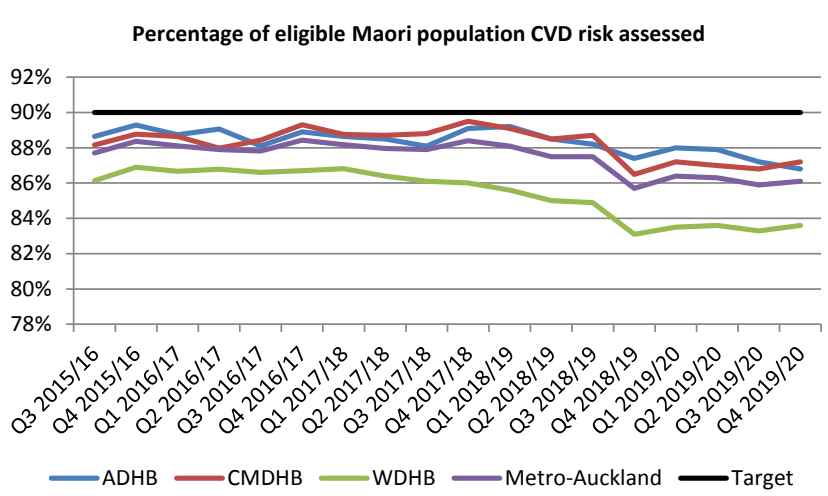
Indicator	Target	Commentary
Rate of prescribing of smoking cessation medications by PHO *Note: PHOs de-identified*	N/A – new indicator developed	Measuring prescribing rates using Read codes under reports primary care prescribing. Again, performance cannot be measured against the target set and a new definition has been developed for an alternative performance indicator that measures prescriptions supplied, sourced from PHOs' PMS systems. 

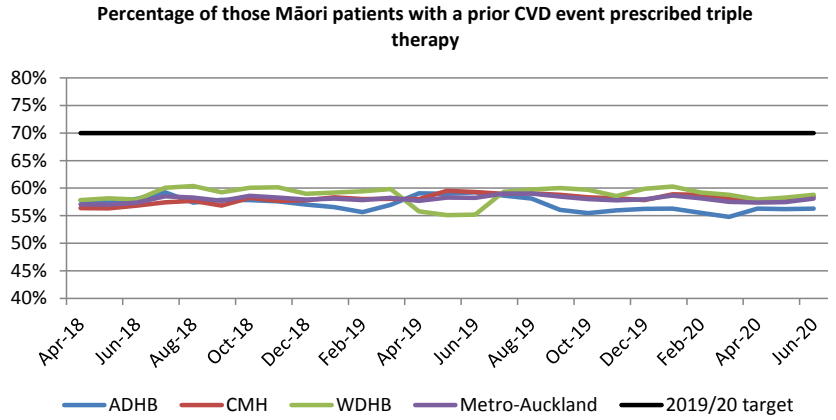
Cardiovascular Disease (CVD) Risk Assessment and Management

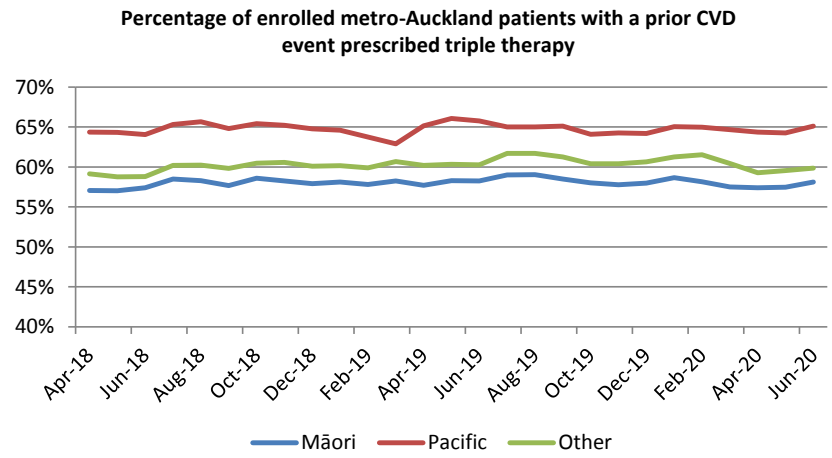
SLM Milestones impacted: ***Acute bed days***
Amenable mortality

CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Patients with established CVD (and those assessed to be at high CVD risk) are at very high risk of coronary, cerebral and peripheral vascular events and death, and should be the top priority for prevention efforts in clinical practice.

The burden of CVD falls disproportionately on Māori and Pacific populations, and there are well-documented inequities in CVD mortality, case fatality and incidence. Reducing these inequities is a high priority and can be achieved through increased use of evidence-based medical management of high-risk patients.

Indicator	Target	Results
CVD Risk Assessment rates for Māori	90%	 **Commentary**

Indicator	Target	Results
		The introduction of the new CVDRA algorithms following the 2018 consensus statement has likely contributed to lower CVDRA rates. The process for risk assessment was less clear. The number of people eligible for risk assessment was increased. Considerable work has been done by PHOs to implement the new risk assessment algorithms. Results show performance is declining over time, particularly for Waitematā DHB, although this seems to have levelled off over the past financial year. Various strategies have been tried by PHOs to engage with young Māori men to measure cardiovascular risk. Considerable resource has been required with minimal results, primary car enrolment and engagement is low for this age cohort. Many of these men do not engage with primary care. PHO led initiatives at work places and at social events have encountered barriers including: • Difficulty in obtaining blood results • No clear criteria for referral and follow-up for patients at different levels of clinical acuity • Lack of processes resulting in poor flow of data between systems including practice management systems, Testsafe and risk assessment tools • Patients being enrolled in different PHOs • Cost of running initiatives Extensive discussions on approaches and results have been had at both Implementation and Steering Group level with the resulting view that a nationally driven health promotion approach is more likely to result in success.
Increase prescribed triple therapy for those Māori with a prior CVD event.	70%	 **Commentary** *Note: there were some data quality issues between April-June 2019 which accounts for the dip in performance at this time* Results remain relatively static over time for Māori and remain lower than for other ethnic groups. All DHBs are below the 70% target, for all ethnicities.

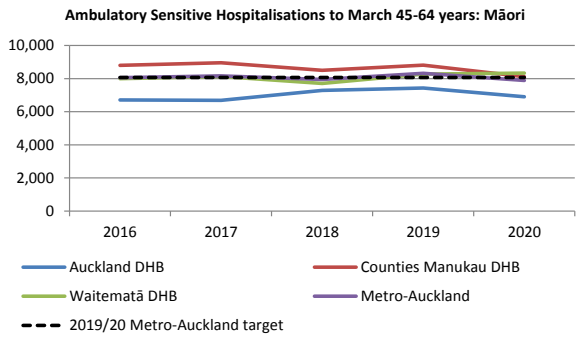
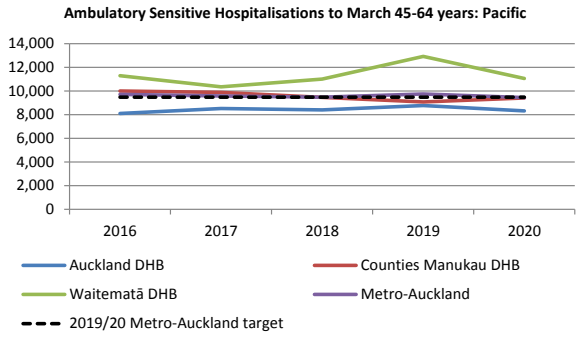
<table>
<tr><th>Indicator</th><th>Target</th><th>Results</th></tr>
<tr><td></td><td></td><td> 

See commentary above.</td></tr>
<tr><td>Influenza vaccination rate for patients with a prior CVD event under 65 years of age</td><td>35%</td><td>
<table>
<tr><th></th><th>CY 2018</th><th>CY 2019</th></tr>
<tr><td>Auckland</td><td>31.6%</td><td>27.1%</td></tr>
<tr><td>Counties Manukau</td><td>30.4%</td><td>31.1%</td></tr>
<tr><td>Waitematā</td><td>25.6%</td><td>31.8%</td></tr>
</table>
<table>
<tr><td>Metro Auckland</td><td></td><td></td></tr>
<tr><td></td><td>CY 2018</td><td>CY 2019</td></tr>
<tr><td>Māori</td><td>28.9%</td><td>25.5%</td></tr>
<tr><td>Pacific</td><td>38.7%</td><td>34.4%</td></tr>
<tr><td>Asian</td><td>32.7%</td><td>30.8%</td></tr>
<tr><td>European/Other</td><td>23.7%</td><td>26.3%</td></tr>
</table>
Waitemata DHB's coverage shows the greatest improvement overall when comparing the two time periods available, as well as significant improvement by ethnicity – results for Māori have increased by 5.7% and for Pacific by 3.5% (absolute). In contrast, Auckland DHB's results have deteriorated across all ethnic groups, but particularly for Māori and Pacific. Māori and Pacific rates for Counties Manukau DHB have also decreased, but not as significantly. However, Pacific rates are closest to (or surpassing) target across all three DHBs.
A key challenge with this indicator is the under recording of vaccinations in the NIR. Vaccinations delivered at work places are not recorded in either the NIR or the practice PMS. This makes setting recalls in primary care an inefficient process.</td></tr>
</table>

Complex Conditions

SLM Milestones impacted: ***Acute bed days***
Amenable mortality

Improving chronic condition hospital admission rates for adults requires improved integration of services and a 'whole of system' approach that engages patients and their families, as well as community and hospital based services. A number of activities have been shown to be effective in reducing avoidable hospitalisations for chronic conditions, including system or institution-wide programmes to improve access to health services, comprehensive disease management programmes which are patient-focused and involve multidisciplinary teams, education and self-management programmes in association with disease management programmes and disease-specific management programmes for long-term conditions.

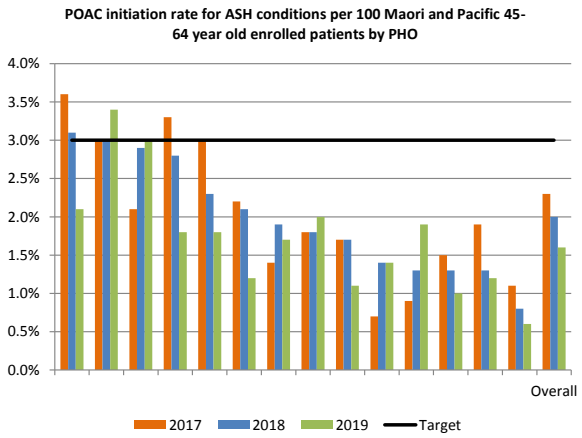
Indicator[3]	Target[2]	Results	Commentary
Reduction in the overall ASH rate for Māori adults aged 45-64 years old.	8,073 per 100,000 (2% reduction) (Baseline = 8,238 per 100,000 at December 2018)		Coding of ASH in primary care has improved over time, with the development of a more robust definition. We are monitoring utilisation of Primary Options for Acute Care (POAC) for ASH related conditions for Māori and Pacific patients aged 45 – 64 years. Data sharing between primary and secondary care to improve coding for ASH conditions contributing to acute hospital bed days has been agreed under the Metro Auckland Data Sharing Framework. Data has been supplied from the Ministry of Health. Processes for improving coding are in development. Improved coding of long term conditions in primary care will support targeting appropriate cohorts with QI activity.
Reduction in the overall ASH rate for Pacific adults aged 45-64 years old.	9,474 per 100,000 (2% reduction) (Baseline = 9,667 per 100,000 at December 2018)		

[3] Note: rates are standardised

Primary Options for Acute Care

SLM Milestones impacted: ***Acute bed days***
Amenable mortality

Primary Options for Acute Care (POAC) provides healthcare professionals with access to investigations, care or treatment for their patient, when the patient can be safely managed in the community. Access to existing community infrastructure and resources is utilised to provide services that prevent an acute hospital attendance or shortens hospital stay for patients who do attend or are admitted. The aim of POAC is to deliver timely, flexible and coordinated care, meeting the healthcare needs of individual patients in a community setting. We aim to have more individuals being treated (where appropriate) through the POAC pathway, thus preventing unnecessary and costly acute hospital admission.

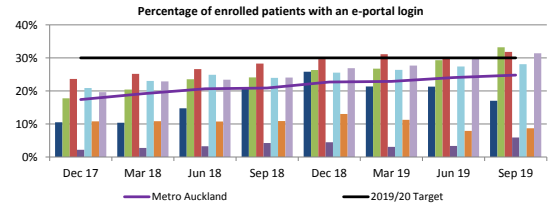
Indicator	Target	Results	Commentary
Increased POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions	3 per 100 (3%) per PHO	 **Variation by PHO (split by DHB location) across the metro-Auckland region (PHOs not identified)**	Initiation rates vary by geographic location, even where the PHO is the same. Overall, rates have declined between reporting periods. Regular POAC data has not been available until recently and there have been various data quality issues to resolve. NHI level data is available to PHOs. *See commentary above.*

Patient Experience

E-portals

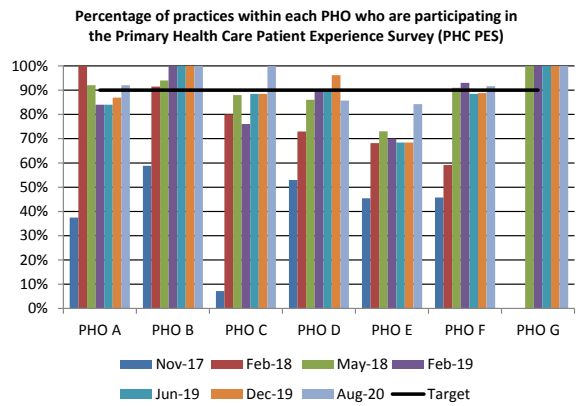
SLM Milestones impacted: ***Patient experience of care***

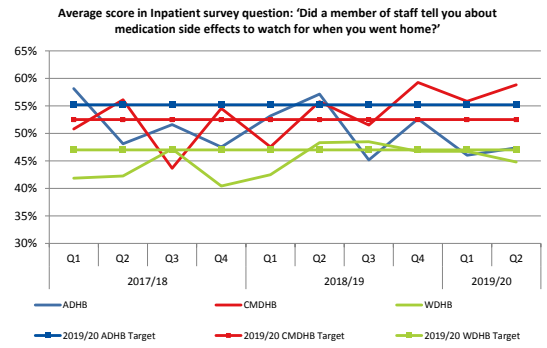
E-portals are a single gateway for patients to gain access to their general practice information which can include: booking appointments, ordering repeat prescriptions, checking lab results, and viewing clinical notes/records. More general practices are offering patient portals and there is scope within primary health care for them to positively impact on patient experience. This can be enabled through alternative access point/navigation for the patient, enabling coordinated self-managed care provision; maintaining and providing online communication; and partnering with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-physical needs).

Indicator	Target	Results	Commentary
Percentage of each PHO's enrolled population with login access to a portal	30%	 **Variation by PHO across the metro-Auckland region and change over time (PHOs not identified)**	Note: data for the last two quarters has been delayed, due to COVID response work. Previous data showed the target was achieved in three of the seven PHOs, but not for the Metro Auckland enrolled population. One PHO that did not achieve the target is actively piloting a new portal system.

Patient Experience Surveys in Primary and Secondary Care

'Person centred care' or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

Indicator	Target	Results	Commentary
Maintain or increase practice participation in the PHC PES (as at February 2019)	February 2019 baseline = 90%		The majority of PHOs are meeting or nearly meeting the target to maintain baseline participation rates.

Indicator	Target	Results	Commentary
Average score in Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?'. Target 5% improvement.	5% improvement Targets: ADHB: 55.2% CMDHB: 52.5% WDHB: 47.0% (Metro-Auckland target = 51.4%)	 **Q2 2019/20 Metro-Auckland result = 49.4%**	Note: no new data available. Survey has been redeveloped and ceased during the second half of 2019/20. New survey implemented from August 2020. As at December 2019, only Counties Manukau DHB was surpassing target, although Waitemata was tracking closely. Auckland DHB had not met target for the previous 12 months.

5.3 Auckland Regional Public Health Service (ARPHS) Briefing

Recommendation:

That the Community and Public Health Advisory Committee receives this update from the Auckland Regional Public Health Service (ARPHS) on key areas of work that are underway and/or have been completed between January and September 2020.

Prepared and submitted by Dr William Rainger (Director) and Jane McEntee (General Manager), Auckland Regional Public Health Service (ARPHS).
Endorsed by: Dr Debbie Holdsworth (Director Funding), Dr Karen Bartholomew (Director Health Outcomes), Dr Margaret Wilsher (Auckland DHB Chief Medical Officer)

1. Purpose

The Auckland Regional Public Health Service (ARPHS) is providing this update to Waitematā DHB's Community and Public Health Advisory Committee (CPHAC) on key areas of work contributing to ARPHS' long-term outcomes that are underway and/or have been completed between January and September 2020. This report provides the following updates:

1. People are protected from the impact of notifiable infectious diseases:
    1.1. COVID -19
    1.2. Other notifiable diseases (Tuberculosis and Vaccine Preventable Diseases)
2. People are protected from the harms associated with harmful commodities:
    2.1. Alcohol
    2.2. Smokefree
3. The environments in which people live, learn, work and play promote health and wellbeing:
    3.1. Healthy Auckland Together
4. People are protected from the impact of environmental hazards
    4.1. Drinking Water
5. Public health leadership, workforce development and organisational sustainability
    5.1. Policy submissions

As part of this update, ARPHS is providing a description of the services it delivers to people residing in the Auckland DHB, Waitematā DHB and Counties Manukau Health. See Appendix A.

Appendix B provides an update on surveillance of other infectious diseases.

2. People are protected from the impact of notifiable infectious diseases[1]

2.1. Novel Coronavirus (COVID – 19)

[1] ARPHS receives notifications of 48 notifiable diseases as defined under the Health Act, 1956. ARPHS' role includes receiving the disease notifications, case confirmation, risk assessment and ensuring appropriate public health actions are undertaken (e.g. contact tracing, investigating potential outbreak sources), daily and weekly monitoring and surveillance of these notifications, and investigation and follow-up of any disease outbreaks.

Executive Summary

Since the beginning of 2020, New Zealand has been responding to the COVID-19 global pandemic. The first case ARPHS managed was notified on 28 February 2020. In February/March, most confirmed cases in Auckland had links with international travel or known cases; however, over time there were some cases for whom no link was readily apparent. Subsequently, with the closing of the borders and the introduction of the first New Zealand lockdown (Alert Level 4), the number of cases fell dramatically. At the beginning of June, there were no cases notified, however, during the last weeks of June 2020 cases started to increase again, this time related to people in quarantine facilities returning to New Zealand.

After 102 days of no new COVID-19 cases in the community, on 11 August 2020, four members of an Auckland household returned a positive result for COVID-19. Within weeks, the number of cases rose and this became the single largest COVID-19 cluster in New Zealand. Auckland was again placed into Alert Level 3 lockdown and ARPHS worked to undertake case and contact management, cluster identification and source investigations to manage the outbreak. Since 25 September, there has been no community transmission.

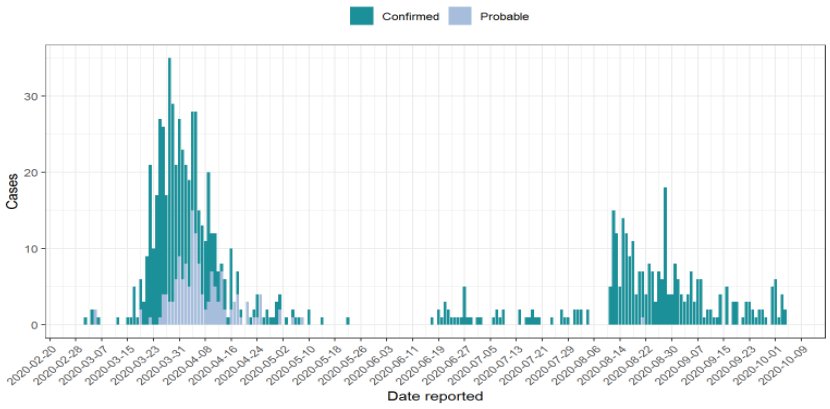
In June 2020, ARPHS established a COVID-19 response unit to support its ongoing response to the pandemic. ARPHS' operating model has centred on the aims of its Outbreak Strategy:

- act in accordance with Te Titiri o Waitangi, including Māori health equity
- ensure an equitable response
- establish the outbreak response
- identify the outbreak source
- stop on-going transmission
- support affected communities
- ensure a safe and sustainable response
- ensure clear communication and documentation.

The total number of COVID-19 confirmed and probable cases in Auckland, since 28 February to 5 October 2020 was 859 (713 confirmed cases and 146 probable). There were also three notifications under investigation (see Figure 1) and six deaths in the reporting period.

The Prime Minister, Ministers, Director General of Health and other officials have visited ARPHS on various occasions and have provided favourable reviews on ARPHS' outbreak response.

Figure 1: Weekly confirmed and probable COVID-19 cases, Auckland region, 2020



Total cases per DHB and in Managed Isolation Facilities (MIF) for the Auckland region for the same period are included in Table 1.

Table 1: COVID-19 confirmed and probable case distribution by DHB, Auckland region,2020[2]

DHB	Confirmed cases	Probable Cases	Under investigation
Auckland DHB	130	51	0
Counties Manukau Health	96	22	0
Waitematā DHB	168	71	3
Managed Isolation Facilities (MIF)	319	2	0

ARPHS Operational Response

The COVID-19 response has placed significant demand on ARPHS and required rapid escalation at times to support the public health response. The response included the need to respond to complex cases and contact tracing, ensuring the needs are met to support isolation and quarantine requirements. In the August outbreak, contact tracing involved multiple settings including churches, workplaces and educational facilities. The complex operational activity for outbreak management included:

- detailed (and often repeated) case interviewing
- communication (and follow up) with multiple contacts
- sophisticated analysis to link numbers of cases and contacts
- implementation of novel processes to delegate contacts in specific circumstances to other PHUs for follow up
- discussion with cases and where possible, household contacts, to quarantine at Jet Park Hotel
- stakeholder engagement with multiple key stakeholders
- meeting welfare needs of highly vulnerable whānau
- detailed internal and external reporting, and

[2] A total of seven cases have not been geocoded. Such cases either appear in the address unknown fields or are assigned to DHB via a suburb lookup until they are able to be correctly geocoded

- simultaneous requirements to assume responsibility for assessing and endorsing isolation exemptions processes.

Given that the resurgence disproportionally affected mostly Pacific but also Māori communities, ARPHS worked with stakeholders, cultural advisors and communities to ensure they were kept well informed and supported and any concerns were addressed. Māori and Pacific workforce and cultural support have been embedded across ARPHS response.

To support its response, following the initial outbreak ARPHS made significant progress on the following:

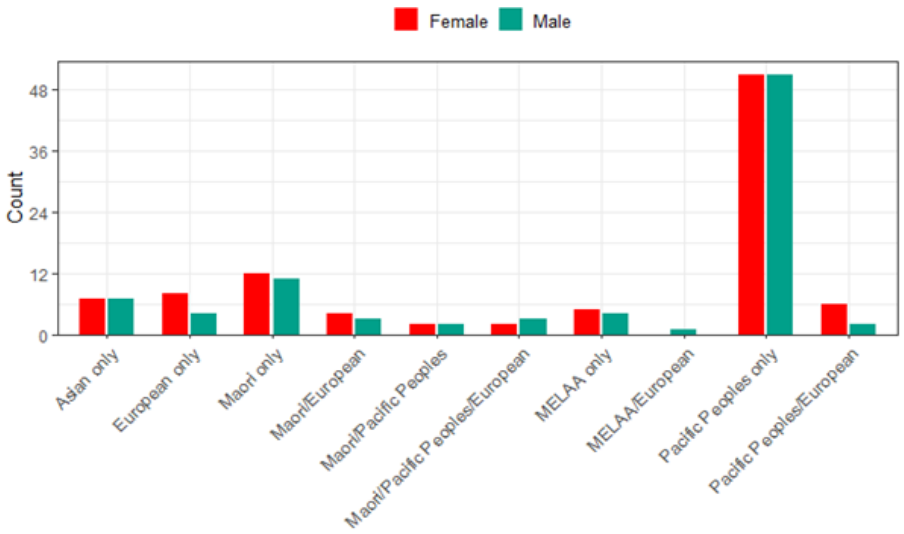
- establishing a dedicated COVID-19 Response Unit (CRU)
- capacity building, providing weekly progress reports to the Ministry
- establishing a Pae Ora (healthy futures for Māori) response model
- establishing a Pacific case and contact management team
- updating existing Standard Operating Protocols
- developing procedures for response at the maritime border and for outbreak management
- working with the DHBs to support the health response part of the isolation and quarantine facilities
- developing a surge framework for our response, which includes triggers and processes for an escalating response (including accessing additional staff from the DHBs)
- ongoing training to maintain competency of internal and external staff who have been involved in the response.

Resurgence of COVID-19: August Outbreak

After a period of 102 days of no reported community transmission of COVID-19, an Auckland household with four confirmed cases was identified on 11 August 2020. This resulted in the largest COVID-19 outbreak New Zealand has seen to date, and is commonly known as the Auckland August outbreak. The earliest symptom onset of this outbreak was identified in a case as at 31 July. The source of the outbreak remains unknown. There were five significant sub-clusters (over 10 cases) related to the August cluster. In addition to the August cluster, there were other non-associated single cases and a small cluster associated to a Christchurch Managed Isolation and Quarantine Facility (six confirmed cases).

Between August 11 (first case of the second outbreak was notified) and October 5, 2020, there were 187 cases in the community in Auckland and 70 imported cases. Population groups significantly impacted by the August outbreak included people self-identified as of Pacific ethnicities (*Figure 2*). Māori people were also affected. Household, workplaces and religious settings were the main places of exposure.

Figure 2: COVID-19 resurgence, confirmed and probable community case distribution by ethnicity[3] and gender, Auckland region, 11 August-October 5th 2020.



The 20 to 29 (17%) and the 30 to 39 (16%) age groups were more affected with the COVID-19 resurgence (Table 2). This in comparison to the previous outbreaks (up to May 2020) where the 20 – 29 age group was the most affected.

Table 2: COVID-19 confirmed and probable case distribution by age group, Auckland region, 11 August-October 5th 2020.

Age	Confirmed and probable cases (community)	Percentage (%)
<1	2	1
1 to 4	8	4
5 to 9	14	7
10 to 14	22	12
15 to 19	17	9
20 to 29	31	17
30 to 39	30	16
40 to 49	26	14
50 to 59	23	12
60 to 69	8	4
70+	6	3
Total	187	100

Surge planning and response

In June 2020, ARPHS moved to a longer-term structure to respond to the COVID-19 pandemic by establishing a response unit which operates seven days per week. The purpose of the unit is to provide an effective, ongoing and scalable platform for ARPHS' ongoing response to COVID-19, while re-establishing ARPHS' usual management processes.

[3] Ethnicity at Level 2

As a response to the current resurgence, ARPHS instigated a surge response including:

- standing up an Incident Management Team
- applying its surge framework to guide surge planning in accordance with current and predicted demand (ARPHS moved from alert level yellow to orange, red and back again to orange and currently is at yellow)
- scaling back on business as usual
- re-deploying nursing and medical staff to ARPHS (many worked on the first COVID-19 response)
- establishing additional case and contact management teams and symptom checking teams
- delegating tasks where appropriate to other PHUs

With Alert Level 3 lockdown, DHBs continued to provide elective services which impacted on the DHBs' ability to provide surge workforce to ARPHS. During September, ARPHS reviewed its operating model, and the updated workforce model has increased the case and contact management team baseline to four teams. This will support management of Managed Isolation Facility cases and relatively small contained outbreaks which are anticipated to occur every two to four months. When ARPHS surge response goes to orange or red DHB and Auckland Council staff will be sourced to support additional teams, according to the size of the outbreak and scalability required.

National Contact Tracing System (NCTS)

For the last ten years or so ARPHS used its Notifiable Disease Case Management System (NDCMS) as the platform for recording and managing cases, contacts and outbreaks. As a result of COVID-19, the Ministry has developed a national platform (NCTS) and mandated its use by all Public Health Units. The NCTS will enable all PHUs (and the Ministry) to access information on cases and contacts to support delegation of contact management between PHUs and the Ministry. After a process akin to user acceptance testing and training of ARPHS staff, ARPHS moved from NDCMS to NCTS in late July which added in complexity for staff to learn a new system whilst responding to the August outbreak. This has supported ARPHS to delegate MIF cases to Waikato PHU and follow up of some contacts to the National Investigation Tracing Centre and other PHUs.

Opportunity costs

ARPHS has deployed over 90 of its 140FTE to support the COVID-19 outbreak response. ARPHS has only maintained its essential regulatory services and TB case management. This will have an impact on the long term public health impacts for the population of Tāmaki Makaurau. The other sections of the report summarises the opportunity costs of the redeployment of ARPHS staff to the COVID-19 response.

Next steps

It is assumed that for the next 12-36 months ARPHS will continue to deliver core COVID-19 'Stamp it Out' public health actions:

- public health surveillance and reporting
- public health management of cases notified from Managed Isolation Facilities (MIF) and cases/outbreaks due to community transmission
- contact tracing and follow up including monitoring effective isolation and quarantine of cases and contacts, assessing their welfare requirements and provision of cultural support
- outbreak identification, investigation and management
- public health management of the maritime border
- provision of public health advice
- public information management, including translated resources

- assessment and endorsement or otherwise of exceptional exemptions requested through Managed Isolation Facilities
- training staff to develop/maintain their case and contact management expertise
- Jet Park liaison, welfare, exemption and "bubble breach" functions.

The core principles for a sustainable response to COVID-19 include:

- maintain a trained workforce and management infrastructure to support rapid scale up
- work in partnership to deliver equitable outcomes for Māori and Pacific communities
- early identification of, and response to, outbreaks and cases in high risk settings
- rapid response with scalability within defined parameters, and
- transfer of cases to the national contact tracing service on an agreed risk basis.

2.2. Other notifiable diseases (Tuberculosis and Vaccine Preventable diseases)

ARPHS continues to manage both Tuberculosis (TB) and vaccine preventable diseases (VPDs) with a reduced team while the workload post lockdown one and two continues to grow. vaccine preventable diseases notifications had remained low until the second lockdown returning to more normal patterns now (See Appendix B). Factors that have likely impacted our work include:

- on-going complex TB outbreaks more challenging where households may not have followed COVID-19 Alert Level rules
- no Latent Tuberculosis Infection (LTBI) clinics are run by ARPHS at this point due to COVID-19 response requirements
- people may not have sought timely medical treatment from their GP during the lockdowns and are potentially more unwell
- resumption in TB contact tracing and contact testing now identifying new TB cases post lockdown (but volumes consistent with previous years).

LTBI and BCG vaccine clinics are planned to resume in November 2020, when the nursing resource redeployed to the COVID-19 response unit, can return to Business As Usual (BAU). ARPHS completed 530 vaccinations between 1 July – 12 August 2020 and currently approximately 2,200 children are awaiting BCG Clinics.

3. People are protected from the harms associated with harmful commodities

3.1. Alcohol

The alcohol programme has been heavily affected by COVID-19 with the redeployment of staff to the response and much of the work has been paused.

Alcohol signage: At the beginning of 2020, 66 bottle stores (alcohol off-licenses) were audited across Māngere, Manukau, Manurewa, Ōtāhuhu, Ōtara, Papakura and Papatoetoe and their compliance with Auckland Council's Signage Bylaw 2015. The audit showed 100% non-compliance with at least one section of the bylaw. All non-compliant bottle stores breached one or more criteria across each signage type (with up to 14 breaches). The summary of the audit results was shared with Auckland Council policy team to assist in their options report to the Auckland Council Regulatory Committee for a new bylaw. In ARPHS' view, the recommendations by Auckland Council's policy staff, to the Regulatory Committee in the options report, were not proportionate to the levels of non-compliance and evidence of the harm caused by excessive exposure to alcohol signage.

In part, due to the prior work by ARPHS and other public health partners such as Alcohol Healthwatch and the Cancer Society, the Regulatory Committee on 13 October 2020 amended the options report to include the recommendations for stronger controls that ARPHS and others had been advocating for during the presentation at the Regulatory Committee in June 2020. ARPHS is pleased the Regulatory Committee also requested that unhealthy food and gambling was added to the Signage Bylaw options report.

Alcohol licensing: Alcohol licensing continues to run at high volumes but reduced capacity. The Immediate Modification Order (IMO), which is empowered by the Epidemic Preparedness (COVID-19) Notice 2020, has extended reporting ARPHS statutory timeframes and allowed this volume to be managed. Applicants continue to apply for new unlicensed premises and novel applications not envisaged by the Act, for instance, restaurants using off-licences. Both of these types of applications generate additional work, through work with agency partners (Auckland Council, Police), and possible hearings with the District Licensing Committees. Priorities continue to be new off licences, particularly bottle shops, in vulnerable communities. At least three of these types of application have been made in the last quarter which is higher than any time in the last two years.

Local Alcohol Policy (LAP): In March 2021, the Court of Appeal hearing of the Auckland Council's appeal of the Judicial Review launched by the supermarkets will be held. ARPHS will be appearing at the hearing as an *Interested Party* in support of Auckland Council's position. Until these legal proceedings have concluded, the Alcohol Regulatory and Licensing Authority (ARLA) cannot re-hear the Provisional LAP elements and therefore endorse the proposed LAP so it can come into effect. One of the main impacts of the LAP, if endorsed, will be off-licence hours reduced to a maximum 9pm across the whole of the Auckland Council region. The continued delay is disappointing for population health and reducing alcohol-related harm as it is envisaged an LAP will likely come into effect in 2023 at the earliest; ten years after the process began.

3.2. Smokefree

Smokefree Environments Act (SFEA) review (Vaping Amendments Bill)
Following consultation with the three Auckland region DHBs and Hāpai Te Hauora, a joint submission signed by ARPHS and the three Auckland region DHBs was submitted on the Smokefree Environments Act review (Vaping Amendments Bill). The submission was supported by a joint presentation to the Health Select Committee by ARPHS and Counties Manukau Health on April 15th 2020.

The submission was supportive of the following proposed amendments to the SFEA:

- Vaping being used as a smoking cessation tool
- Prohibiting vaping and smokeless tobacco products in legislated smokefree areas
- Prohibiting advertising, endorsements and sponsorship of vaping and smokeless tobacco products
- Prohibiting the sale and supply of regulated products (including vaping under the new definition) to people under the age of 18
- Allowing approved vaping premises with controls
- Introducing a product notification scheme
- Introducing a regulatory mechanism to develop plain packaging, labelling and safety standards for regulated products
- Significantly restricting flavours of vapes available outside of specialist vape retailers.

The submission also made a number of additional recommendations, including

- Māori should be consulted to ensure a strong equity focus is placed on the Bill

- That the definition of 'regulated products' be expanded to capture other non-tobacco nicotine containing products
- That the development regulations for vaping products be expedited.

The full list of additional recommendations and other details about the submission can be found in Appendix C.

The legislation received Royal Ascent on 11 August 2020. All of the recommendations above were finalised in the amendment. We are now awaiting the development of the supporting regulations to implement the changes to the legislation by August 2021.

Tobacco Retail Reduction: ARPHS chairs the National Tobacco Supply Reduction steering group which aims to reduce the commercial availability of tobacco in New Zealand and participates in the research and communications sub-groups. The steering group consists of members from the Cancer Society, Northland DHB, Mid-Central DHB, Hapai te Hauora, Pegasus Health, Otago University, T&T Consulting Ltd and Tākiri Mai te Ata Whanau Ora Collective Regional Stop Smoking Service. Three steering group meetings were held during this period.

All other smokefree work has been put on hold due to staffing limitations resulting from COVID-19 redeployment.

4. The environments in which people live, learn, work and play promote health and wellbeing

4.1. Healthy Auckland Together (HAT)

Healthy Auckland Together (HAT) is a coalition of 32 partners committed to making it easier for Aucklanders to eat better, be physically active and maintain a healthy weight. HAT partners include health entities (including Auckland region DHBs), local government, iwi-based organisations and non-governmental organisations. ARPHS is the backbone organisation for HAT, providing a coordination and administrative function as well as being a partner.

Due to the continuation of the COVID-19 outbreak in Auckland, the majority of ARPHS staff, including members of the HAT Backbone team, were re-deployed to roles in the ARPHS COVID-19 Response Unit. Again, HAT partners understood the necessity for ARPHS resources to be re-prioritised to contain the outbreak. This has impacted on deliverables during the reporting period, as seven out of the nine ARPHS-based backbone team members were redeployed to substantive COVID-19 roles. Despite this, HAT has carried out the following:

Collaboration and Leadership: The Cancer Society Auckland Northland branch has joined HAT and will add significant value to the Marketing to Children action area in particular. This is the 32nd partner in the coalition.

An Interagency Group (IAG) meeting was held at the end of July with 37 representatives from 17 organisations in attendance. The focus of this hui was a workshop session on COVID-19's impacts and recovery. A Public Health Medicine Specialist registrar is currently collating feedback from this session with support from the backbone team to help inform HAT actions for the next twelve months.

Food and Marketing Environments - Marketing to Children: A powerful eight minute video was created to showcase marketing strategies the food industry has used to leverage the COVID-19

pandemic, including donations to essential workers. The video was met with positive feedback from HAT partners at the Interagency Group meeting. The team are developing a plan to maximise the impact of this new resource.

HAT submitted an Advertising Standards Authority (ASA) complaint on 'The HELL Reading Challenge' which is being run by the NZ Book Awards Trust and promoted through Auckland Libraries and schools nationwide. To encourage reading, children are incentivised with free pizza rewards. The ASA will facilitate a meeting between Auckland Libraries, Hell Pizza and the NZ Book Awards Trust to discuss breaches and changes required to the challenge.

ARPHS and University of Auckland worked together to create a training package about making complaints to the ASA on critiquing unhealthy food and beverage advertising. The package includes an introduction to the research and the current complaints process, an example of an effective complaint and actions that students can take to promote government change.

ARPHS completed a submission to the ASA Influencer Guidelines consultation document which detailed clearer labelling of advertising on social media. The team also supported other organisations to have their say and submit on the key issues.

HAT also received five ASA complaint decisions. These were either not upheld or there were no grounds to proceed as the ASA determined that the advertisements targeted adults and parents.

Food and Marketing Environments – Google Street View: ARPHS and The University of Auckland continue to collaborate on a Google Street View project to analyse advertising on convenience stores near schools. Two undergraduate Public Health Placement students are building on data collection that began last semester (February – July 2020) by two postgraduate dietetic students. This project was not impacted by the COVID-19 response due to the online nature of data collection and supervision via Zoom.

Food and Marketing Environments - Wai Auckland: There have been two major events in 2020 that have affected the use of drinking water fountains – COVID-19 and the drought. Fountains have been turned off by a range of organisations, including Auckland Council and Auckland Transport (AT), to mitigate the spread of disease and reduce wasted water. Consequently, the infrastructure work stream of Wai Auckland has paused.

Eight new RefillNZ Stations were signed up, during the first quarter of 2020/2021 period, bringing the Auckland total to 155. Due to COVID-19 restrictions and reduced staff capacity, it has been difficult to visit premises for sign-ups. A 'Safe Refilling Tips' resource was developed to encourage people to continue refilling their water bottles in a COVID-19 world.

Due to relationships with Auckland Council and RefillNZ, Wai Auckland contributed to the Ministry for the Environment's Feels Good to Refill Campaign (January 2020). Recently commissioned research found that single-use plastic drink bottle are the most common item in New Zealand's waste despite being easily recycled, which led to the creation of this campaign. It was a huge success, described as transforming this Ministry's social engagement, and additional funding has been secured to run another campaign later in 2020.

HAT continued to build a strong research relationship with the University of Auckland with four student projects completed during the first six months of the year. A brief description of each project and its outcomes are listed below:

- To support Wai Auckland, a drinking water fountain survey in Auckland shopping malls found that only two out of the 31 places had infrastructure. Advocacy is being planned to encourage more shopping malls to provide fountains.
- Google Street View (GSV) analysis of advertising on bus stops near Auckland schools found that 12.8% of all advertising is for non-core foods. Advocacy is being planned to influence guidelines to create healthier marketing environments around schools. Previously noted, this research was published in the *Nutrients* journal.
- a Wai Auckland business case for improving the provision of public drinking water fountains was accepted by Auckland Council and will be piloted to test its acceptability.
- GSV analysis of advertising on convenience stores near schools was initiated with a research protocol being complete. Additional student resource is required to complete data collection and analysis.

Food Environments and Marketing – Good Food Kai Pai: Preparation began for the annual Diwali Festival and training for vendors with the Good Food Kai Pai initiative. Most major events planned for Tāmaki Makaurau have now been cancelled or postponed, including Diwali, due to COVID-19 uncertainties. Consequently, this component of HAT has been paused.

Food Environments and Marketing – Public Health and Environmental Determinants Toolkit: HAT intended to update the Public Health and Environmental Determinants Toolkit using one of the undergraduate Health Placement Students. This toolkit helps visualise the availability and density of fast food outlets and grocers across Tāmaki Makaurau and was last updated in 2015. This update was put on hold as a result of COVID-19 response; however, the student provided support for the Google Street Viewproject.

Research – Journal articles: Two journal articles from HAT projects were published in the *Food Marketing and Dietary Behaviours Among Children Special Edition* of *Nutrients*:

- *Wai Auckland* partnered with the *University of Auckland* to assess the types of advertising on bus stops within a walkable distance (500m) from all schools across the region. Three students were involved in the project and used Google Street View (GSV) to collect data and get around almost 600 schools in an efficient manner. They found that 12.8% of the advertisements were for non-core foods, which highlights an opportunity to create healthier environments around our schools to limit children's exposure to unhealthy food and drink (Huang. D., et al; *Nutrients*, *Bus stops near schools advertising junk food and sugary drinks*; (2020), *12*(4),1192).
- ARPHS partnered with *University of Auckland* to review New Zealand's self-regulatory ASA Codes against a public health law framework. They found that the majority (12 out of 16) of complaints assessed were not upheld. Many facets of the public health law framework were not met in the Complaints Board's interpretation of the Codes. This highlights that the current self-regulatory system does not adequately protect children from being exposed to the power of unhealthy food and drink marketing (Sing. F., et al; *Nutrients, Food advertising to children in New Zealand: A critical review of the performance of a self-regulatory complaints system using a public health law framework* (2020) *12*(5), 1278).

Forty two people attended a HAT Research Platform Zoom event in mid-September. The purpose of the event was to encourage greater collaboration between academics and HAT partners. ARPHS and The University of Auckland led planning and delivery of the event. Next steps include sharing information about research funding and student availability; facilitating targeted conversations regarding common HAT prioritised issues; and highlighting research gaps.

Schools and Early Learning Services – Healthy Active Learning: Healthy Active Learning (HAL) is a joint initiative from Ministry of Health (MoH), Ministry of Education and Sport NZ. Public Health Units are

responsible for delivering the nutrition component while Regional Sports Trusts (RSTs) are responsible for physical activity.

The Tāmaki Makaurau team started in early February with a workforce of four fulltime and two part-time HAL Advisor roles, including two New Zealand Registered Dieticians to provide specialist nutrition support. The scope of work includes exploring the status of food and drink policies of all secondary, intermediate, primary schools and Early Learning Services (ELS) across the region.

The schools and ELS prioritisation tool, including criteria set from the MoH service specifications, has been completed for the greater Auckland region. From this exercise, 53 secondary schools and 28 ELS have been identified as priority education settings.

The development of a national toolkit to support the programme has been delayed due to COVID-19. Led by the dieticians in the team, an interim food and drink policy guide has been developed to assist schools to implement HAL and meet contractual obligations. As part of the school nurses agreement in Auckland and Waitematā DHBs, schools must have a food and drink policy. Twelve of the 15 identified priority schools have taken up this guide.

The team continue to work on stakeholder engagement regionally, nationally and internationally. The newly developed food and drink policy guide was presented by our dieticians to the RSTs Activators to show how our nutrition team can support their work in primary schools. HAL is also working on strengthening relationships with other nutrition providers in schools to avoid duplication and ensure a consistent approach across the region. Networking with schools nurses contracted by the three Auckland Metro DHBs has identified needs and gaps in the schools they work with.

The team met with the Healthy Eating Advisory Service from Victoria, Australia, via zoom, to learn from their eight years of experience implementing a similar model across their state. This will help inform our regional approach.

5. People are protected from the impact of environmental hazards

5.1. Drinking Water

Completion of drinking water annual survey: In August, ARPHS Drinking Water Unit (DWAU) completed the drinking water annual survey for the period of 1 July 2019 to 30 June 2020. This was conducted by the Drinking Water Assessors (DWAs) in ARPHS on behalf of the Ministry of Health, against the drinking water requirements of the Health Act 1956 (the Act) and the Drinking-water Standards for New Zealand 2005 (Revised 2018)

Data collected is checked by the Institute of Environmental Science and Research (ESR) and verified by the water suppliers. From there, ARPHS will complete compliance reports to inform water suppliers of the survey outcome in due course. Data will also be used by the Ministry of Health to prepare a report on the quality of drinking water in New Zealand.

Drought planning: The Auckland and Northern regions have experienced unusual drought conditions in 2020. ARPHS took the following actions to support our stakeholders:

- ARPHS was a major stakeholder in the Auckland Emergency Management drought planning strategy. ARPHS Environmental Health manager led the health and welfare sub group.
- ARPHS worked collaboratively with Watercare as the major local supplier of drinking water in Auckland. This included supporting Watercare to split its analytical laboratory capacities (and

staff) into two as to guard against the possibility of one COVID-19 case impacting their entire laboratory function.
- Registration of drinking water carriers was expedited by ARPHS Drinking Water Assessment Unit (DWAU) in anticipation of higher demand for drinking water from safe sources.

6. Public Health Leadership, workforce development and organisational sustainability

6.1. Policy submissions

ARPHS develops policy submissions to represent the public health view for the Auckland region on behalf of the three Auckland metro DHBs.
Policy capacity has been reduced with the redeployment of staff to the COVID-19 response.
ARPHS completed four submissions between January and September 2020 on the following topics:

- Employment, labour markets and income report
- Accessible Streets
- Smokefree Environments Act review (Vaping Amendments Bill
- Advertising Standards Authority (ASA) Influencer Guidelines consultation.

Appendix C briefly summarises the key points for each submission

Appendix A
Overview of ARPHS and its role

ARPHS is one of New Zealand's 12 public health units (PHUs). ARPHS provides regional public health services to people residing in the rohe of Counties Manukau Health and Waitematā and Auckland District Health Boards (DHBs) through health protection and promotion, and disease prevention. A key role for ARPHS is provision of regulatory public health services and work to improve population health outcomes for the people of Tāmaki Makaurau. ARPHS is funded via a direct contract from the Ministry of Health to ADHB, who manage the contract with ARPHS on behalf of the three DHBs in the metro Auckland rohe.

ARPHS' vision is Te Ora ō Tāmaki Makaurau. ARPHS' strategic long term outcomes are:

- People are protected from the harm of notifiable infectious diseases
- People are protected from the impact of environmental hazards
- People live free from the harms associated with harmful commodities
- The environments in which people live, learn, work and play promote health and wellbeing.

Long term outcomes are supported by the organisational enabler: Public Health leadership, sustainability and workforce development.

ARPHS strategic priorities 2017-2022 include:

1. Reduce the harm of notifiable infectious diseases, in particular:
    - Reduce the spread of Tuberculosis through TB case and contact management
    - Actively manage infectious diseases and pursue an 'up stream' approach to infectious disease prevention
2. Build healthy and resilient environments and communities, in particular:
    - Early identification and active management of enteric diseases
    - Active support and management of waters and wastes
3. Reduce obesity, improve nutrition and physical activity
4. Support Smokefree 2025
5. Enhance surveillance of communicable and non-communicable diseases and risk factors for public health action and reporting
6. Enhance and build stakeholder relationships with organisations and communities to continuously improve public health for Tāmaki Makaurau.

The work of ARPHS

ARPHS' work includes management of notifiable infectious and environmental diseases, including operational management of the regional tuberculosis control programme. ARPHS provides advice and support on actual/potential environmental hazards such as drinking and recreational water quality, air quality, border health protection, and hazardous substances. Much of ARPHS' work involves working with other agencies, including work on liquor licensing, smokefree, emergency response, physical activity and nutrition and obesity prevention activities. These other agencies include central government agencies, Auckland Council, non-government organisations and workplaces.

Intersections between the work of ARPHS and the three Auckland metro DHB

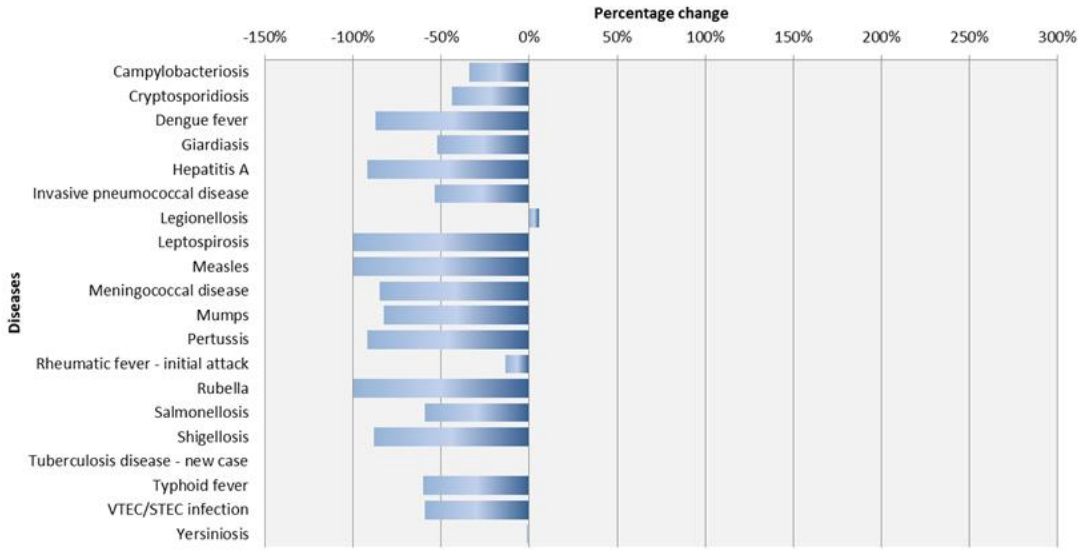
Key points of intersection for ARPHS with DHB activities are interfaces with primary and secondary services in sharing surveillance information, managing communicable disease outbreaks, policy engagement and submissions and improving physical and social environments to support reduced harm from tobacco, alcohol and unhealthy food. For example, ARPHS provides the backbone support team for the Healthy Auckland Together (HAT) coalition, of which the three DHBs are partners. The recent Coronavirus preparedness and response is an example of where strong collaboration between ARPHS and DHBs is critical.

Appendix B
Surveillance

ARPHS undertook a comparison of notifications between the six month period between April 1st to September 30th, 2019 and the same period in 2020. In general and with the exception of COVID-19, notifiable disease notifications reduced in April-September 2020 compared to April-September 2019 (Figure 3) :

- Leptospirosis notifications are usually around six in any six month period. There were none over the reporting period in 2020.
- Salmonellosis, cryptosporidiosis, and giardiasis notifications were down 59%, 41%, 52% respectively over the six month period.
- Shigellosis notifications were down to six cases compared with 50 in 2019.
- There were only four typhoid notifications for the six month period compared with 10 in 2019. Two cases were acquired in India, while the other two were family members whose illness was locally acquired, the most likely source being visitor from Samoa.
- VTEC notifications were down 59% with 38 notifications compared with 93 in 2019. There was one case of haemolytic-uremic syndrome. Serotyping was completed on 17 of the 38 cases. The predominant serotype was O157 at 53% followed by O128 and O26 at 12%.
- There was only one case of Hepatitis A notified. The possibility of a Korean source featured in this case with ESR serotyping identifying a single serotype which has been noted by ARPHS in three Korean cases over the past 18 months; interviews have not elicited a common source or event.
- Listeriosis cases notifications were around average at five. There were no deaths.
- There have been no confirmed cases of measles or rubella during the six month period and only eight cases of mumps were notified compared with 46 cases for the same period in 2019.
- Invasive pneumococcal disease is a seasonal disease and tends to accompany seasonal influenza however the number of notifications (41) in the last six months has been well down (53%) on the same period last year in 2019 (88).
- There were concerns that under lock down conditions that meningococcal cases might increase. This has not been observed and there has been only six cases notified compared with 40 over the same period in 2019. Three cases were serotype B, two were W and one was serotype Y.
- Hepatitis B notifications were down from four cases in 2019 to one for the six month period.
- There were 14 Hepatitis C cases notified compared with 14 cases for the same period in 2019.

Figure 3. Selected infectious diseases percentage change in the Auckland region for April to September 2020 compared with the same period in 2019.

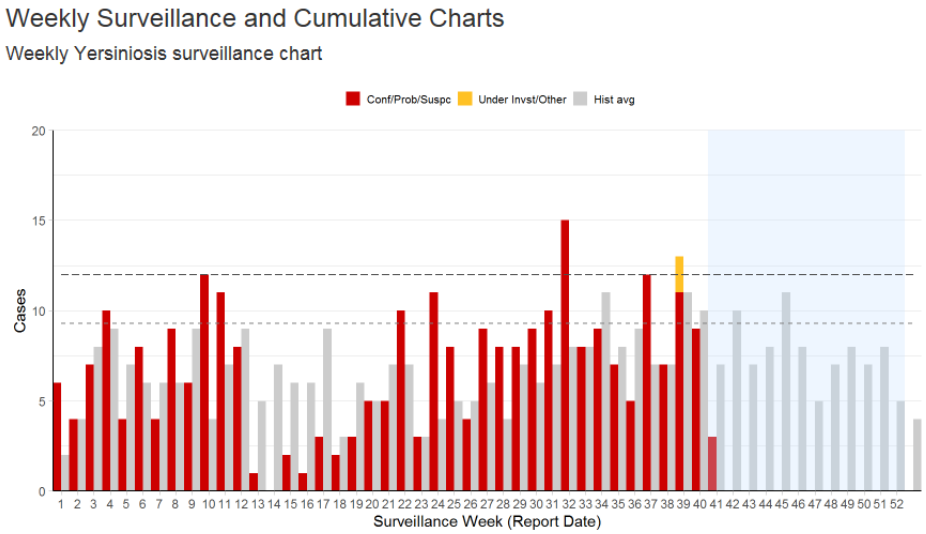


B.1 Foodborne diseases - Yersiniosis

Enteric disease notifications dropped significantly during the two COVID-19 lock down periods with notifications down between 30% and 60% across the enteric diseases. Campylobacteriosis is now slowly returning to normal as COVID-19 restrictions are eased. Stringent infection control precautions at aged residential care and other institutions have resulted in virtually no gastroenteritis outbreaks in residential care since late March.

The exception to this trend was yersiniosis (Figure 4). While notifications dropped markedly in the first lock down period, notifications for yersiniosis gradually returned to normal and even reached warning level triggers in September. A RedCap questionnaire was initiated at the second week of the warning level surveillance triggers but the response rate was poor and no common cause was identified. Serology has identified a small number of Yersinia pseudotuberculosis cases during September and October which is not uncommon for this time of year. Since PCR testing does not identify Y. pseudotuberculosis, these notifications are based on Yersinia serology. Unfortunately serology does not meet the current surveillance criteria for laboratory confirmation.

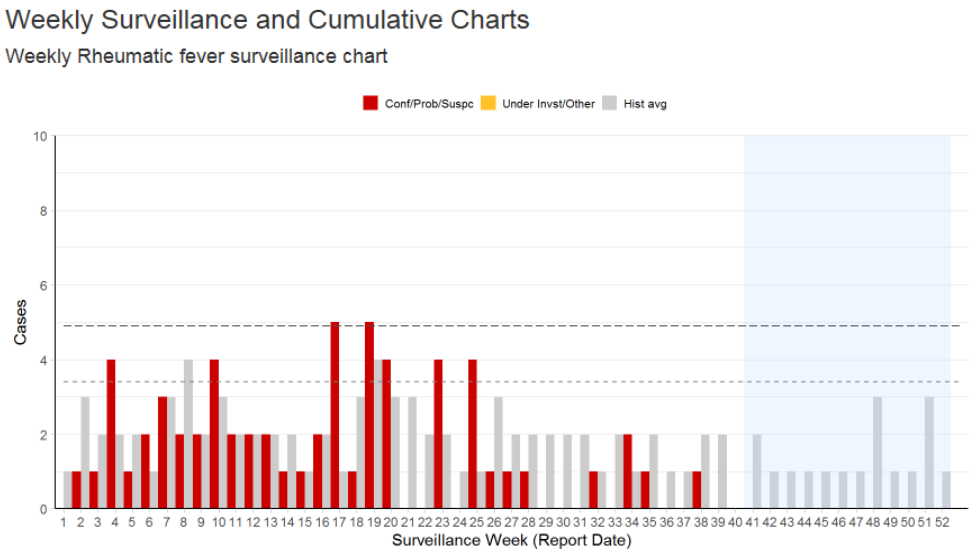
Figure 4: Yersiniosis weekly surveillance and cumulative charts, Auckland region, 2020



B2. Acute Rheumatic Fever (ARF)

Acute rheumatic fever notifications for the six month period April to September 2020 were 35 compared with 39 for the same period in 2019. ARPHS had concerns that an increase might occur with COVID-19 lockdown periods, as a result of household crowding and winter climatic conditions, however, this did not occur (Figure 5). Of the 35 cases, 31 were aged 0 – 19 years (86%), while 26 cases (74%) were aged between five and 14 years. Of those aged 0 - 19 years, nine self-identified as Māori, and 21 were of Pacific descent, the majority of whom identified as Samoan. The largest burden of disease remains in CMDHB with 50% (3.2/100,000) of cases compared with ADHB (1.7/100,000) and WDHB (1.3/100,000) at 25% each. The majority of the cases were notified in April (10), May (9), and June (10) with the last three months seeing only five cases.

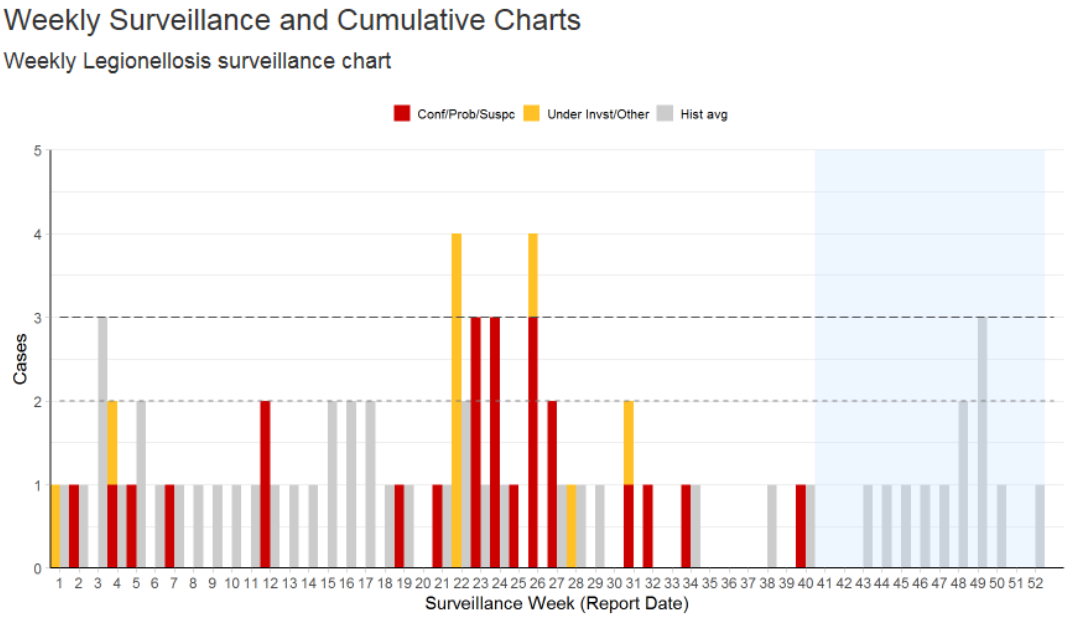
Figure 5: Acute rheumatic fever, weekly surveillance and cumulative charts, Auckland region, 2020



B3. Legionellosis

At the beginning of the year, the number of notifications showed a reduced pattern, however, the number of confirmed and under investigation cases increased in the period May to June with a subsequent decrease in notification numbers (Figure 6). L. pneumophila sero-group one was identified in six out of 18 cases notified since April, which is typically associated with aerosolised water and man-made warm water systems, especially cooling towers. There was one L. longbeachae case over this period but this serotype typically increases during spring and summer months as a result of increased contact with soil and landscaping products.

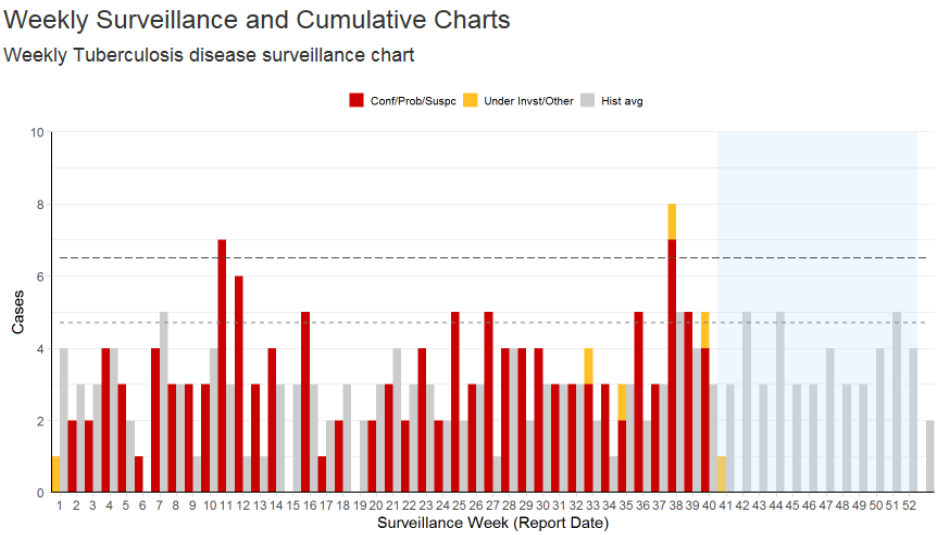
Figure 6: Legionellosis weekly surveillance and cumulative charts, Auckland region, 2020



B4. Tuberculosis

TB notifications overall are tracking at the same number of cases (80) compared with 80 for the same period in 2019. Although the numbers have not increased and we would not necessarily expect the COVID-19 lockdown to impact on the incidence of new TB cases, the management of cases and their contacts has been challenging. Of the 80 cases, 83% of new TB cases were born outside of New Zealand. The probable source countries were India (29%), China (13%), Philippines (12%), South Africa (5%), Tonga (4%), and Tuvalu, Kiribati, Myanmar and England (2%) respectively. Average time between arrival in NZ and onset date was ten years. Twenty cases were diagnosed within the first two years of their arrival, ten between one and two years and four within one year of arrival (Figure 7).

Figure 7: Tuberculosis weekly surveillance and cumulative charts, Auckland region, 2020



Appendix C
Submissions summary

Summary points for ARPHS' submissions between January and September 2020:

Topic	Brief note
Employment, labour markets and income report ***7 February 2020***	The Productivity Commission is undertaking an inquiry that explores the impacts of new and changing technology on the quantity and nature of work. It aims to answer two main questions: • What are the current and likely future impacts of technological change and disruption on the future of work, the workforce, labour markets, productivity and wellbeing? • How can the Government better position New Zealand and New Zealanders to take advantage of innovation and technological change in terms of productivity, labour-market participation and the nature of work? ARPHS's submission commented on the second of five draft reports, noting that good quality, secure work improves health and wellbeing, and that income is arguably the most important social determinant of health as it determines the quality of other determinants such as food security, housing, and other basic prerequisites of health. ARPHS's submission recommended the Commission: • Recognises the health promoting value of work beyond financial reward; • Prioritise active and on-going collaboration with Māori representatives as part of the inquiry; • Include a recommendation that considers how specific aspects of income smoothing policies such as coverage and replacement rates support health and reduce inequities.
Accessible Streets ***20 May 2020***	To increase the safety and accessibility of our footpaths and streets, and encourage active modes of transport, the Government sought public feedback on the 'Accessible Streets' rules package. The package proposed a number of new rules to respond to the rise of micro-mobility devices like e-scooters. Rule changes are also proposed to improve the safety and efficiency of active transport modes and buses. ARPHS submission supported many of the proposals such as: • users of mobility devices should give away to pedestrians and wheelchair users; • having a mandatory minimum overtaking gap for motor vehicles when passing pedestrians, cyclists, horse riders and other users of other devices; • turning traffic should give away to path users crossing a side road; • introducing lighting and reflector requirements for powered transport devices at night, that pedestrians should always have right of way on the footpath etc.

	ARPHS did raise a concern that the current regulatory package does not address the status of powered transport devices that have yet to be declared a motor vehicle, as this leaves many popular devices in use illegal. ARPHS also considered the speed limit of a *shared path* should be determined by its users (15km/h was deemed an appropriate speed limit) rather than the adjacent roadways speed limit, or having a default speed of 50km/h .
Smokefree Environments Act review (Vaping Amendments Bill ***1 April 2020***	ARPHS was supportive of the following proposed amendments : • Vaping being used as a smoking cessation tool • Prohibiting vaping and smokeless tobacco products in legislated smokefree areas • Prohibiting advertising, endorsements and sponsorship of vaping and smokeless tobacco products • Prohibiting the sale and supply of regulated products (including vaping under the new definition) to people under the age of 18 • Allowing approved vaping premises with controls. • Introducing a product notification scheme • Introducing a regulatory mechanism to develop plain packaging, labelling and safety standards for regulated products • Significantly restricting flavours of vapes available outside of specialist vape retailers. ARPHS made the following additional recommendations: • Māori should be consulted to ensure a strong equity focus is placed on the bill. • That the definition of 'regulated products' be expanded to capture other non-tobacco nicotine containing products. • The Director General be given powers to extend the types of products defined as 'regulated' • Allow pharmacies and cessation services to provide vaping products and demonstrations on correct use to people who smoke and are seeking to quit. • Limit the sale of not just flavours, but vape devices themselves to specialist retailers who can offer appropriate support. • That legislated smoke free areas be extended to include outdoor hospitality areas. • Extend restrictions on advertising, endorsements, sponsorship, promotion, sale and distribution of regulated products, removing exemptions allowing specialist vaping retailers to market and display vaping products where they are visible from outside the premises. • Require mandatory training on supporting cessation for all specialist vape store employees serving customers. • Restrict online sales through regulation. • That the development regulations for vaping products be expedited • That a positive licensing system is introduced for the sale of regulated products, ensuring tobacco remains at least as heavily restricted as other nicotine products.

	• Numerous small changes to the wordings in various sections to increase the enforceability of the act ARPHS challenged/did not support: • Allowing vaping devices to continue to be sold at 'generic' retailers – Idea is first time users are channelled towards specialist retailers who can offer support and ensure they have the right product. • That specialist vape stores be allowed to market and advertise regulated products where it is visible to the public from outside the premises. • The proposed approach (or lack thereof) in the bill for dealing with online sales of regulated products. • The length of time taken to introduce and pass this legislation.
Advertising Standards Authority (ASA) Influencer Guidelines ***3 August 2020***	The Advertising Standards Authority (ASA) developed AdHelp guidance to support responsible advertising and the requirement for Influencers to clearly identify advertising content to their audiences. ARPHS's submission recommended: • The influencer guidelines provide clarity around monitoring and enforcement • The ASA should not have to rely on the public for monitoring and highlighting breaches of the Codes • The influencer guidelines only recommended 'hashtags' to be used in content produced by influencers, this should be mandatory • The ASA communicate these guidelines to the relevant parties • The influencer guidelines should not be used to circumvent the existing Codes • More stringent rules in relation to marketing of unhealthy food and beverages to children and young people (under 18 years) • A mandatory regulatory system would ensure New Zealand is implementing the WHO Global Action Plan on the Prevention and Control of Non-communicable Diseases and upholding the United Nations Convention on the Rights of the Child.