Waitematā
District Health Board

Best Care for Everyone

Community and Public Health Advisory Committee Meeting

Wednesday 3 March 2021

11.00am

Zoom link:

https://waitematadhb.zoom.us/j/94681931704

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
Best Care for Everyone

WAITEMATĀ DISTRICT HEALTH BOARD
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) MEETING
3 March 2021

Zoom Link: https://waitematadhb.zoom.us/j/94681931704 **Time: 11.00am**

COMMITTEE MEMBERS	MANAGEMENT
Kylie Clegg – Committee Chair Warren Flaunty – Committee Deputy Chair Judy McGregor – Ex-officio as Board Chair John Bottomley - Board member Chris Carter - Board member Sandra Coney - Board member Allison Roe - Board member Renata Watene - Board member cc: All Board Members BOARD OBSERVERS Amber Paige Ngatai Wesley Pigg	Tim Wood – Executive Director, Tier 1 Community Services Debbie Holdsworth –Director, Community and Provider Funding and Procurement Karen Bartholomew - Director Health Outcomes Murray Patton – Director, Specialist Mental Health and Addiction Services

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.	**PRESENTATION - nil**
	3.	**CONFIRMATION OF MINUTES**
11.05am	3.1	Confirmation of Minutes of the meeting held on 28/10/20 Actions Arising from previous meetings
	4.	**STANDARD REPORTS**
11.40am	4.1	Specialist Mental Health and Addiction Services Update
11.20am	4.2	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**
11.10am	5.1	AAA Screening Pilot with Tongan men
11.35am	5.2	System Level Measures – Quarter 2 Report
12.00nn	**6.**	**GENERAL BUSINESS**

Waitematā District Health Board

Community and Public Health Advisory Committee

Member Attendance Schedule 2021

Member	March	May	August	November
Kylie Clegg (Committee Chair)				
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 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	03/12/20
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 Member – Cartwright Collective	16/12/20
Allison Roe	Chairperson – Matakana Coast Trail Trust Member – Rodney Local Board, Auckland Council Member – Wilson Home Committee of Management (past role)	22/08/18
Renata Watene	Owner – Occhiali Optometrist Board Member – OCANZ Strategic Indigenous Task Force Council Member – NZAO Member- Te Pae Reretahi (previously Toi Ora Advisory Board) Professional Teaching Fellow, University of Auckland Optometry Department	17/02/21
Wesley Pigg (Board Observer)	Employee (physiotherapist) – Waitematā DHB	14/10/20
Amber-Paige Ngatai (Board Observer)	Employee (nurse) – Waitematā DHB	14/10/20

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.

3.1 Minutes of the Community and Public Health Advisory Committee meeting held on 28 October 2020

Recommendation:

That the draft Minutes of the Community and Public Health Advisory Committee held on 28 October 2020 be approved.

DRAFT Minutes of the meeting of the Waitematā District Health Board

Community and Public Health Advisory Committee

Wednesday, 28 October 2020

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

BOARD MEMBERS PRESENT:

Kylie Clegg (Committee Chair)
Warren Flaunty (Committee Deputy Chair)
Judy McGregor (Ex-officio as Board Chair)
John Bottomley
Allison Roe – present from 10.14am
Renata Watene – present from 11.19am

ALSO PRESENT:

Dale Bramley (Chief Executive)
Peta Molloy (Board Secretary)
Debbie Holdsworth (Director Funding)
Karen Bartholomew (Director Health Outcomes)
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:

Simon Maude (NZ Doctors) – present until 10.45am
Tracy McIntyre (Waitakere HealthLink)

KARAKIA:

A Karakia was led by Dr Dale Bramley

WELCOME:

The Committee Chair welcomed everyone present.

APOLOGIES:

Apologies were received and accepted from Chris Carter and Sandra Coney and for late arrival from Allison Roe and Renata Watene.

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.

The Committee Chair acknowledged the work of staff during the response to the second COVID-19 (alert level 3) lockdown in the Auckland region.

2 BOARD AND COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Board Meeting held on 5 August 2020 (Agenda pages 7-13)

Resolution (Moved John Bottomley/Seconded Warren Flaunty)

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

Carried

Actions arising from previous meetings (Agenda page 14)

The matters arising noted that an update for the Healthy Auckland Together was included in Item 5.3 of the agenda. A correction was made noting that a paper will instead be provided at a future meeting.

No further issues were raised and the updates were noted by the Committee.

3 DECISION PAPER

3.1 Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023, Auckland and Waitematā District Health Boards (agenda pages 15-69)

Samantha Bennett (Manager), Raj Singh (Project Manager) and Dr Suneela Mehta (Public Health Physician) were present for this item.

Matters covered in discussion and response to questions included:

- It was noted that while some Asian health groups have an overall good health status, there continues to be disparities in health outcomes for other sub-groups. The Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023 focuses on the results of the bench marking report, health needs assessments, feedback and health consultations, to prioritise efforts to improve health outcomes where there are health inequities.
- The plan will be managed by the Asian, New Migrant, Former Refugee Manager, however, work streams and mechanisms are owned by each of the services.

- The progress made and relationship built with primary care is a continued focus to enable long-term gains. There is also a focus on addressing long-term condition and mental health. Other pieces of work include culturally appropriate responses around services, building awareness of the health and disability system for new migrant groups, working with Public Health Organisations for former refugees and working with community leaders for minor ethnic groups.
- There is a national direction in relation to asylum seekers and immigration.
- The plan highlighted the need for a partnership approach with community leaders and groups as an enabler. This is consistent with the learning from the COVID-19 response. There is on-going work with the Northern Region Health Coordination Centre and the Ministry of Social Development to address welfare needs and provide wrap-around services.

Resolution (Moved Kylie Clegg /Seconded Warren Flaunty)

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.

Carried

4 INFORMATION PAPERS

4.1 Planning, Funding and Outcomes Update (agenda pages 70-85)

Kate Sladden (Funding and Development Manager Health of Older People), Ruth Bijl (Funding and Development Manager Women, Children and Youth) and Meenal Duggal (Funding and Development Manager, Mental Health and Addiction Services) were present for this item.

Karen Bartholomew (Director Health Outcomes) highlighted the on-going review of the Māori Health pipeline work, in particular the work underway to develop the Lung Cancer screening programme, the inaugural meeting of the Consumer Advisory Group focused on Māori and whānau needs and the on-going provider and Public Health Organisation (PHO) data matching.

Debbie Holdsworth (Director Funding) acknowledged the efforts of the team towards the COVID-19 response. The on-going Zoom sessions with aged residential care (ARC) facilities around COVID-19 preparedness and the impact of the pandemic on the provision of face to face services including immunisation were highlighted.

Matters covered in the discussion and response to questions included:

- An update on the National Measles Catch-up campaign was provided. Waitematā DHB's focus is towards increasing awareness and enhancing community settings (marae, churches workplaces, women's health clinics and other community locations). There is work on identifying barriers to

immunisation through focus group discussions with Māori and Pacific rangatahi.
- Informed consent is provided as part of the immunisation process.
- A plan is underway to catch-up on immunisation through the enhanced school based health service and looking at schools with high Māori population.
- Uri Ririki is well-established. Work is underway to strengthen and referrals to the Noho Āhuru- Healthy Homes initiative.
- An update on the development of a vaccine for Rheumatic fever was noted. There is a need to continue advocacy by the Northern Region for the development of a vaccine. A deep dive on rheumatic fever will be provided at a future meeting.
- The evaluation and learning from the Kaimanaaki programme was requested in the next report.
- The service is reviewing the data on Zoom sessions provided for ARC facilities and is looking into developing engagement by facilities focusing on 'at-risk' facilities. The sessions are not compulsory, but the messaging is focused on the support available to the ARCs and benefits of maintaining COVID-19 preparedness.
- Enrolment with a PHO expires after three years, in the absence of a first level consultation in that time period or, active confirmation of enrolment from the patient. It was noted that this is a mechanism to ensure PHOs are only claiming capitation for active patients and this is subject to audit.
- The work around building awareness of the health and disability system for the Asian population is included in the Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan.

The Committee thanked the team for the updates and received the report.

5 INFORMATION ITEMS

5.1 Oral Health in the Auckland Region (agenda pages 86-110)

Ruth Bijl (Funding & Development Manager Women, Children and Youth), Deepa Hughes (Programme Manager, Oral Health and Youth Health) and Stephanie Doe (General Manager, Child Women and Family) were present for this item.

Ruth Bijl summarised the paper noting the compounding impact of COVID-19 on oral health outcomes.

- The efforts and the gains made by the service in the implementation of the Oral Health Action plan were acknowledged. There is catch-up work underway, which is in line with the Ministry of Health and Dental Council New Zealand guidelines.
- It was noted that oral health is one of the top five preventable conditions for child health hospitalisations (ASH indicator).
- Changes in the system and at service level are needed to improve outcomes, including reviewing and looking at different models of care and how services are provided. There are opportunities through partnership with schools, investing in preventative care and looking into best-practice international

models such as CHILDSMILE. A link to the CHILDSMILE programme website a will be provided to the Committee.

The Committee thanked the team for the update and received the report.

5.2 System Level Measures – Quarter 4 Report (agenda pages 111-139)

Wendy Bennett (Planning and Health Intelligence Manager) was present for this item. The report was taken as read.

Matters raised and response to questions included:

- Much of the work and activities have been impacted by COVID-19.
- Results of the Alcohol Harm reduction data is a Ministry of Health indicator. The result is attributed to an issue in the ED data capture process, which has improved from the changes in July, however coding and recording improvement work is on-going.
- Noting that some of the PHOs targets are not being met. It was clarified that the SLM work programme is both a whole of sector programme and a quality improvement programme where shared data, approaches and learning are all important components.
- In response to the result of the inpatient survey related to medication, it was identified that mechanism to which instructions was provided to the patient need to be improved. There is a programme of work underway with the Patient Experience team and key hospital services to improve this. The inpatient survey questionnaire has also recently been updated.

The Committee thanked Wendy for the update and received the report.

5.3 Auckland Regional Public Health Service (ARPHS) Briefing (agenda pages 140-162)

Dr William Rainger (Director) was present for this item. Jane McEntee (General Manager) joined by video conference.

The Committee Chair acknowledged the effort of the Auckland Regional Public Health Service (ARPHS) team towards the COVID-19 response.

The report was taken as read. Matters raised and response to questions included:

- The focus for ARPHS has been on the COVID-19 response. Following the first wave, there were learnings identified and changes were made on internal capacity and process. ARPHS focused on building specific resources and developing Pae Ora and Pacific response.
- Core public health services continue to be provided at reduced levels during the response to the pandemic including control of communicable diseases, drinking water survey, Healthy Auckland Together (HAT) initiative and alcohol programme.
- An update on the progress of funding of ARPHS was noted. A national level working group will look into the future of model of a sustainable public health system.

- The COVID-19 testing strategy sits under the NRHCC (Northern Region Health Coordination Centre) and is continually updated.
- There is work planned on a national level to look into the long-term effects of COVID-19 on those who have contracted the virus.
- The whole-of-government COVID-19 coordination is a work in progress and is continuously being improved. The advantage of this is ARPHS is able to provide inputs on matters that could influence national policy. Building and maintaining relationships with key people and establishing clarity on responsibilities is critical.
- There is regional emergency planning and response in place in relation to the ongoing Auckland water shortage. From an ARPHS' perspective, their work is focused on ensuring that water delivered is safe.

The Committee Chair thanked Jane and William for the report and acknowledged the work of the ARPHS during the COVID-19 response. The Committee received the report.

6 GENERAL BUSINESS

No matter of general business was raised.

The Committee Chair thanked everyone for their time.

The meeting concluded at 11.55am.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATĀ DISTRICT HEALTH BOARD – COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE HELD ON 28 OCTOBER 2020.

_____CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committee as at 25 February 2021

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back/ Update
28/10/21	4.2	<u>Planning, Funding and Outcomes Update</u> - Deep Dive on Rheumatic fever - Evaluation of the Kaimanaaki programme		 12.05.21 12.05.21

4.1 Specialist Mental Health and Addiction Services

Recommendation:

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

Endorsed by: Sarah Wallbank (Acting General Manager), Murray Patton (Director, Specialist Mental Health and Addiction Services) and Tim Woods (Executive Director, Tier 1 Community Services)

Service Overview

This service is responsible for the provision of specialist community and inpatient mental health services to Waitematā residents. This includes child, youth family and infant mental health services, adult mental health services including two acute adult in-patient units, community alcohol, drug and other addiction services across the Auckland metro region including inpatient detox beds, Whītiki Maurea providing kaupapa mental health services to Waitematā residents and addiction services across metro-Auckland, Takanga a Fohe - Pasifika Peoples mental health services and regional forensic psychiatry services that deliver services to the five prisons across the northern region, as well as eight in-patient villas and a regional medium secure Intellectual Disability unit, including an intellectual disability offenders liaison service. Mental Health and Addiction Services have around 9,000 active tāngata whai i te ora in our care at any point in time. Less than 1% of these would be in an inpatient unit. This means 99% of the tāngata whai i te ora in our care are living in the Community.

The group is led by Dr Murray Patton (Director Mental Health and Addictions Lead) and Sarah Wallbank (Acting General Manager). The Acting Associate Directors of Nursing are Carole Schneebeli and Michelle Dawson and the Clinical Directors are Dr Greg Finucane for Adult, Dr Frances Agnew for Whītiki Maurea and Takanga A Fohe, Dr Krishna Pillai for Forensics, Dr Emma Schwarcz for Community Alcohol & Drug, and Dr Mirsad Begic for Child, Youth and Family.

Highlight of the Month

COVID-19 readiness exercise

The Adult community service based in the Waimarino building at Paramount Drive, Henderson, underwent a COVID-19 response readiness exercise led by Graham Zinsli. This occurred prior to the most recent COVID-19 Alert Level 3 restrictions and demonstrated a high level of readiness from Mental Health Services to respond to the presentation of a COVID-19 positive client in a community setting. The service was familiar with their business continuity plan and were able to use the client tracking systems very effectively. The subsequent Level 3 alert showed mental health were quick to stand up their respective service response plans and all actions were completed within 24 hours of the alert.

Key Issues

Adult Mental Health Services

Community services have been managing high acuity and demands for beds within the acute service throughout January. The service is working closely with both inpatient units and the bed flow co-ordinator to identify early discharges and respite options, in order to meet the ever-increasing demands placed on acute services in the community and inpatient settings. Furthermore, there have

been challenges due to a busy holiday period with many staff taking annual leave during this time. Increasing caseloads within the community service are also noted and impacting on patient flow. The Emergency Departments have been exceptionally busy, with high volumes of mental health clients. Planning is underway to enhance the response within the Emergency Departments in conjunction with improving staffing profile and capacity within the inpatient units to enable improved flow.

Community Alcohol and Drug Services (CADS)
The lease for the current premises that houses Community Alcohol and Drug Services in South Auckland is coming to an end and will not be renewed. New premises to accommodate Te Ātea Marino, Community Alcohol and Drug Counselling and Auckland Opioid Treatment Services have been identified in Ronwood Avenue, Manukau. Remedial works are required to this building resulting in a likely four-month gap where services will not have premises. The service is developing mitigation plans including work from home options and other community spaces for groups. There is potential for the timeframe to be extended dependent on building works.

How to interpret the scorecards

Traffic lights
For each measure, the traffic light indicates whether the actual performance is on target or not for the reporting period (or previous reporting period if data are not available as indicated by the *grey bold italic* font).

The colour of the traffic lights aligns with the Annual Plan:

Traffic light	Criteria: Relative variance actual vs. target		Interpretation
	On target or better		Achieved
	95-99.9% achieved	0.1–5% away from target	Substantially Achieved
	90-94.9%*achieved	5.1–10% away from target AND improvement from last month	Not achieved, but progress made
	<94.9% achieved	5.1–10% away from target, AND no improvement, OR >10% away from target	Not Achieved

Trend indicators
A trend line and a trend indicator are reported against each measure. Trend lines represent the actual 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. The small data range may result in small variations appearing to be large.

Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result, their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance trend, use the trend indicator as described below.

The trend indicator criteria and interpretation rules:

Trend indicator	Rules	Interpretation
▲	**Current > Previous** month (or reporting period) **performance**	Improvement
▼	**Current < Previous** month (or reporting period) **performance**	Decline
--	**Current = Previous** month (or reporting period) **performance**	Stable

By default, the performance criteria is the actual: target ratio. However, in some exceptions (e.g., when target is 0 and when performance can be negative (e.g., net result) the performance reflects the actual.

Look up for scorecard-specific guidelines are available at the bottom of each scorecard:

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. ESPI traffic lights follow the MoH criteria for funding penalties: ESPI 2: the traffic light will be green if no patient is waiting, blue if greater than 0 patients and less than or equal to 10 patients or less than 0.39%, and red if 0.4% or higher. ESPI 5: the traffic light will be green if no patient is waiting, blue if greater than 0 patients and less than or equal to 10 patients or less than 0.99% and red if 1% or higher.

Scorecard – Specialist Mental Health and Addiction Services

Waitematā DHB Monthly Performance Scorecard

Specialist Mental Health and Addiction Services

January 2021

2020/21

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	76%	80%	▲

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	15 days	≤14 days	▲
Improving Outcomes			
Better help for smokers to quit	100%	95%	▲
Seclusion use Forensics - Episodes	15	≤14	▼
Seclusion use Adult - Episodes	3	≤5	▼
High Care Area/ICU 15 min observations	100%	95%	--
a. MH Access Rates 0-19 years (Total)	*3.81%*	*3.82%*	▲
a. MH Access Rates 0-19 years (Māori)	*5.19%*	*5.24%*	▼
a. MH Access Rates 20-64 years (Total)	*3.77%*	*3.77%*	▼
a. MH Access Rates 20-64 years (Māori)	*8.92%*	*9.40%*	▼
HR/Staff Experience			
Sick leave rate	*3.7%*	*≤3.4%*	--
Turnover rate - external	*8%*	*≤14%*	--
Vacancies - %	*6%*	*≤8%*	--

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. COVID-19	9,636 k	8,998 k	▼
Expenses excl. COVID-19	93,192 k	90,197 k	▲
Net surplus/(deficit) excl. COVID-19	-83,556 k	-81,200 k	▼
COVID-19 net benefit/(cost)	-725 k	0 k	▼
Net surplus/(deficit) incl. COVID-19	-84,281 k	-81,200 k	▼

Service Delivery

	Actual	Target	Trend
Waiting Times (latest available)			
a. Adult (20-64) <3 weeks	*82%*	*80%*	--
a. CADS (0-19) <3 weeks	*75%*	*80%*	▲
a. CADS (20-64) <3 weeks	*85%*	*80%*	▼
CYF <3 weeks	100%	95%	--
a. Forensic (20-64) <3 weeks	*77%*	*90%*	--
Prison inpatient waiting list	0	0	--
Patient Flow			
Bed Occupancy - Adult Acute	95%	80-90%	▲
Bed Occupancy - CADS Detox	97%	80-90%	▲
Bed Occupancy - Forensics Acute&Rehab	99%	80-90%	--
b. MH IPU readmission rate - Adult	*14%*	*10%*	▲
Community Care			
Preadmission community care - adult	68%	75%	▼
Post discharge community care - adult	64%	90%	▼
Clinical contact directly with consumer - adult	86%	80%	▲
Clinical contact directly with consumer- CADS	88%	80%	▼
Clinical contact directly with consumer - CYF	90%	80%	▲
Clinical contact directly with consumer - Forensic	87%	80%	▼
Whanau contacts per service user - adults	59%	70%	▲
Whanau contacts per service user - child	65%	80%	▼
Whanau contacts per service user - youth	100%	80%	--

How to read		
	Performance indicators:	**Trend indicators:**
	Achieved/ On track	Substantially Achieved but off target	▲ Performance ***improved*** compared to previous month
	Not Achieved but progress made	Not Achieved/ Off track	▼ 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-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. A small data range may result in small variations appearing to be large.
	a. Reported approx 3 months in arrears (Oct 20 data). b. Reported one month in arrears- Dec 20

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

Scorecard Variance Report

Best Care

Patient Experience- Complaint Average response Time- 15 days against a target of ≤14 days

The average response time was affected by the complexity of complaints and investigation, particularly to the Opioid Treatment Services (AOTS). A meeting was rescheduled several times to

accommodate the needs of the complainant which pushed the average response time above the target of 14 days.

Improving Outcomes- Seclusion use for Forensics – Episodes – 15 against a target of <14
There were 14 service users who presented with psychiatric and/or behavioural acuity in the month. The episodes were spread across the admitting units in the Service. There were three distinct service users in Pohutukawa (male intellectual disability admissions) who presented with behavioural acuity. In relation to mental health there were eight service users in Kauri (male admission) and three service users in Totara (female admission) who required seclusion.

Improving Outcomes- MH Access Rates 20-64 years (Māori)- 8.92% against a target of 9.40%
The services continue to try to improve access for Māori including initiatives such as provision of kaupapa services and enhanced recruitment for staff identifying as Māori.
Staff are undertaking engaging effectively with Māori training across all services.
The target continues to rise in line with population growth, particularly in West Auckland and more rural Rodney areas. It has been noted by Whitiki Maurea services that Māori engage less with online options such as zoom / online groups and this may impact access rates subsequent to the pandemic.

HR/ Staff Experience- Sick leave rate- 3.7% against a target of ≤3.4%
While this is a small variance, it is likely due to the impact of the DHB approach to encourage staff even with minor ailments to stay home.

Service Delivery
Waiting Time- CADS (0-19) < 3 weeks- 75% against a target of 80%
Altered High had a higher number of Did Not Arrive (DNA) and cancellations which is a usual pattern and is attributable to school holidays. The Service reports that young people often engage and attend appointments because they are at school and the team see them there.

Waiting Time- Forensics (26-64) < 3 weeks-77% against a target of 90%
This metric has a three-month lag and is based on a data set covering September 2019-September 2020.This metric was adversely affected by the COVID-19 lockdowns. During the higher alert levels, our ability to enter the prisons to conduct routine psychiatric in-reach work was constrained by the Department of Corrections. During this time the Forensic Prison Team continued to receive referrals. Those referrals that were triaged as non-urgent were deferred until constraints around entrance to prisons had relaxed.

Patient Flow- Bed Occupancy – Adult Acute 95% against a target of 80-90%
Adult occupancy remains high, although reduced from previous months. There have been challenges in staffing the increased acuity and increased levels of observation (one to one) in the inpatient units. This combined with the availability of Intensive Care Unit beds continues to impact significantly on the wards. People with a long length of stay due to unavailability of specialised inter-agency rehabilitative accommodation or packages of care also have an impact on occupancy. These clients often present with an aggregate of conditions such as intellectual disability and challenging behavioural difficulties that requires complex inter-agency care from specialised staff. A regional approach including packages of care and residential rehabilitation to support this group of patients across metro Auckland has been approved by the Chief Executives and will be progressed over the coming months led by the Northern Regional Alliance. This group of patients and the actions to facilitate their discharge into appropriate care are being reviewed weekly by needs assessment coordinators, funders, inpatient senior staff and senior adult service leadership.

Patient Flow- Bed Occupancy – CADS Detox 97% against a target of 80-90%
The Detox Occupancy is higher than the 80-90 % target due the opening of an 11th (unfunded) bed to help with patient flow and to try to meet current need with a wait list in place. At the time of the report, the waitlist has 65 clients with an average wait time of seven weeks for admission.
Since the implementation of Substance Addiction Compulsory Assessment and Treatment (SACAT), access to beds for voluntary clients has decreased, as on average, two beds are being used by SACAT clients that have a longer average length of stay.

Patient Flow- Bed Forensics Acute & Rehab- 99% against a target of 80-90%
The Service continues to have supernumerary intellectual disability contracted beds, but the Ministry of Health has agreed to purchase five additional beds. This is being worked through with Funding and Planning.

NEW KPI: Patient Flow – MH IPU 28-day readmission rate – Adult 14% against a target of 10%
This is a new target for the scorecard and is helpful in identifying when patients are being readmitted to the units within 28 days of discharge. This indicator is generally considered to be a measure of an unsuccessful return to community care related to a discharge too soon from care (It is worth noting that in some cases short readmissions may be considered therapeutic). There are a number of challenges with limited inpatient bed availability for reasons of:

- Low numbers of beds per head of population in Waitematā when compared nationally
- Limited placements for appropriate supported accommodation or intensive packages of care, meaning that there are a number of people requiring rehabilitative placement who remain in acute in-patient units
- Increasing numbers of acute presentations to mental health services.

For each area of concern raised above, there are work streams progressing to address the limitations that are affecting bed-flow through acute in-patient unit and are being reported on.

Community Care- Pre-Admission Community Care – Adult Acute 68% against a target of 75%
The inability to meet this target indicates the inability to see people within the community and the number of people who are presenting to the Emergency Department who are then admitted to the in-patient unit. It is an indicator of acuity and demonstrates that acuity during the period is high.

Post-Discharge Community Care – Adult Acute 64% against a target of 90%
The reduction in meeting this target is due to increased acuity and needing to respond to people presenting with acute care needs rather than those who have been discharged from hospital.

Community Care- Whānau contacts per service user – Adult Services 59% against a target of 70%
This KPI continues to increase although is not yet at target. Ongoing training for staff in whānau inclusive practice and prioritisation of whānau engagement, including section 76 auditing and monitoring, is supporting working towards achieving the target.

Community Care- Whānau contacts per service user – Child Services 65% against a target of 80%
Child and Youth Services typically achieve this target due to the nature of the work with young people and whānau, this data indicates a more than 20% drop in achievement against this target over a month which indicates a data reporting error that will be investigated.

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Placing people at the centre of all service planning, implementation and monitoring programmes		
Continue to operate the Waitematā DHB Consumer and Family/Whānau Advisory Team, which is embedded into our service (12 FTE) (EOA)	Ongoing	On track
Enhance family/whānau participation in Mental Health Act reviews to reduce the number of Māori treated under compulsory treatment order in the community (EOA)	Jun 2021	On track
Implement and retrieve data from a new feedback system to improve quality of services for tāngata i te whai ora and whānau across the services, including the Māori kaupapa and Pacific services. Paper and electronic surveys will be available to suit users and data will be available by service and by ethnic group so improvements can be targeted (EOA)	Dec 2020	Completed Q1
Develop a new model of care across the Specialist Mental Health and Addiction Services. Plan for improved access to cultural support (as per Code of Consumer Rights) (EOA)	Jun 2021	Not on track but underway. More project resource secured via MOH sustainability funding. ETA Jan 2022
Embedding a wellbeing and equity focus		
Implement an Equally Well strategy across specialist services, including: • implement the National Patient Deterioration System (NZEWS) in inpatient services • metabolic screening and follow-up for at risk groups (including Māori and Pacific people on olanzapine and clozapine medication) (EOA) • wrap-around medication initiation package for people starting atypical anti-psychotics, including testing of the agreed package	Jun 2021	On track
With Tūhono (cross-DHB and NGO forum), develop a green prescription pathway for people supported by specialist and NGO services who are at high risk of co-morbidities (EOA)	Jun 2021	On track
Complete the delivery of an Individual Placement and Support (IPS) trial within Waitematā DHB secondary mental health services	Jun 2021	On track
Continue with implementation of Supporting Parents, Healthy Children (COPMIA) and form a cross-sector partnership, which will enable an integrated service to children identified as vulnerable, including establishing inter-agency forum terms of reference	Dec 2020	Not on track but underway
Engage with collaborative forums to drive transformational change in line with He Ara Oranga, including: • Tūhono (Auckland-Waitematā DHBs MHA executive leadership sector collaborative body) • the Northern Region MHA network • the Integrated Primary MHA Services governance group • the Suicide Prevention and Postvention governance Group • Supplement ongoing engagement with Ministry of Health and the Mental Health and Wellbeing Commission	Jun 2021	On track

Develop a new model of care across the specialist services, including planning for improved engagement with Māori, Pacific, youth and rainbow communities (EOA)	Jun 2021	Not on track but underway. ETA Dec 2021
Increasing access and choice of sustainable, quality, integrated services across the continuum		
Improve sustainability of ED mental health and liaison psychiatry services by implementing a one-team model	Jun 2021	On track
Implement brief acute assertive community interventions in three specialist mental health hubs in adult mental health	Jun 2021	On track
Partner with NGO and PHO services to develop a model for delivery of specialist and consult-liaison MHA interventions in primary care settings (using an in-reach model) (EOA)	Mar 2021	Not on track - awaiting model of care work, new ETA Dec 2021
Strengthen and increase the focus on mental health promotion, prevention, identification and early intervention by increasing the delivery of a wider range of MHA community-based options in line with the Ministry investment in primary MHA. This includes: expansion of Health Improvement Practitioners, Health Coaches and Awhi Ora positions, in line with funding agreement to be confirmed with MoH • Contracts signed with NGO and PHO partners • Initiate procurement processes for expansion of delivery of all three models	 Sep 2020 Mar 2021	Completed in Q1
Develop a metro-Auckland governance group to oversee the primary mental health investment from Ministry into access and choice. To include partnership with NGO, PHO, DHB, Māori, Pacific, young people and those with lived experience • Terms of reference endorsed by governance group • Develop reporting mechanisms, including setting of baseline data for primary mental health investment	 Jul 2020 Oct 2020	Completed in Q1
Apply cost pressure funding to the price for all NGOs in the district to ensure their sustainability; develop new contracts with updated price, inclusive of cost pressure	Dec 2020	Completed
Suicide prevention		
Work with the new national prevention and post-vention office and MoH, contribute to plans and implement programmes as required	Dec 2020	Ongoing communication with the Suicide Prevention Office for support with the suicide action plan.
Review the current Suicide Prevention Action Plan and develop a plan for 2020–2023, in partnership with people with Māori, people with lived experience and population groups who experience disproportionately higher rates of suicide (EOA). The actions will align with key DHB-led actions from Every Life Matters and be approved by the Suicide Prevention Office	Jul 2020	The suicide action plan is to be presented to the Board for approval. All 4 focus areas within the plan align with Every Life Matters

		suicide prevention strategy. However, we have commenced reporting to MOH on actions on the revised Action Plan.
Investigate data capture options to analyse the effectiveness of implementing the Waitematā DHB specialist mental health and regional AOD and Forensic services plan and provide data to the national suicide prevention research plan	Dec 2020	This is an ongoing process. Data are generated from the suspected suicide notification process. Currently this process is being reviewed together with the suicide postvention response process. Data will need to be analyse and reports will be generated on quarterly basis.
Workforce		
Work with the DHB's Māori recruitment specialist to develop a Māori recruitment initiative (EOA)	Jun 2021	On track
Scope workforce expansion to carry out clinical support functions with people within specialist MHA services by developing a business case	Jun 2021	Not on track but underway (delayed by COVID)
Procure new positions to expand primary mental health models, including specific focus and reference to the value of lived experience, peers and whanau	Mar 2021	On track
Forensics		
Contribute to the MoH Forensic Framework project to identify an agreed Forensic model of care, including provision of Kaupapa Māori services (EOA), and implement the plan	Sep 2020	Not on track as MoH audit still underway
Pending confirmation of the wellbeing budget, work with the Ministry to	Jun 2021	Not on track as

improve and expand the capacity of forensic responses		Wellbeing budget allocation not confirmed
Work with the Ministry to agree the long-term capacity of forensic intellectual disability responses	Mar 2021	On track
Complete building works as required to replace deteriorating building stock at Mason Clinic, including planning and securing funding	Ongoing	On track
Commitment to demonstrating quality services and positive outcomes		
Improve the quality of data input for consult-liaison functions (MH01), including extension of the capability for consult-liaison reporting to addiction services	Dec 2020	Not achieved but underway

Financial Results – Specialist Mental Health & Addictions Services

Waitematā DHB Statement of Financial Performance

Specialist Mental Health and Addiction - Jan-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	1,186	1,182	4	7,921	7,366	555	12,708
Other Income	96	190	(94)	1,715	1,632	83	2,905
Total Revenue (excluding COVID)	1,282	1,372	(90)	9,636	8,998	638	15,613
EXPENDITURE							
Personnel							
Medical	1,972	2,500	528	17,493	19,282	1,789	31,665
Nursing	5,419	5,374	(45)	40,196	38,190	(2,006)	66,532
Allied Health	2,266	2,527	261	21,589	20,742	(847)	33,867
Support	140	138	(2)	1,112	1,085	(27)	1,839
Management / Administration	479	551	72	4,318	4,091	(228)	6,706
Outsourced Personnel	381	155	(227)	2,969	1,212	(1,757)	2,058
	10,657	11,245	588	87,677	84,600	(3,077)	142,667
Other Expenditure							
Outsourced Services	4	13	9	79	88	9	149
Clinical Supplies	91	108	17	533	748	215	1,270
Infrastructure & Non-Clinical Supplies	711	765	53	4,904	4,762	(142)	8,422
	806	885	80	5,515	5,597	82	9,842
Total Expenditure (excluding COVID)	11,462	12,130	668	93,192	90,197	(2,995)	152,508
Surplus/(Deficit) excluding COVID	**(10,181)**	**(10,758)**	**577**	**(83,556)**	**(81,200)**	**(2,357)**	**(136,895)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(39)	0	(39)	(725)	0	(725)	0
Surplus/(Deficit) including COVID	**(10,220)**	**(10,758)**	**538**	**(84,281)**	**(81,200)**	**(3,081)**	**(136,895)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Comment on major financial variances

The overall result for Specialist Mental and Addictions Services was $538k favourable for December and $3,081k unfavourable for the YTD.

Revenue ($90k unfavourable for January, $638k favourable YTD)
The unfavourable variance for January stemmed mainly from the new Registrar Training program (-$124k). This component of the service is funded via a cost recovery model, which is currently being actioned to ensure a break-even position.
Year to date, the additional revenue for service users within care needs (Intellectual Disability) in the Pohutukawa ward of the Mason Clinic resulted in a $326k YTD favourable to budget, an additional funding provided from the Ministry of Health for the level of care exceeding the base level funding of an one-off funding injection of $145k (in Sep-20) was received to set up crisis support in the Emergency Department and research grants received ($77k YTD).

Expenditure ($668k favourable for January, $2,995k unfavourable YTD)
The favourable variance for January was due to the high annual leave taken especially in medical and allied staff. The continued effects of COVID-19 is still reflected in higher staff retention, high sick leave taken (this was especially high in Medical leading to an increase in additional sessions and locum cover). Retention and recruitment of staff has increased year on year such that 34.17 additional FTEs are now in service. It is noted however, that vacancy increased in January to 132.8 from 128.0 FTEs from prior month.

Personnel ($3,077k unfavourable YTD)
Medical ($1,789k favourable YTD)
The favourable variance was due to vacancies of 15.3 FTE ($256k) for January 2021 and an average of 13.0 FTE YTD, however, this is offset against the overspend in outsourced personnel (locum spend). High annual leave taken in December and January ($655k) also contributed to the favourable position.

Nursing ($2,006k unfavourable YTD)
The unfavourable variance was due to 62.9 FTE nursing variances in Jan and an average of 65.16 FTE YTD offset by premium overtime (36.5k T2 hours YTD) and the use of Healthcare Assistants to support gaps in Registered Nursing positions as well as to cover the high level of acuity.

Allied Health ($847k unfavourable YTD)
The unfavourable variance was mainly due to retention of staff average of 36.9 FTE YTD versus prior year average of 49.1 FTE YTD this is due to backfill requirements and the increased need to support nursing vacancies where possible.

Support and Management/Administration ($255k unfavourable YTD)
The unfavourable variance was mainly due to retention of staff and additional sick leave taken for July, August, September.

Outsourced Personnel ($1,757k unfavourable YTD)
The unfavourable variance was due to an increase in cover for sick and maternity leave mainly in medical, as well as cover for vacancies, equivalent to 6.46 FTEs. In addition, overflow work for court reporting accounts for around 30% of the outsourced personnel spend which is offset against court report revenue.

Other Expenditure ($82k favourable YTD)

Outsourced Services ($9k favourable YTD)

The favourable variance was due to the reduced use of contract staff to cover non-medical vacancies. This is offset by staff overtime in personnel costs.

Clinical Supplies ($215k favourable YTD)

The favourable variance was due to a reduced number of after care services in the Flexifund, the number of service user increased in January and is expected to increase over the next few months.

Infrastructure and Non-Clinical Supplies ($142k unfavourable YTD)

The unfavourable variance was mainly driven by additional OPEX charges on rented properties and outsourced meals to reduce the risk of COVID-19 spread in service user self-catered facilities. Laundering and cleaning cost are also above budget due a higher standard of COVID appropriate activity.

COVID-19 impact

Total COVID-19 impact ($725k YTD)

Medical ($326k) overspend mainly from sick leave in August 2020 where resulting in 1,121 hours compared to 609 hours this time last year. As a result, extra additional sessions and locums were used to cover.

Nursing ($304k) overspend mainly from sick leave, and redeployment of nurses (managed facilities) resulting in high overtime to back-fill rosters. Allowances were paid out to casual staff (totalling $10k) to top up their salary due to limited work provided to them during COVID-19 Alert levels 3 & 2 from workforce bubbles being enforced across the service.

4.2 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), Jesse Solomon (Senior Programme Manager Women, Children & Youth), Meenal Duggal (Funding & Development Manager, Mental Health and Addiction Services), Leani Sandford (Portfolio Manager, Pacific Health Gain), Raj Singh (Project Manager, Asian, Migrant and Former Refugee Health Gain), Shayne Wijohn (Acting Funding and Development Manager, Primary Care and Māori Health Gain Manager)
Endorsed by: Dr Debbie Holdsworth (Community and Provider Funding and Procurement) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

AAA	-	Abdominal Aortic Aneurysm
ACC	-	Accident Compensation Corporation
AF	-	Atrial Fibrillation
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
B4SC		B4 School Check
CADS	-	Community Alcohol and Drug Services
CASA	-	Clinical Advisory Services Aotearoa
CIR	-	COVID Immunisation Register
CPHAC	-	Community and Public Health Advisory Committee
CTC		Community Testing Centre
CVD	-	Cardiovascular Disease
CWF	-	Child, Women and Family
DCNZ		Dental Council of New Zealand
DHB	-	District Health Board
ESBHS	-	Enhanced School Based Health Services
FPA	-	Family Planning Association
GP	-	General Practitioner
HBHF	-	Healthy Babies Healthy Futures
HC	-	Health Coach
HCSS	-	Home and Community Support Services
HEEADSSS	-	Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety
HIP	-	Health Improvement Practitioner
HPV	-	Human papillomavirus
IPMHAS	-	Integrated Primary Mental Health and Addiction Services
IPS	-	Individual Placement and Support
IMT	-	Incident Management Team
LARC	-	Long Acting Reversible Contraception
MELAA	-	Asian & Middle Eastern Latin American and African
MMR	-	Mumps, Measles and Rubella
MoH		Ministry of Health
MSD	-	Ministry of Social Development
NA-HH		Noho Āhuru – Healthy Homes

NCHIP - National Child Health Information Platform
NCSP - National Cervical Screening Programme
NGO - Non-Governmental Organisation
NIR - National Immunisation Register
NRHCC - Northern Region Health Coordination Centre
NSU - National Screening Unit
PFO - Planning, Funding and Outcomes
PHO - Primary Health Organisation
TWoW - Te Whanau o Waipareira
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 first draft of the 2021/22 Annual Plan was presented to the Audit and Finance Committee at its meeting of 17 February for their consideration and review. This is to be circulated to the Board for final approval prior to being submitted to the Ministry of Health (MoH) on 5 March 2021. Feedback on the first draft is expected from 9 April from the MoH. The Plan will subsequently be updated and the second draft – post Board approval – is due with the MoH by mid-June.

2.2 Annual Reports

The audit approved 2019/20 Annual Report has been finalised and printed. Following presentation to parliament, this documented will be published to the DHB's website.

Development of the timeline for 2020/21 audit and development of the 2020/21 Annual Report has commenced.

3. Primary Care

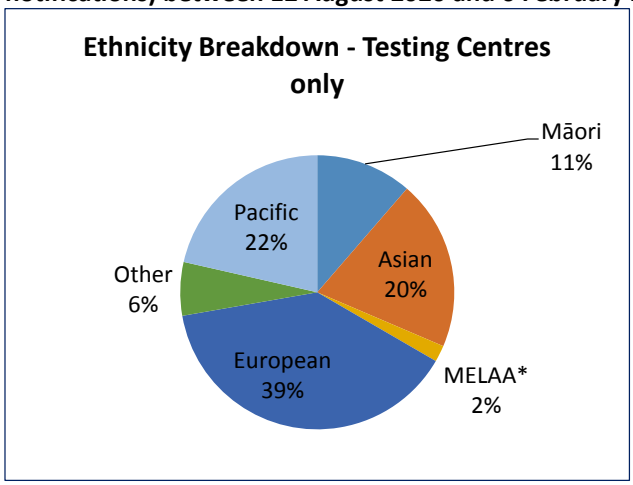
3.1 Response to COVID-19

The primary care team, with staff working within both the DHB and the NRHCC, continues to support the Metro Auckland response. With the pandemic response entering a more settled phase, the team have been re-prioritised to support COVID-19 vaccination planning.

The framework of semi-permanent fixed site Community Testing Centres (CTCs) and mobile testing units that was established in July last year is still in place. General practices and urgent care clinics continue to support our COVID-19 testing programme. This Framework was able to adapt quickly during the recent surge in testing demand due to the three positive community cases that were confirmed in January. To meet increased demand for testing over this period two additional 'pop-up' testing sites were stood up at Victor Eaves Park (28 – 30 January) and North Harbour Stadium (27 January – 1 February). During this period of heightened risk 11,284 swabs were taken through CTCs, mobile testing units and 'pop-up's alone (28 January 2021 – 6 February 2021).

Since the August COVID-19 outbreak (between 12 August 2020 and 6 February 2021), CTCs and mobile clinics completed 330,152 swabs, while another 266,399 swabs were taken through general practice and urgent care clinics across metropolitan Auckland.

Graph 1. Proportion of tests taken at CTCs and mobile testing clinics by ethnicity (Source: e-notifications) between 12 August 2020 and 6 February 2021.



* Middle Eastern Latin American and African

COVID-19 vaccination programme

Planning for how the metro-Auckland primary care network will support the rollout of the COVID-19 vaccination programme is underway; the PFO Primary Care Team will lead this work. This is a part of a larger regional process to develop and execute a COVID-19 vaccination roll out starting with tier 1 (border staff and their whānau) and tier 2 (front line health workers), and eventually leading to the whole community vaccination roll out.

Mobile Outreach Health clinics

During COVID-19 Alert Level 4, approximately 500 rough sleepers were accommodated in motel units ("managed accommodation") across metropolitan Auckland; 41% of these people are Māori and 15% are Pacific. Auckland and Waitematā DHBs successfully implemented mobile health clinics to provide health services to those living in managed accommodation from 1 July 2020 to 30 September 2020.

The mobile 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 evaluation of the services demonstrated the benefits of the Auckland/Waitematā programme to Māori and Pacific people. These services have been extended to 31 March 2021 to continue providing services to people in managed accommodation.

Your Health Summary

The 'Your Health Summary' Shared Primary Care Summary is an on-going initiative that provides clinical information to better support high quality patient care when a patient accesses care at an alternative setting to their 'medical home'. This might be because their practice has closed due to COVID-19 or they are accessing care at an Urgent Care Centre or hospital. The programme provides a secure centralised repository of summary primary care information, for all patients in the Auckland region, that is accessible for patient care by appropriate health practitioners in other settings. There is the ability for patients to opt out of the system.

Your Health Summary is an important component of a high functioning regional health care system to enable quality continuity of care. There is a focus to achieve high coverage for Māori, Pasifika, people living in quintile 5 areas, and people 65 years and older, as these population groups have, on average, higher healthcare needs, require healthcare more often and may be more mobile regarding where they seek healthcare.

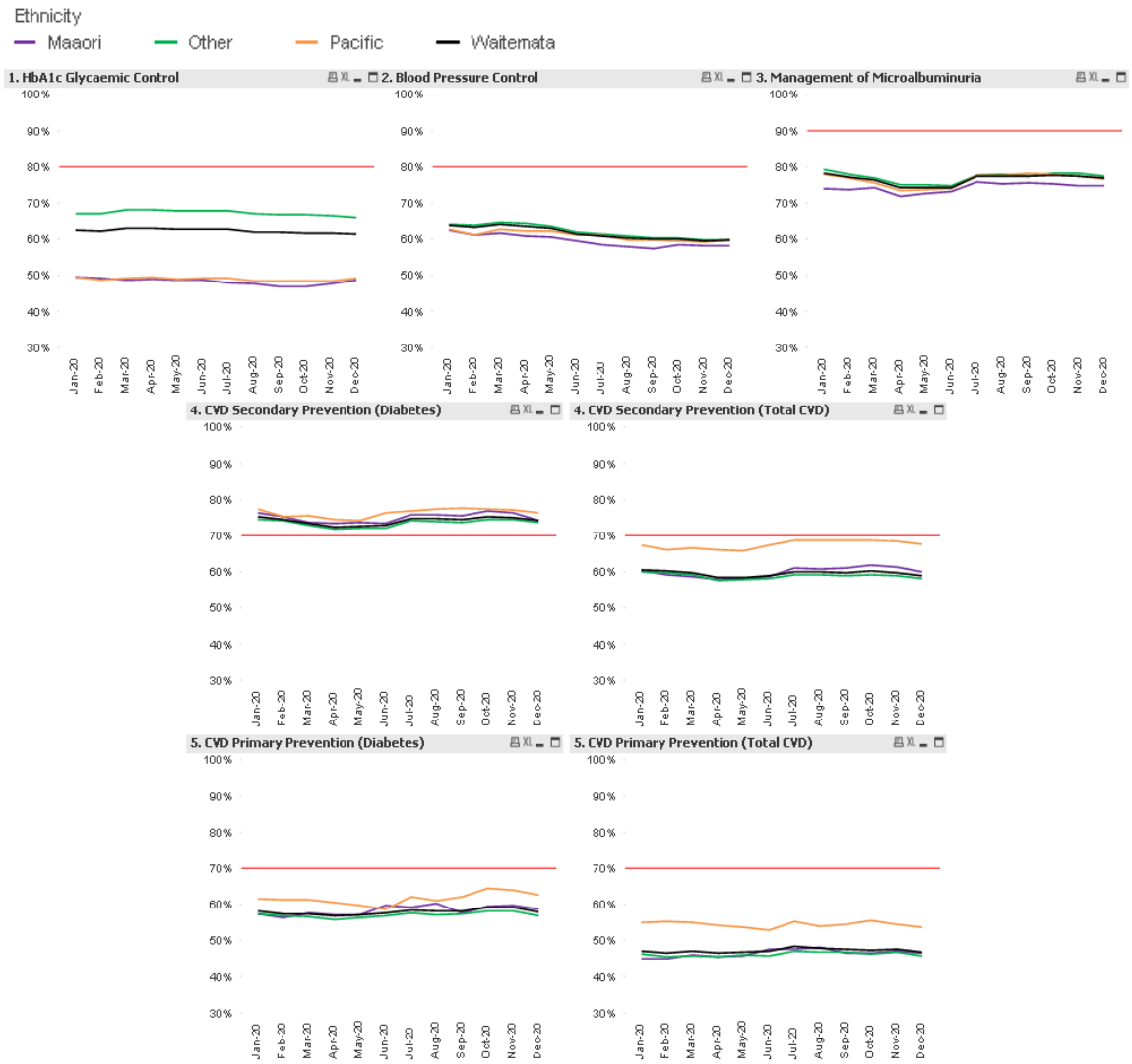
Primary Healthcare Organisations have agreed to make this a priority area to improve the rate of uptake.

3.2 Diabetes

The following are some key facts from the latest (December 2020) diabetes quarterly report for Waitematā DHB. At the end of quarter two 2020/21 the following can be noted:

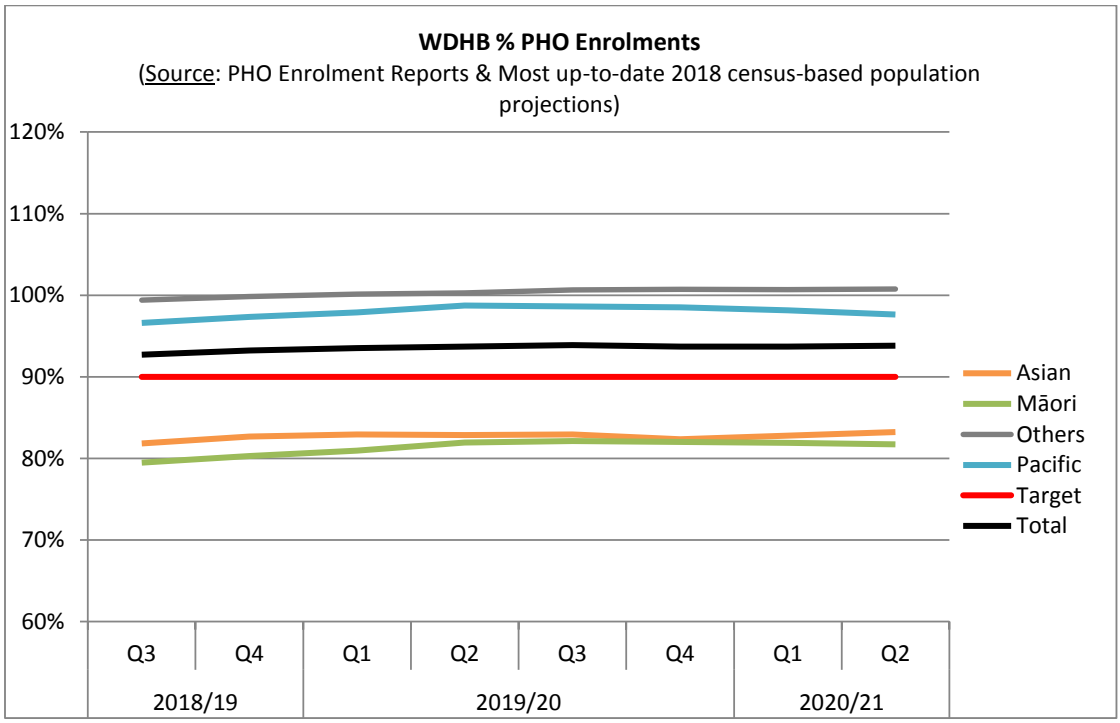
- Despite COVID-19, performance against six of the seven indicators, with the exception of blood pressure management, has remained within +/-2% of their January 2020 result.
- Performance against the diabetes control (HbA1c) indicator remains consistently poor with stark inequities for HbA1c with almost 20 percentage points across ethnicities. Despite this, Waitematā DHB has the highest percentage of patients with diabetes that have good glycaemic control (61%).
- Waitematā DHB has the highest percentage of patients on secondary prevention for those with diabetes (74%) and the equal highest percentage (with Auckland DHB) for management of microalbuminuria (77%).

The following graphs present the performance between January 2020 and December 2020 (NB: the target is represented by the red line).



3.3 PHO Enrolment

Below is the most recent PHO enrolment data from quarter three 2018/19 to Q2 2020/21. The data is sourced from the National Enrolment System and the most up-to-date population projections based on the 2018 census.



NB: 2018/19 Q3 new data source (National Enrolment System) and 2020 update of 2018 census population projections.

4. Health of Older People

4.1 Aged Residential Care

The COVID-19 preparedness status of Aged Residential Care (ARC) has remained a focus. There is a Northern Region structure to oversee this work comprising the following groups:

- ARC Outbreak Steering Group – to identify and agree the areas that require a consistent and aligned regional response to ensure effective management of a COVID-19 outbreak in an ARC facility
- ARC Outbreak Operations Working Group – to address planning relevant to operations in a COVID-19 outbreak including the notification process and logistics
- ARC Outbreak Clinical and Public Health Working Group - to provide clinical and public health recommendations to the Steering Group on specific topics e.g. principles for resident transfer decisions, infection prevention and control support/protocols, principles for staff stand downs.

A Northern Region multi-agency workshop held in November worked through a range of COVID-19 outbreak scenarios in ARC, testing assumptions and identifying areas requiring additional clarity or alignment. ARC providers, DHBs, public health units and unions attended the workshop. Key themes from the workshop have identified opportunities for further action, which the working groups have incorporated into their work plans.

4.2 Home and Community Support Services

The national framework and service specification for Home and Community Support Services (HCSS) was published at the end of last year. 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 flex 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 is that all DHBs transition to the new model by 1 July 2022.

There have been a number of discussion with TAS, who has been leading this work on behalf of the DHBs, to clearly determine the steps that Waitematā DHB needs to undertake to progress to the new HCSS model. In order to fully understand the implications of this transition, including financial implications, it is critical that the casemix representation of the HCSS client population is accurate. Currently, approximately 900 clients have not had a comprehensive interRAI assessment, which is required to assign the casemix. A proposal to resource this necessary assessment work is being prepared but it is significant in its scale.

4.3 Falls and Fracture Prevention Services

There has been a period of uncertainty around ongoing Accident Compensation Corporation (ACC) funding for the In Home Strength and Balance Programme and the Fracture Liaison Service. Waitematā DHB and ACC currently jointly fund both services but ACC funding was due to end on 31 December. ACC has recently announced ongoing investment in its Live Stronger for Longer suite of activities. This means ACC will continue to contribute funding to the In Home Strength and Balance programme until 30 June 2021. Whilst, it will have a longer-term commitment to funding the Fracture Liaison Service up to 30 June 2024. A national focus will be on Fracture Liaison Services achieving International Osteoporosis Foundation accreditation (note: Waitematā DHB Fracture Service has already achieved this accreditation in December 2020).

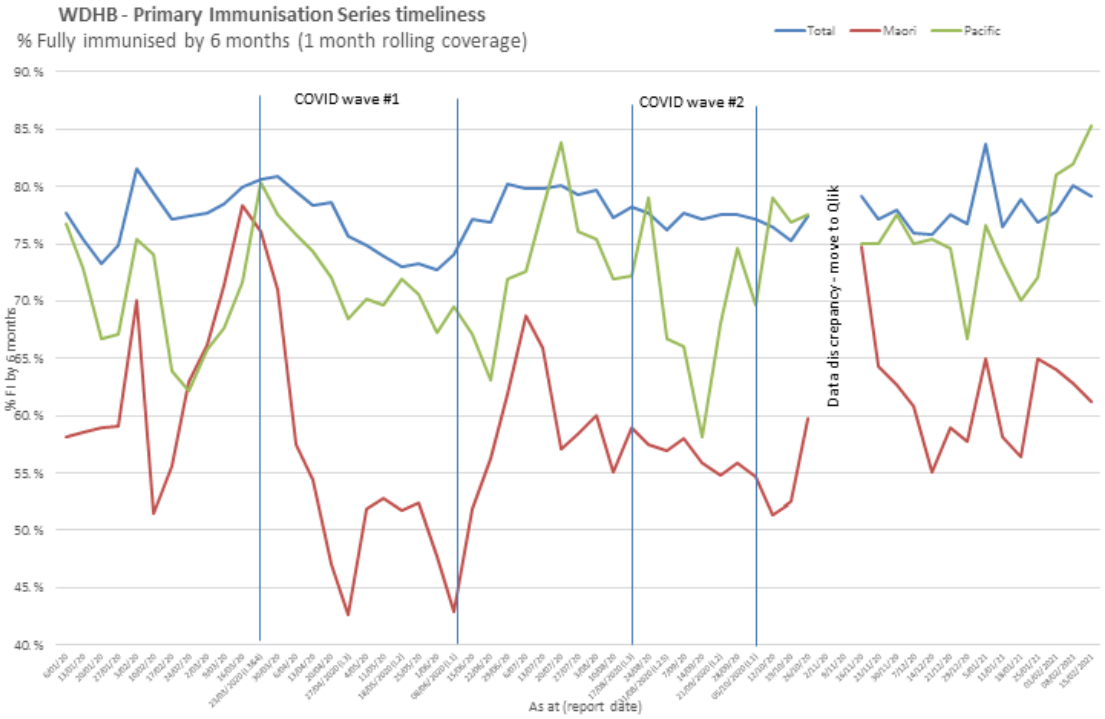
5. Child, Youth and Women's Health

5.1 Immunisation

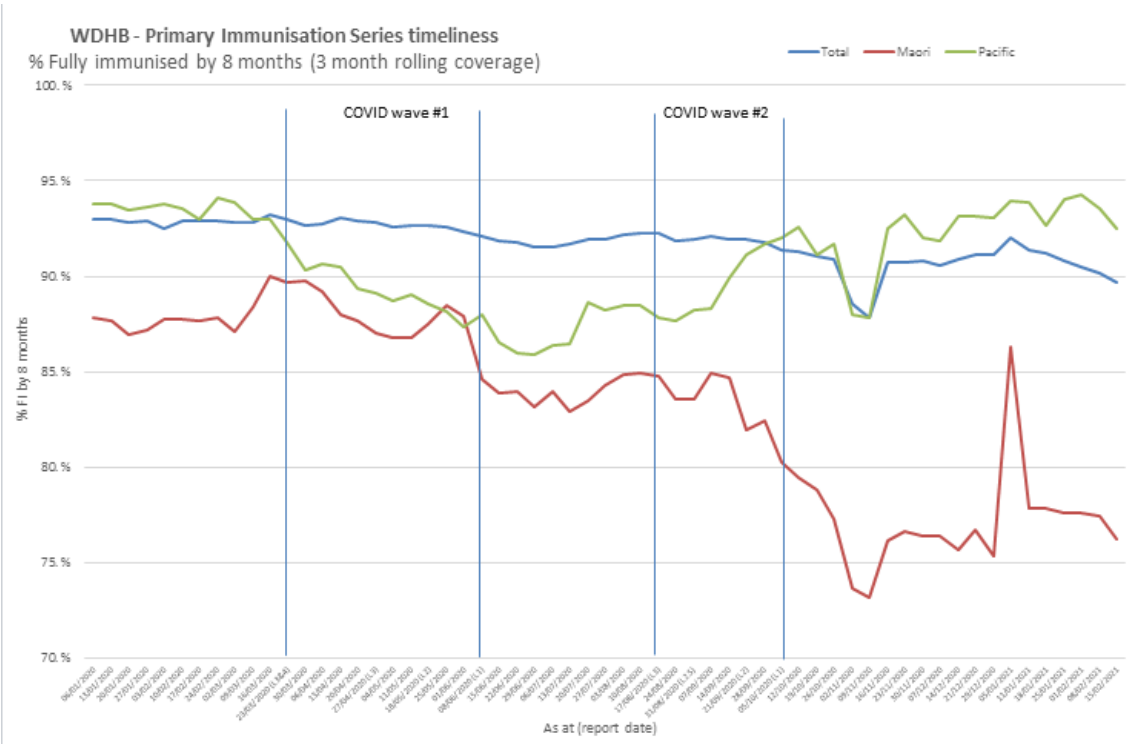
5.1.1 Childhood Immunisation Schedule Vaccinations

COVID-19 has had an impact on immunisation coverage. As at 15 February 2021, coverage for tamariki in Waitematā DHB is 90% fully immunised at eight months, following our counterparts around the country that have seen coverage falling many to the low 80%s. For tamariki, Māori coverage is stable at 76%, with coverage for Pacific children at 94%. At the same time last year (pre-COVID-19), coverage was 93% for the total population, 88% for tamariki Māori and 93% for Pacific children.

The PFO continues to monitor the impact on "on-time" immunisation as measured at six months of age, particularly the rolling 1-month coverage which demonstrates the "real time" coverage although this is more prone to fluctuation due to smaller population size. As demonstrated by the following graph, coverage has fallen during the lockdowns, with recovery as we have moved into Alert Level 1, the drop in coverage has been more sustained for tamariki Māori. When looking at the more stable three-month coverage (not graphed), we are seeing Pacific and total coverage at pre-COVID levels for on-time immunisation, with on time coverage improving for Māori but still remaining lower than pre-COVID-19.



The COVID-19 impact on on-time immunisation rates is now reflecting on the eight-month immunisation rates, particularly for tamariki Māori in WDHB. Pacific rates are now back to pre-COVID levels.



Vaccine hesitancy continues to be a challenge for Waitematā DHB – with the decline /opt-off the National Immunisation Register (NIR) rate for the total population at eight months 5.1% as at 15th February. The ethnicity insights from the Qlik platform show Māori as having over twice the vaccine hesitancy (11%) of non-Māori and this has continued to deteriorate when compared with the same time last year, when our Māori decline/opt-off rate at eight months is estimated to have been 7%, whilst the total population was 3.5%. We are supporting the Māori Health Gain team on their initiative to engage with iwi to support positive immunisation messages.

Review of other DHBs reflects high Māori decline rates are a national issue, with other DHBs experiencing rates as high as 15% at eight months. Reports from the sector continue to reflect social media as well as opinion from some groups against immunisation having an impact. We have requested assistance from the MoH at a National level to promote immunisation. We are also working with our colleagues in Counties Manukau on hosting a hui of child health providers to identify the factors for vaccine hesitancy and delay, and strategies to address these.

We have been working with our PHO colleagues to support them with data access with the move to the Qlik reporting platform. The next focus is ensuring all PHOs can access identifiable lists of their Māori tamariki to ensure focus is directed to this area.

The move to the Qlik platform for immunisation coverage has seen some data issue discrepancies, now affecting the 18-month coverage following the schedule changes in October 2020. This has been escalated to the MoH.

5.1.2 Measles

Work as part of the national MMR catch-up focused on 15 to 30 year olds, particularly Māori and Pacific, continues, with the Waitematā strategy to increase awareness of the need to be immunised and increasing access to the vaccine.

Since the campaign was soft launched by Associate Minister of Health Julie Anne Genter in July 2020, 462 MMR doses have been recorded on the NIR for Waitematā 15 to 30 year olds, with 566 doses claimed for to December 2020. Of these, 51 were to Māori (46 claimed) and 44 to Pacific (60 claimed). The discrepancy between NIR and claims data is recognised, there are challenges with not all recipients being opted on to the NIR, and not all providers having access to the NIR.

Whilst the volume is lower than desired, this still represents a great achievement with the MMR catch-up competing with COVID-19 and also the limited promotion. The Ministry/Health Promotion Agency resources were not available until late October/November.

As per the last report, we have adapted the national communications suite based on feedback from focus groups with Māori rangitahi and Pacific young people. Posters, leaflets and campaign t-shirts have been distributed to primary care and GP practices.

The MoH has commissioned digital and audio advertising. The DHB is also commissioning washroom advertising in malls across the DHB, as well as social media postings.

With the support of Waitematā DHB communications team, we are developing some local promotional videos. One will be a Pacific young person getting their MMR in a local pharmacy – this is to promote MMR and also address issue identified via focus groups that pharmacies as an immunisation venue is not well known. We are also looking to develop a te reo Māori video with Hoani Waititi to promote immunisation.

The vaccine numbers will start to increase in the coming months with events scheduled in our enhanced school based health service schools and tertiary institutes (campus and halls of residents). A health promotion event on Waitangi Day that the project was supporting Ngati Whatua Orakei with, was cancelled due to COVID-19 concerns. There are also discussions about health promotion events at community libraries following focus group feedback. Contracts are now in place with Family Planning Association (FPA) and the Regional Sexual Health Clinics, with negotiations progressing with private occupational health providers. An initiative is also being explored to deliver MMR to patients receiving Bicilin injections.

5.1.3 COVID-19 vaccine

The MoH has confirmed the replacement for the NIR – the "National Immunisation Solution" will be released to support the COVID-19 vaccination information and then will be extended to include replacing the entire NIR by early 2022.

The Immunisation Programme Manager and NIR team leader have been part of a subject matter expert workshop in reviewing the new COVID-19 Immunisation Register (CIR) and how it would be used in practice for delivering the COVID-19 vaccine, particularly in the first phase of MIQ and border workers.

Further work in the implementation of COVID-19 vaccine is moving at a high pace with input from across the teams as appropriate.

5.2 Uri Ririki – Child Health Connection Centre

National Child Health Information Platform (NCHIP) data is now actively being used to investigate which babies are missing their first Well Child Tamariki Ora (WCTO) core check (4-6 weeks). Following a data quality check, priority is given to Māori, Pacific or babies living in areas of high deprivation (Quintile 5) for direct whānau contact to link them with an appropriate WCTO provider of their choice. A six-month evaluation of this Newborn Enrolment Process project is planned for March 2021.

As at 31 January 2021, Waitematā DHB received 1,524 referrals to Noho Āhuru – Healthy Homes (NA-HH). This included 5,932 family members getting access to healthier home interventions. Of the referrals received, 622 (41%) were for families with a newborn baby or hapu woman.

The service has developed some new promotional resources which are now available and are being shared to all families entering the service, as well as with referrers and community agencies over the coming months.

Summer students have completed an audit process for Auckland DHB and Waitematā DHB whānau referred to the NA-HH service. The reporting of the audit is being prepared, and will help identify opportunities to strengthen on-referral and support in a number of domains in addition to core healthy housing interventions.

5.3 Well Child Tamariki Ora and B4 School Check

All providers have continued to provide face-to-face WCTO services under COVID-19 alert level 1. Phone screening still occurs before undertaking home visits.

Recent data as shown in the table below is for three WCTO providers. The data shows that there has been progress catching up those tamariki that had missed their core checks during the lock downs. However, the Pacific tamariki are still falling behind. Overall, for the period November to December 2020, the three WCTO providers in Waitematā DHB delivered 664 core checks compared to 444 for the same period of 2019. Waitematā DHB will be working closely with the providers to make sure that there are no outstanding core checks.

WCTO Core checks November – December 2020 and November – December 2019

	Asian	European	Māori	Pacific	Other	Unknown	Total
Nov- Dec 2020	11	87	496	67	3	5	664
Nov-Dec 2019	8	58	243	71	0	64	444

The WCTO core checks in the table above do not include Plunket. Waitematā DHB has worked with Te Whanau o Waipareira (TWoW) on importing their WCTO data into the same data system as all the other providers, therefore, for the first time the data in the above table includes that of TWoW. The MoH funds Plunket directly, however, Plunket is now required to share some information with the DHBs and therefore we expect to have some monitoring data from them going forward.

COVID-19 Alert Levels continued to impact B4 School Check (B4SC) services. The provider indicated that since COVID-19, no one can be at work or engage with B4SC with any sickness, including a slight cold. This resulted in more cancellations. The provider further indicated that the Christmas season impacted the targets because of staff taking leave and families being on holidays and not wanting to book appointments. In addition, there had been nurse vacancies, however recruitment is complete with 1.6FTE having commenced employment in January 2021. The provider rescheduled cancelled appointments to 2021 and is currently prioritising children turning five that missed their B4SC check due to COVID-19 including Māori, Pacific and children of Q5 families.

The table below shows that the B4SC coverage target for high deprivation, Māori and overall for January 2021 was much lower than that of January 2020. The provider continues to prioritise tamariki as outlined above. It is positive to note that despite COVID-19 lockdowns, coverage for Pacific children is higher in 2021 YTD compared with 2020 YTD.

B4SC Comparison Waitematā DHB January 2020 and January 2021

Percentage of eligible population checked	High deprivation	Māori coverage	Pacific coverage	Overall coverage
January 2020	50.5%	50.3%	46.9%	51.6%
January 2021	44%	44%	48.0%	47%

Waitematā DHB has continued to achieve the Health Target with 100% of obese children identified in the B4SC programme being offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions in January 2021.

5.4 Rheumatic Fever

Work is on going for the four short-term/high impact initiatives in the Waitematā DHB region in support of managing Rheumatic Fever (RF) as follows:

- *Identification of culturally safe ways to increase referrals to the NA-HH initiative.* A procurement process has been completed to recruit both kaupapa Māori and Pacific researchers who will use guidance from families to develop resources. Insights from health workers who will be 'end users' of the resources are being gathered. In addition, guidance and insights from social workers who work closely with families accessing the NA-HH are being gathered.
- *Piloting of whānau support worker programme*. A service specification for this programme alongside the nursing service which will partner with the social workers in NA-HH is in development.
- *Piloting dental health services for adults with Acute RF / Rheumatic Heart Disease*. Early costings and pathways are being developed for community based clinics. Discussions with the Hospital Dental Service to pilot regular clinics in Greenlane have not progressed due to capacity issues in the service. Consideration of providers contracted to provide Relief of Pain services is now underway.
- *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 working with a Public Health Physician Registrar on opportunities for increasing awareness, which may include schools and pharmacy settings.

PHOs have approved the sharing of Age Sex Register data with Auckland DHB and Waitematā DHB for an initiative to identify general practice providers for patients on rheumatic fever secondary prophylaxis, with a view to planning for a potential initiative to improve health services support for people who have had rheumatic fever.

5.5 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.

Over the past two-years, there has been a significant focus on improving the systems and processes that support equity and attendance. This has included undertaking initiatives such as: Saturday

clinics; the supportive treatment pathway; the development of a small centralised booking and scheduling team; implementing new booking practices; and focusing on the date in which the child was last seen, rather than their recall date.

However, the COVID-19 pandemic had a significant impact on service performance, as routine oral health care (as per Dental Council of New Zealand (DCNZ) guidance) was unable to be provided during Alert Levels 4 and 3. Consequently, ARDS was unable to operate for eleven weeks in 2020. In addition, the DCNZ has issued new infection control and pre-screening requirements. This has impacted on productivity and means the service is unable to operate its usual model of care (where the majority of children are seen while at school, without a parent present). The overall situation has resulted in a significant increase in the number of children in arrears. It is estimated that arrears grew approximately 0.8% each week during Alert Levels 4 and 3, when the service was unable to operate.

In view of the DCNZ requirement to screen all children prior to their appointment, the service has experienced challenges in reaching some families/whānau to complete the pre-screening requirement. Those children whose parents cannot be contacted are missing out on their dental examination and preventative treatments.

Improvement Plan

An improvement plan has been developed and is being implemented to focus on improving service performance, without further exacerbating oral health inequities. Specifically, the plan aims to:

- reduce the number of children with an incomplete episode of care ('under treatment')
- reduce the number of long waiting children
- reduce arrears
- improve chair utilisation
- improve attendance

In addition to the improvement plan:

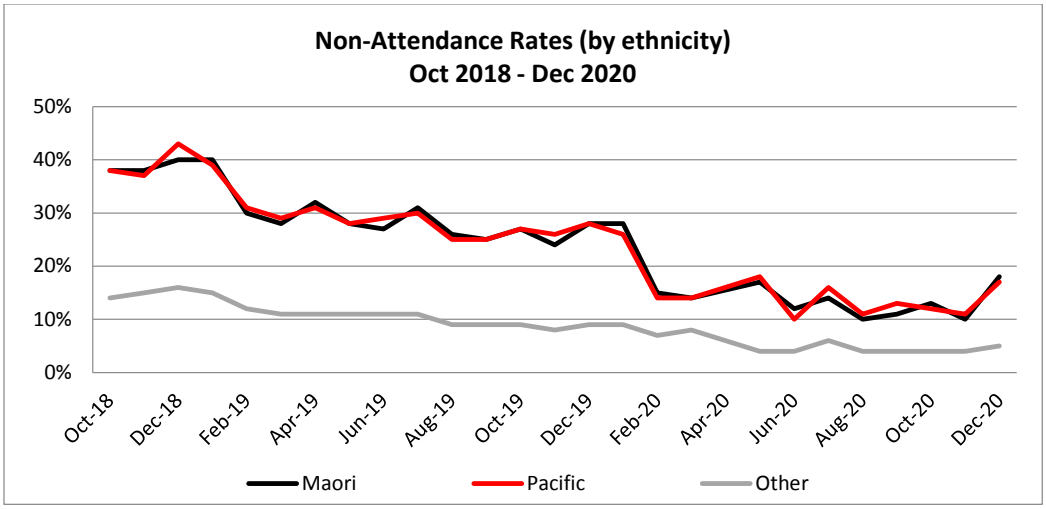
- The Northern Region Chief Executives have allocated $560k to support a redesign of Oral Health service provision for children and adolescents across the continuum.
- $195k has also been allocated from the MoH DHB led Improvement Sustainability fund to ARDS to redesign and reconfigure the service in order to optimise productivity and operational efficiency; improve oral health outcomes; and reduce oral health inequities.
- 10.50FTE additional (over-recruited) new graduate oral health therapists have been recruited, who will commence with the service in January 2021.
- A pilot programme, using elements from the Scottish ChildSmile programme, is currently being scoped to be delivered in high-need communities in West Auckland from mid-2021. The pilot will be used to design a targeted mode of care which, over time, will reduce oral health inequities and see sustained improvements in the oral health status of children. It will also assist in determining the cost and feasibility of extending the programme to other areas of Auckland.

Progress to Date

Non-attendance rate

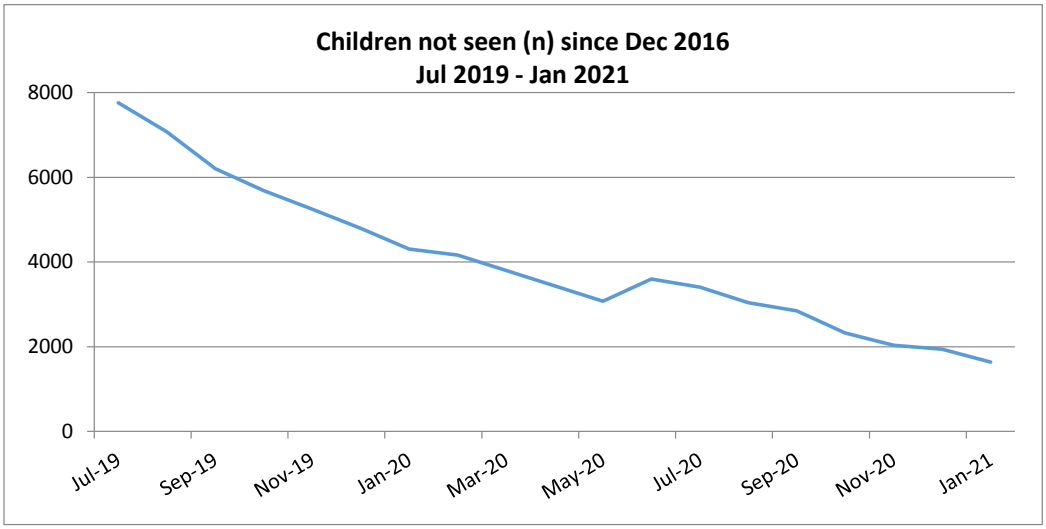
Over the past two-years there has been a significant focus on improving the systems and processes that support equity and attendance. This has included undertaking initiatives such as: operating Saturday clinics; implementing a structure pathway to locate children and support them to attend appointments; development of a centralised booking and scheduling team; and implementing new booking practices. These initiatives have resulted in a significantly improved attendance rate. As

demonstrated in the graph below, non-attendance rates have improved across all ethnicities and the gap between Māori/Pacific and other children has narrowed.



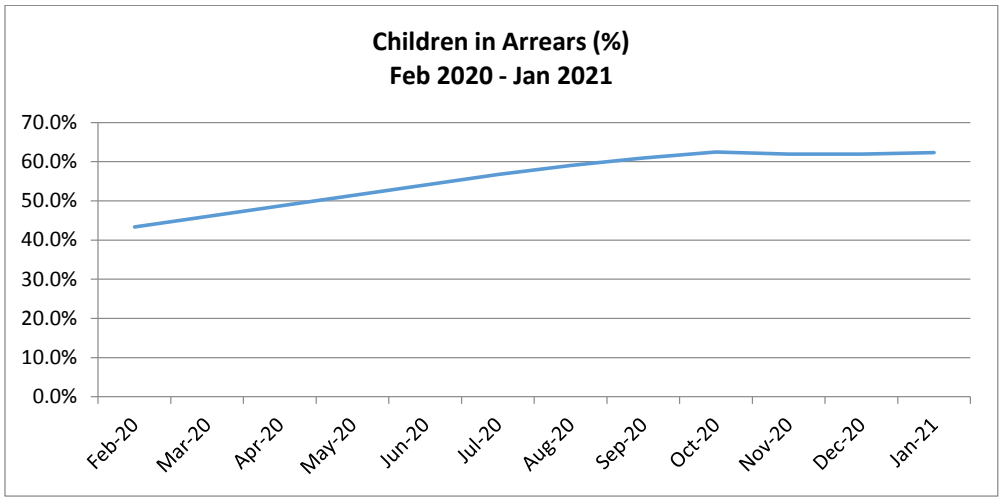
Long waiting children

As demonstrated in the graph below, there continues to be a steady reduction in the longest waiting children. The service continues to prioritise these children and progress by team is being tracked weekly. The supportive treatment pathway is being utilised to support children and whānau to access the service but COVID-19 pre-screening requirements continue to create challenges in supporting children who experience barriers to accessing care.

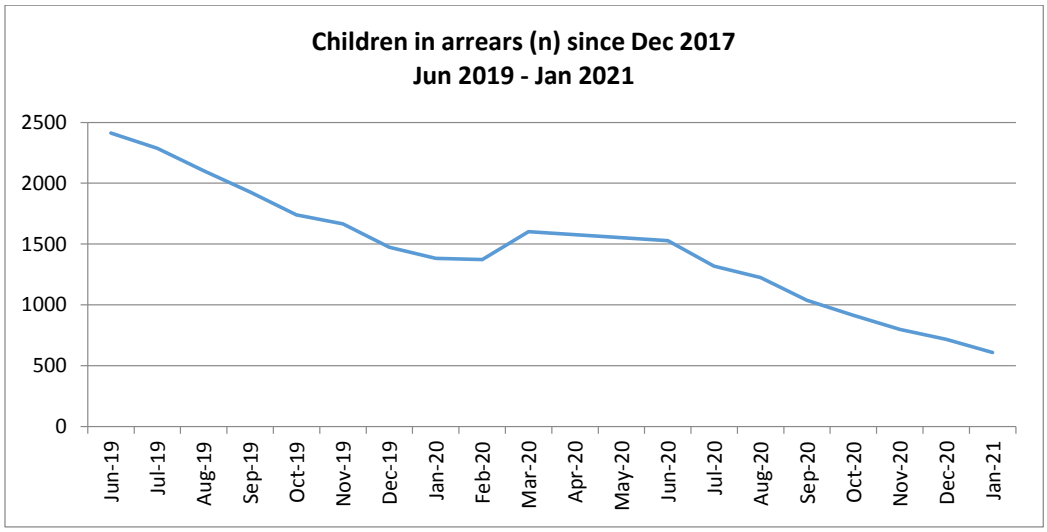


Arrears

The growth in arrears has been stabilised and the first reduction since the onset of COVID-19 was seen in November 2020. There was a slight increase in arrears in January 2021 due to planned clinic closures over the Christmas and New Year period. However, improvement is now being seen – over the first week of February 2021, arrears have reduced by 0.5%.



Of note, there has been on-going improvement in the number of children in arrears the longest. This is demonstrated in the graph below. This has been supported by the introduction of a new patient prioritisation co-ordinator role, which ensures that each clinic receives regular lists of children they need to prioritise for care and ensure that progress continues to be made.



In summary, COVID-19 has had a significant impact on community oral health service provision. The Auckland Regional Dental Service has implemented an improvement plan, which focuses on prioritising resources to children with the greatest oral health needs. Improvements have been seen across a number of domains, including attendance rates, and arrears growth has been stabilised.

5.6 Youth Health - Enhanced School Based Health Services

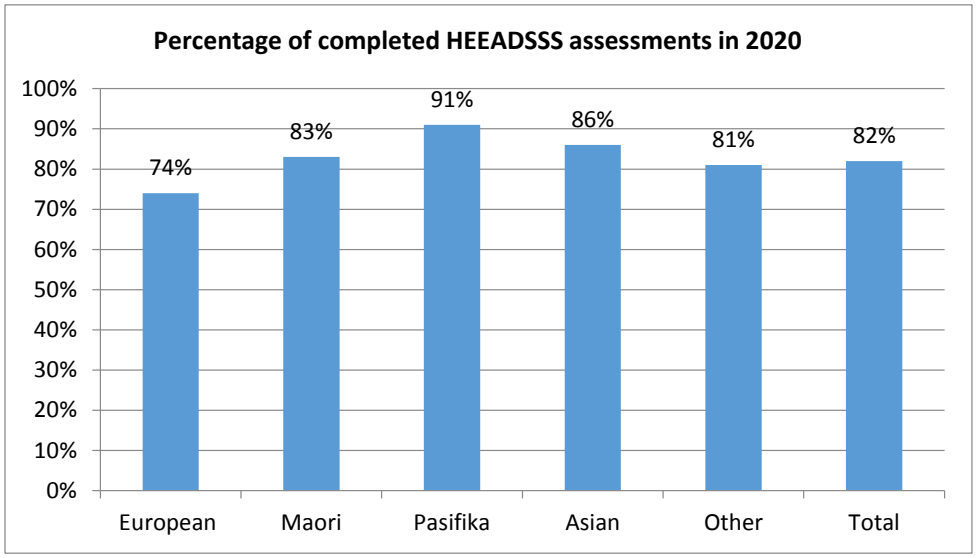
The Enhanced School Based Health Services (ESBHS) programme is delivered in ten mainstream secondary schools, Alternative Education settings and the Teen Parent Unit. The programme provides youth friendly, confidential, and easy to access health services – the nurse is available at school every day, 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.

The model involves a contract between the DHB and school to fund and employ appropriately qualified nurses and set expectations, such as all Year 9 students having a bio-psychosocial HEEADSSS

(Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) assessment to identify unmet health needs.

HEEADSSS completed by ethnicity

The graph below shows the percentage of completed HEEADSSS assessments by ethnicity, acknowledging Māori and Pacific students as priority groups. Overall, despite the impacts of COVID-19, WDHB funded schools have completed 82% HEEADSSS assessments in 2020. Schools such as Massey High, Waitakere College, Kelston Boys, Kelston Girls had 100% HEEADSSS assessments completed for their Year 9 students.



5.7 Contraception

We continue to monitor uptake of the Long Acting Reversible Contraception (LARC) service in primary care and promote the opportunity to providers. We are working with the provider arm to ensure that services provided within DHB services are captured accurately.

The MoH has commissioned the preparation of National Contraception Guidelines, these have now been released, they are published on the MOH website and are being uploaded to Health Pathways currently.

FPA have completed their training package and we are working with them to prioritise enrolment for the training opportunity and maximise the reach for our district. Access to training and clarity around training requirements has been a challenge to date and remains an issue in achieving a robust network of providers who can offer all types of contraceptive options. In addition to the FPA training, MoH are working with professional groups to agree a 'training standard' which we hope will provide clarity about the expectations of required training from a variety of programmes.

We are continuing to work with FPA to confirm the offering for our DHB and prioritise recipients of training as well as work towards a sustainable training programme going forward. We have signalled this may include additional training, as concern remains that FPA programme will not be sufficient to meet the demand and need to significantly improve coverage of service provision and address access barriers.

5.8 Cervical Screening

Cervical Screening coverage for Waitematā DHB remains significantly below the coverage target of 80%, for the total population with December 2020 coverage reported at 70%. The coverage rate remains inequitable for Māori (now 58.9%), there is a 17% difference in coverage between Māori and 'Other' women who are meeting 76.6% coverage. Coverage for Pacific and Asian women also remains inequitable at 61.1% and 62.3% respectively. Coverage for priority groups as defined by the National Cervical Screening Programme (NCSP) continues to decline. NCSP have launched a campaign aimed at younger people to start screening, Support to Screening activity, increased recall activity in Primary Care and systematic access to PHO data matching have not been able to achieve the expected gains in coverage.

COVID-19 restrictions have had a significant impact on completion of cervical screens which are largely provided in primary care; decreasing coverage continues. Those with abnormal screening history and those who have never been screened, or have not been screened for more than five years remain at highest risk and efforts to prioritise these groups continue in our work with PHO's Practices and other stakeholders. The National Screening Unit (NSU) 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 NSU have recently confirmed will be included in the HPV Primary Screening Programme. An implementation timeline remains unclear. The HPV self-testing research continues in the Māori Health Pipeline.

A project to evaluate the effectiveness of incentives for cervical screening is being developed by the Māori Public Health Registrar, and will be implemented early in the New Year. This is based on the maternal smoking cessation incentives programme, and a range of incentives schemes across the country, however there is not currently high quality evidence evaluating their effectiveness and reach.

Changes have been made to the system used for enquiries to the NCSP toll free line, calls in metro Auckland during business hours are now answered by the Regional Register Team and directed to DHB Coordinators or Support to Screening providers as appropriate. It is expected to simplify access to correct information for both providers and programme participants.

5.9 Breast Screening

Breast screening coverage for Waitematā DHB is not currently reaching the coverage target of 70% and is currently around 65%. Coverage for Māori women is below the target and is currently 66%. Māori coverage in Waitematā has fluctuated from 66% to 70% over the last five years. Pacific women's coverage has been over the 70% target until the most recent coverage reporting in June 2020; it remains below target 68.3% as at December 2020. Coverage and access to screening has been impacted by COVID-19 restrictions, there has been a significant step down in coverage in the most recent period.

5.10 Abortion Services

Changes to Abortion Legislation came into effect on 24 March 2020. Changes were made to the law to decriminalise abortion, better align the regulation of abortion services with other health services and modernise the legal framework for abortion services in New Zealand. Changes were also intended to improve access to services by, for example, allowing women to self-refer and by permitting a wider range of health practitioners to provide services (within their scope of practice).

A metro Auckland review group made recommendations on the configuration of services, which were endorsed by the Boards in August 2020 when the Boards also endorsed tendering for services.

Members of the review group sat on the procurement panel, and endorse the recommendations made in this paper.

The PFO has led a tender process and received three potentially viable responses and this has informed papers to the respective boards for local service delivery. This also includes the following recommendations requiring metro Auckland DHB agreement:

- Women have a choice of provider
- To safeguard quality and consistency, all providers would be contractually required to participate in a metro Auckland clinical governance/advisory group and provide data for independent analysis, against the locally developed service specification and KPIs.

Subject to all Metro DHB Board approvals and timely negotiation processes, some services may be available from 1 July 2021, with a full complement of services anticipated being contracted for by 1 October 2021.

6. Mental Health and Addictions

6.1 Integrated Primary Mental Health and Addiction Services (IPMHAS)

The contract for the implementation of integrated primary mental health and addiction services (IPMHAS) is a Ministry funded initiative based on the recommendations of He Ara Oranga. It aims to expand choice and increase access to support with wellbeing, including mental health and addiction needs, within primary care. Priority reach is to high needs populations with a focus on equity (Māori, Pasifika, Youth) for people/ whānau with mild to moderate needs.

In metro Auckland region / Tāmaki Makaurau, a range of providers (including the three DHBs, seven PHOs and twenty plus NGOs) collaborated as the Auckland Wellbeing Collaborative in putting together a proposal for this funding. The proposal was successful and Auckland DHB became the contract holder, on behalf of the Auckland Wellbeing Collaborative (Tū Whakaruruhau) [http://www.aklwellbeingcollab.co.nz/].

Implementation started in April 2020 and continued through all three COVID-19 alert level restrictions. Following the second Auckland cluster in August/September, there was a slow return of people seeking support via GP practices. Virtual support is available during COVID-19 Alert Level restrictions.

The key elements of this contract for 20/21 include:

a. Implementation of three new roles with their services available through the GP Practice environment (64 practices in this first year)
    - Health Improvement Practitioners (HIPs) 49 FTE across metro Auckland: HIPs are specially trained registered practitioners, such as psychologists, nurses, occupational therapists and social workers. Their job is to assess the person's needs, develop a plan, provide evidence-based health interventions and coordinate support activities. They are a key link in warm handover from GP/Practice nurse directly in the clinic immediately (not a referral based system).
    - Health Coaches (HC): Health Coaches come with diverse backgrounds and cultures and often have 'lived experience' of learning to live well with long-term health issues. They are trained to help understand health issues and learn to manage them better. They will support lifestyle change, provide emotional support, help access services and act as advocate

- Expanding availability of Awhi Ora (already available in some Waitematā DHB and Auckland DHB practices as part of this model with approx. 40 FTE). Additional Awhi Ora FTE with Awhi Ora are a key part of the integrated three roles.

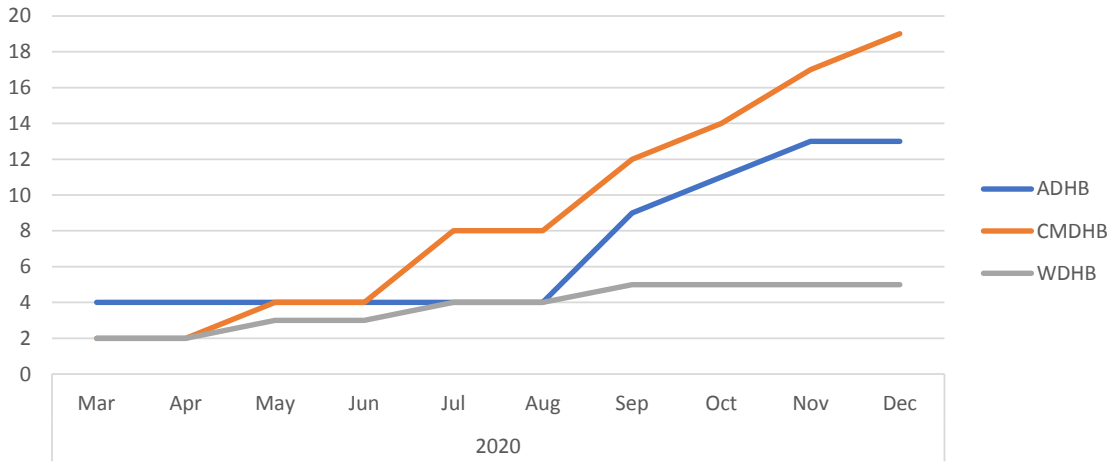
b. Strengthening interface between primary and secondary services including enhancing GP phone line support – Auckland DHB and Waitematā DHB only. Funding will see the provision of 0.5 FTE to Auckland DHB for the SMO specialist advice phone line – working alongside the existing Waitematā DHB model: plus recruitment of two senior nurses (one for each DHB) to provide support, consultation and advice to general practice with particular focus on mental health credentialed nurses(due to start in April).

c. Funding for coverage of Wellness Support – Counties Manukau DHB only: Wellness Support is an enhancement to the usual GP/PN "funded extended primary mental health consultation", available in all Counties Manukau GP clinics – the programme combines further education for GPs/PNs re primary mental health, and a structured assessment and management template, in an online form that prints back into the patient record and also doubles as a funding claim form. Wellness Support is available to all patients, and there are no criteria for access.

Implementation to date (Dec 2020) of HIPs, HC and Awhi Ora

As of 31st December 2020, there were 37 of planned 54 practices with a HIP or HC. There are 34 practices with a HIP and 34 practices with a HC. They will all have Awhi Ora.

Comparison by DHB – live practices over time



- As of 31st December, Counties Manukau DHB had 19 live practices (planned 26), Auckland DHB 13 (planned 18) and Waitematā DHB five (planned 10).
- NB Eleven additional practices (seven are small and in clusters) have been brought forward to this year (ending June). This adds additional practices to Waitematā DHB area but are not due until April.

Current Activity for WDHB

Role Recruitment: HIP FTE 3.85 of budget 7.85: HC FTE 3.05 (budget 5.9): Awhi Ora 7.85 FTE excluding utilisation of 10% support hours contracts

Five Waitematā DHB practices with a HIP and HC: 34 WDHB practices "have" Awhi Ora although some of these are going through a process of review and reinvigorating the relationship the practice where HIP and HC are not yet in place

HIP/HC/WS	Contacts WDHB	Unique people WDHB
HC	261	207
HIP	278	198
Awhi Ora	714	143

6.2 Primary Mental Health Investment Review

Waitematā DHB funds primary mental health initiatives (apart from IPMHAS). This funding has been in place for some time and the existing services contracted have been specified in line with Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017. This plan articulated Government expectations at that time about the changes needed in the delivery of mental health and addiction services.

The Auckland DHB and Waitematā DHB Mental Health and Addictions Funding team has an opportunity to review and increase clarity around existing primary mental health investment and service delivery in both DHB areas, with a view to making recommendations about the current state and possible future state.

Primary mental health initiative investment is being reviewed now in the context of *He Ara Oranga* (2018), IPMHAS and with health equity for Māori and Pacific people front of mind.

An existing review took place in 2016/2017 and we will review learnings from that time.

6.3 Suicide Prevention and Postvention

A review of our current postvention response to family and whānau bereaved by suicides is being undertaken. A working group has been set up to progress this work, and will report to the suicide prevention and postvention governance group. We recently appointed a full time whānau support coordinator to provide support services to whānau bereaved by suicides, which is a welcoming addition to our effort to provide care to those bereaved by suicide and to reduce suicides.

We are in the initial stage of rolling out Aoake te Ra, bereaved by suicide support service to Waitematā DHB area. This is a free, brief therapeutic service for individuals and whānau needing specific support for bereavement by suicide. This service is funded by the Ministry through Clinical Advisory Services Aotearoa (CASA), in collaboration with Waitematā DHB.

6.4 Individual Placement and Support

In line with additional investment from the Ministry of Social Development (MSD), the employment support trial has now expanded from 8 co-located FTE to 13. New Waitematā DHB Mental Health sites for delivery of this service include the Early Psychosis Intervention (EPI) team, and the CADS West and North teams.

As at the end of December, there have been 651 referrals and 395 consents (359 unique people) into Individual Placement and Support (IPS) and 123 people have gained (or in a few cases, retained) 166 jobs across a wide range of industries. Over half of jobs are greater than 30 hours/week. From an equity perspective, Māori made up 32% of those consented and 29% of those getting jobs.

The current term of the contract finishes in June 2021 and in line with a Letter of Intent received from MSD, a new contract is expected imminently to continue full delivery for a further 12 months.

7. Pacific Health Gain

7.1 Pacific Regional response to COVID-19

The Pacific team continues to provide advice and support to the NRHCC. Pacific providers involved in setting up pop up mobile community COVID-19 testing centres across Auckland have resumed their business as usual activities following a return to Alert Level 1, and returned to delivering primary care services for example immunisations.

7.2 Pacific Mobile service

The Fono Pacific Mobile service continues to work with individuals and families to ensure they can access primary care services during this period while Auckland remains at Alert Level 1. However, the recent community cases over the past month has resulted in the Fono Pacific Mobile service providing additional COVID-19 testing capacity in Waitematā DHB and also across the Auckland region when requested by the NRHCC.

7.3 Measles Mumps Rubella (MMR) Vaccination plan

The MMR team has started to implement Pacific youth recommendations about how to approach and connect with Pacific youth and encourage them to get a MMR vaccination. A plan is currently being developed, which will include training Parish Community nurses to be vaccinators and a communication plan which will set out the dissemination of MMR messages with key stakeholders and identify community opportunities to engage and implement the vaccination plan.

7.4 Rheumatic fever

The Pacific team is working with the Child Health team to provide appropriate advice and information about approaches to reach, engage and connect with Pacific people. This has extended to the Rheumatic Fever Co-design initiative with MoH and ThinkPlace. The co-design initiative is focusing on improving communication and services to Māori, Samoan and Tongan populations across the Auckland region. The Samoan stream met early in January to start discussion on the plan of action going forward.

7.5 Community based Pulmonary Rehabilitation Request For Proposal

The Community based Pulmonary Rehabilitation RFP process is complete and negotiation is underway with the preferred provider. This service is likely to start in February 2021.

7.6 Pacific smoke free project

The Pacific team is supporting a Stop Smoking Services –Pacific Community Based Treat Project with The Fono (Ready Steady Quit service) to provide support to churches and community groups to host and coordinate stop smoking groups for their communities. The project requires enrolling 291 pacific participants to the stop smoking programmes.

7.7 Integrated services, Aiga Fono Care

Many Pacific families have experienced hardship and difficulty due to the COVID 19 pandemic. The Aiga Fono Care team engaged with a large number of families with moderate and severe health and social needs during the August Auckland outbreak. Many experienced financial, mental, physical, emotional wellbeing challenges including difficulties managing existing long-term conditions.

The Aiga Fono Care team has been working closely with families to ensure they are able to continue with their health and financial plans and goals and are able to continue to have access to a safe, reliable and supportive service at all levels of COVID19.

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)

For the previous quarter, our focus was on re-establishing the Māori Mobile Units that were redirected to COVID-19 testing following the August outbreak. We have maintained three mobile testing units operating across both Auckland and Waitematā DHBs.

To date the three mobiles have:

- A total of 649 contacts(with 241 through marae based clinics)
- 80 flu vaccinations
- 88 child vaccinations
- 6 GP enrolments
- Over 500 wellbeing assessments and accompanying wellbeing support
- 83 strep throat swabs
- 28 referrals to other agencies and care providers

These mobiles will form a critical part of the wider COVID-19 response and management going forward. All three are capable of supporting/leading the vaccination roll out or testing strategy in high needs communities, where an outreach strategy is important to ensure access for residents.

8.2 Māori Pipeline Projects

8.2.1 Māori Health Plan Acceleration Projects

Breast Screening Data Match: A data match was undertaken between primary care enrolment and the breast screening services of the Northern Region to identify Māori women not currently enrolled in breast screening and invite them to be screened. Across the region, 730 Māori women were enrolled in the breast-screening programme. This project is now complete and a draft report is being prepared to share with stakeholders.

Cervical Screening High Grade Project: Our previous research project on HPV self-testing for cervical screening in Waitematā DHB and Auckland DHB identified a large group of women who had a history of an abnormal previous screening result (high grade; at high risk of cervical abnormality/cancer) who had not been followed up. This project sought to systematically identify these women and offer screening via an alternative service based on Māori values. An audit tool to be used at practice level was created since due to legal considerations, the National Cervical Screening Programme was unable to provide data to triage women and offer service to those most at risk. The audit tool has been completed and undertaken in three pilot practices by the project team, and has subsequently been trialled as a self-audit tool with approval by the College of General Practice to accredit the tool for use nationally. Lessons learned are being shared with the NCSP and locally with cervical screening stakeholders.

8.2.2 New Services

Lung Cancer Screening Project: This is a large-scale collaborative project with Otago University, Waitematā DHB and Auckland DHB, led by Professor Sue Crengle and supported by a Māori-led steering group. The Consumer Advisory Group Te Ha Kōtahi, developed from participants in the previous focus groups and surveys, has met twice and supported a range of project material development. A Decision Aid tool is under development, and Health Literacy NZ have been engaged to assist with development of participant materials. A pilot with four to six general practices will get underway when the ethics approval is granted. The team are awaiting research-funding decisions for a larger trial and additional studies.

AAA Screening: The data analysis for the abdominal aortic aneurysm (AAA) risk prediction for Māori, as part of the original project, is underway. A small number of practices unable to complete the original Māori AAA project have been offered to have screening undertaken for their population. A small team is working together on invitations. The Pacific AAA screening project (under the Māori Health Pipeline as it is the same team) has completed the pilot with Tongan men, and moved on to offer screening to other Pacific ethnic groups. Kōtui Hauora agreed to consider AAA screening extension to Northland DHB; discussions are underway.

Hepatitis C: the Ministry of Health have agreed to the Northern Region leading the datamatch for the country, a proposal is currently being finalised. The project will support appropriate datamatching to enable the re-offer of treatment to those with known Hepatitis C who have no record of receiving treatment. The project focuses on elimination for Māori first, with the clinical team led by a Māori pharmacist.

PHO enrolment: This was the first project in the DHB to formally undertake a Māori Data Sovereignty Assessment and act on its results (Iwi and MoU partner governance and decision making about the data). The data match with Māori providers has been closed-off although not all providers in Waitematā DHB and Auckland DHB provided their data. Counties Manukau DHB was originally involved in the project, however their providers chose not to participate. The project demonstrated a significant number of people enrolled in Māori providers were not enrolled in primary care, which means the project can progress to Phase 2, which is the development, with Māori providers of either a facilitated primary care enrolment service or an alternative offer of service.

8.2.3 New Models of Care

Kapa Haka Pulmonary Rehabilitation: This project seeks to use Kapa Haka as an intervention to improve respiratory fitness and determine whether it can on its own, or augmented, be used as pulmonary rehabilitation. The project developed out of Dr Sandra Hotu's PhD studies, and was on hold for some time as this work was completed. It has now been restarted with the support of Kapa Haka expert Annette Wehi and whānau, and physiotherapists from DHBs across metro Auckland.

8.3 Healthy Babies Healthy Futures

The Healthy Babies Healthy Futures (HBHF) programme is on track despite COVID-19 disruptions to educating parents in nutrition and physical activity. The programme is seeking additional funding to develop videos suitable for 15 e-Learning courses and as a video resource for live webinars and face to face workshops. The community partnership grants particularly with Kōhanga Reo and church based groups will be a main feature for educating Māori and Pasifika parents in the 2021 – 2022 year. The Asian community enjoys a large waiting list of parents ready to learn while the South Asian community have exceeded their targets.

Table 1: HBHF Key measures July 1st 2020 - Jan 31st 2021

	TextMATCH Enrolments		Programme (6 courses) enrolments		Lifestyle reviews collected - 6 weeks post	
PROVIDER	**Actual**	**Performance**	**Actual**	**Performance**	**Actual**	**Performance**
HealthWEST - Māori	140	105%	67	84%	35	62%
FONO - Pasifika	121	91%	106	126%	53	94%
TANI – South Asian	176	132%	134	159%	91	162%
CNSST - Asian	186	139%	322	335%	102	159%
Total	623	138%	629	175%	281	141%

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 is awaiting the Forward sign off from CEO before it is published.

The Asian, new migrant and former refugee health gain team continue to support NRHCC to provide culturally appropriate guidance for COVID-19 response.

The team is in consultation with key trusted Asian and Middle Eastern, Latin American and African (MELAA) ethnic partners in collating feedback on COVID-19 vaccine hesitancy to inform culturally appropriate messaging via NRHCC.

The team is providing feedback from an Asian and MELAA perspective into the development of the COVID-19 Public Health Strategy and Operational Programme (led by MoH).

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 number of Asian enrolees Q1 2021 has increased by 1,696 for Waitematā DHB, compared to last quarter. The Waitematā DHB PHO enrolment is 83%. (The population projections '2020 Update' (based on Census 2018) is used for the analysis of Q1 2021. Earlier (eg Q4 2020), the '2019 Update' which was based on Census 2013 was used).

The team have provided input into the Refugee Health Handbook Edition 2 and into the Migrant and Refugee section of the Health Pathways page.

We continue to work with community stakeholders and promote the updated resources and flyers, on the NZ Health and Disability System.

- 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).

In October 2020, the New Zealand government agreed to resettle refugee and asylum seekers under emergency priority (people who need protection because they face an immediate life-threatening situation, deportation, detention or imprisonment) referred by the United Nations Refugee Agency (UNHCR).

As part of this, a variation to the existing eligibility criteria in the Improving access to general practice services for former refugees and current asylum seekers agreement is being made to include a new category – 'quota refugee emergency cases referred by the United Nations Refugee Agency (UNHCR)'. This is to ensure that those arriving under the emergency quota and resettling in the metropolitan Auckland region are able to access the funded services under the existing aforementioned agreement.

Earlier in February, the Government announced that New Zealand's Refugee Quota Programme will be resuming, and small groups of refugee families will start arriving for resettlement from mid-February 2021.

The team has provided feedback into Ministry of Health review on Mental Health Pathway and settlement support available for Former Refugees after they are resettled in the communities.

5.1 AAA Screening Pilot with Tongan men

Recommendation:

That the Community and Public Health Advisory Committee:

1) **Notes that a pilot project screening 150 Tongan men aged 60-74 years for abdominal aortic aneurysm (AAA) and atrial fibrillation (AF) has been completed.**
2) **Notes the project demonstrated that the approach is acceptable to the Tongan community and resulted in a high uptake rate. Participant interviews are to commence shortly and will provide more information to inform future implementation.**
3) **Notes that the Pacific AAA/AF screening research project continues with other Pacific ethnic groups as part of the broader research programme into AAA/AF screening.**

Prepared by: Dr Karen Bartholomew (Director Health Outcomes), Anna Maxwell (Research Study Coordinator), Erin Chambers (Project Manager, AAA screening), Aivi Puloka (Clinical Coordinator, Tongan AAA screening), Mr Andrew Hill (ADHB Vascular Service), Mellissa Murray (AAA screening administrator), Dr Corina Grey (previous AAA screening clinical lead and advisor) and Leani Sandford (Pacific Health Gain team).
Endorsed by: Dr Debbie Holdsworth (Director Community and Provider Funding and Procurement)

Glossary

AAA		Abdominal aortic aneurysm
AF		Atrial fibrillation
ADHB		Auckland District Health Board
WDHB	-	Waitematā District Health Board
PHO	-	Primary Health Organisation

1. Executive summary

This paper reports to the Waitematā District Health Board (WDHB) Community and Public Health Advisory Committee (CPHAC) on the recently completed pilot of abdominal aortic aneurysm (AAA) and atrial fibrillation (AF) screening with 150 Tongan men.

The project follows on from the success of the Māori AAA/AF screening programme and is the first part of the DHB programme assessing the feasibility, acceptability and potential benefits of AAA screening among Pacific populations, in order to inform recommendations regarding a national AAA screening programme in NZ.

The project began with focus groups with Tongan men in December 2019 and screening was completed in October 2020 with a high uptake rate. Seven AAAs were identified and these participants are being followed up in a surveillance programme.
This paper notes the key lessons learned relevant for implementation from the project and outlines next steps.

2. Background

Abdominal aortic aneurysm is a disease in which the main artery in the abdomen balloons out and, if it becomes large enough, can burst, usually with fatal consequences, unless it is repaired surgically beforehand. Studies have shown that Māori men and women and Pacific men have a particularly high risk of dying from AAA.[1] Among Māori and Pacific men who undergo surgery for AAA, most (60%) do so in an emergency, rather than elective basis, whereas the reverse is true for European men (61% undergo elective repair).[2] Mortality from AAA can be significantly reduced for men ≥64 years through once-in-a-lifetime abdominal ultrasound screening of the aorta.[3]

Atrial fibrillation is an irregular heart rhythm that is an important risk factor for stroke. It can be managed with antithrombotic therapy (mostly warfarin or dabigatran) to reduce symptoms and prevent complications. Both Māori and Pacific populations have strokes at younger ages than non-Māori, non-Pacific[4] therefore identification of AF as a stroke risk factor could potentially be important in reducing stroke inequities.

The CPHAC has previously received reports on the successful WDHB/ADHB pilot projects in which 2,500 Māori men and women completed screening for AAA/AF from 2016-2018. Based on the findings of these pilots, Māori men aged 65 years had a prevalence of AAA approximately double that of the men who participated in UK and Swedish AAA screening programmes. There have been no studies to date examining the prevalence of AAA in Pacific populations. Previous NZ research into AAA mortality using national datasets indicates that AAA mortality is just as high in Pacific men as in Māori men [1], and risk factors for AAA, including smoking and a history of vascular disease, are also high in Pacific people. Aside from a lack of data about AAA prevalence, there are uncertainties regarding the impact of higher rates of obesity and diabetes in Pacific populations on the validity of abdominal ultrasound as a screening tool.

Given the significant gaps in our current knowledge about the impact of AAA screening on Pacific populations, as well as a need to ensure that Pacific health and equity remains central to health system decision making, further research to assess the benefits and harms of screening in Pacific people is needed in order to make evidence-informed recommendations regarding a national AAA screening programme in NZ.

3. DHB Research Programme

The Waitematā DHB and Auckland DHB AAA/AF research programme consists of a series of interconnected implementation projects that aim to achieve better understanding of these conditions in NZ populations and robust testing of potential approaches focused on equity (Figure 1 below).

[1] Rossaak J, Sporle A, Birks C and van Rij A. Abdominal aortic aneurysms in the New Zealand Māori Population. Br J Surg 2003;90(11):1361-1366 and Sandiford P, Mosquera D, Bramley D. Ethnic inequalities in incidence, survival and mortality from abdominal aortic aneurysm in New Zealand. J Epidemiol Comm Health 2012;doi: 10.1136/jech-2011-20075

[2] Chiang N, Jain JK, Hulme KR, et al. Epidemiology and outcomes of abdominal aortic aneurysms in New Zealand: a 15-year experience at a regional hospital. Ann Vasc Surg 2018; 46:274-284.

[3] Takagi H, Ando T, Umemoto T : ALICE (All-Literature Investigation of Cardiovascular Evidence) Group. Abdominal aortic aneurysm screening reduces all-cause mortality: make screening great again. Angiology 2018; 69(3):205-211

[4] AM Tomlin, H. L. (2017). Atrial fibrillation in New Zealand primary care: Prevalence, risk factors for stroke and the management of thromboembolic risk. European Journal of Preventive Cardiology, 311-319.

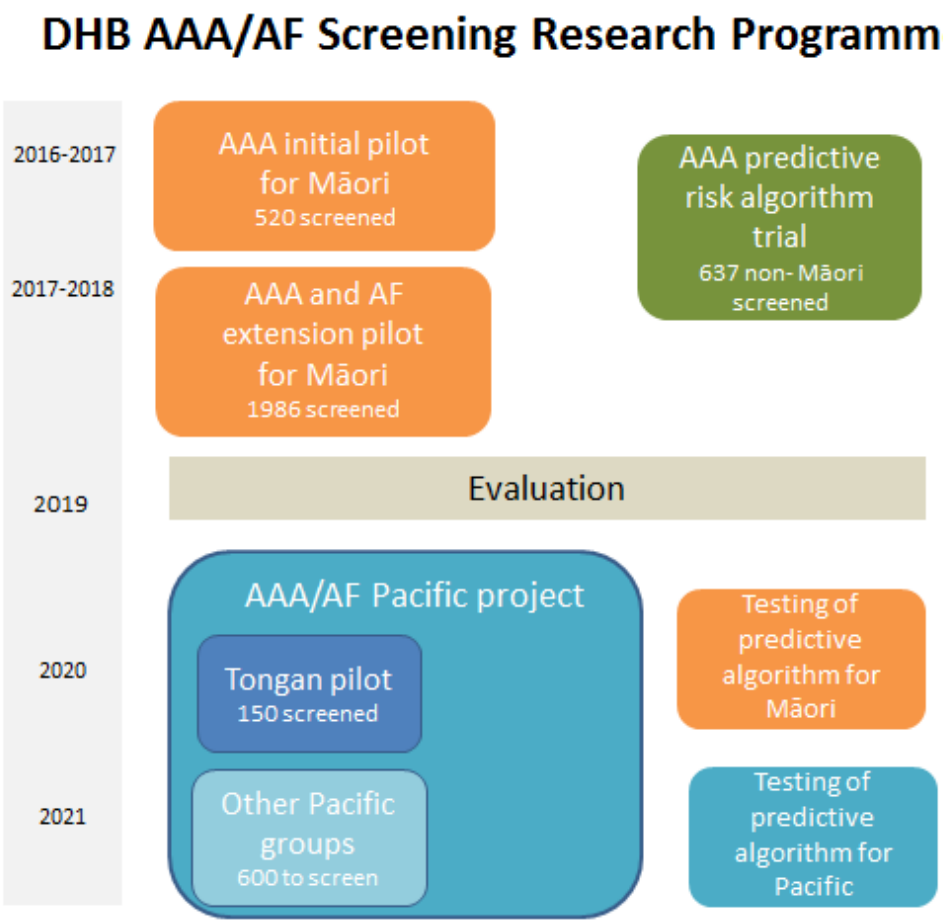


Figure 1. DHB AAA/AF Research Programme

The Pacific AAA/AF screening project is an observational cross-sectional study screening 750 Pacific men (60-74 years). It will provide robust data on AAA prevalence and the suitability of abdominal ultrasound as a screening tool in Pacific people. It also tests a range of parameters of importance to the development of national policy on AAA and AF screening, including the acceptability and feasibility of community screening, effective strategies for optimising invitation methods and follow-up, and the feasibility of offering other health interventions within the context of the screening session. Alongside results from the previous AAA/AF screening pilots, results from the Pacific pilot will contribute to policy options for future regional and national AAA screening programmes.

The Pacific AAA/AF screening research programme has strong clinical and academic leadership from ADHB Vascular Service and Cardiology, the University of Auckland and University of Otago. The steering group has representation from vascular service (ADHB vascular service and Lupe Taumoepeau, Pacific vascular surgeon Capital & Coast DHB), primary care, Pacific advisors within DHB Planning & Funding and the Pacific community.

The project has chosen to take a Pacific ethnic-specific approach, beginning with a pilot with Tongan men, supported by DHB Tongan staff that have close links with the Tongan community and strong language and cultural skills.

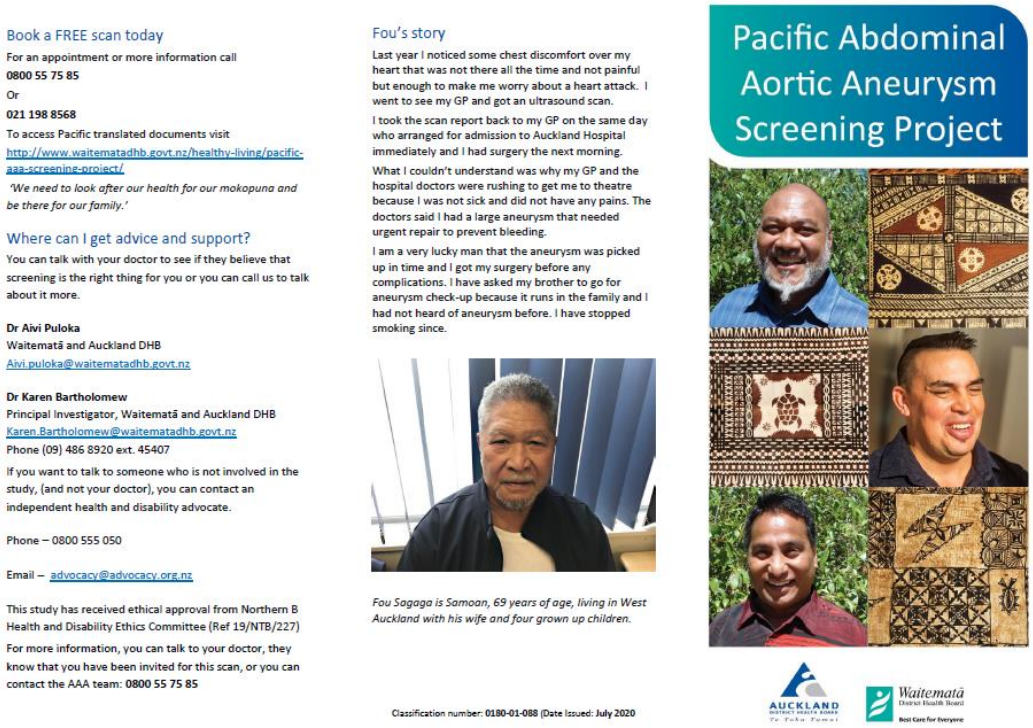
A grant for the pilot was received from ADHB A+ Trust.

4. Tongan pilot methods

Focus groups

The Tongan Pacific AAA/AF screening project began with focus groups with men likely to be eligible for screening. The groups advised on invitation methods and resources, whether the draft participant invitation material was easy to understand, the amount and content of information and how participants responded to the design of the brochure.

Feedback from the focus group participants directly informed the changes to the study materials (including written, graphic design, instructions, use of QR codes) as well as informing support pathways. Based on the findings, amendments were made to participant materials.



Book a FREE scan today

For an appointment or more information call
0800 55 75 85
Or
021 198 8568
To access Pacific translated documents visit
http://www.waitematadhb.govt.nz/healthy-living/pacific-aaa-screening-project/

'We need to look after our health for our mokopuna and be there for our family.'

Where can I get advice and support?

You can talk with your doctor to see if they believe that screening is the right thing for you or you can call us to talk about it more.

Dr Aivi Puloka
Waitematā and Auckland DHB
Aivi.puloka@waitematadhb.govt.nz

Dr Karen Bartholomew
Principal Investigator, Waitematā and Auckland DHB
Karen.Bartholomew@waitematadhb.govt.nz
Phone (09) 486 8920 ext. 45407

If you want to talk to someone who is not involved in the study, (and not your doctor), you can contact an independent health and disability advocate.

Phone – 0800 555 050

Email – advocacy@advocacy.org.nz

This study has received ethical approval from Northern B Health and Disability Ethics Committee (Ref 19/NTB/227)

For more information, you can talk to your doctor, they know that you have been invited for this scan, or you can contact the AAA team: **0800 55 75 85**

Fou's story

Last year I noticed some chest discomfort over my heart that was not there all the time and not painful but enough to make me worry about a heart attack. I went to see my GP and got an ultrasound scan.

I took the scan report back to my GP on the same day who arranged for admission to Auckland Hospital immediately and I had surgery the next morning.

What I couldn't understand was why my GP and the hospital doctors were rushing to get me to theatre because I was not sick and did not have any pains. The doctors said I had a large aneurysm that needed urgent repair to prevent bleeding.

I am a very lucky man that the aneurysm was picked up in time and I got my surgery before any complications. I have asked my brother to go for aneurysm check-up because it runs in the family and I had not heard of aneurysm before. I have stopped smoking since.

Fou Sagaga is Samoan, 69 years of age, living in West Auckland with his wife and four grown up children.

Classification number: 0180-01-088 (Date issued: July 2020

Pacific Abdominal Aortic Aneurysm Screening Project

Figure 2. Brochure for Pacific invitees

Screening

Screening sessions were held either at practices or convenient community locations, drawing on our experience from previous pilots of the importance of appropriate screening venues and times. In addition to an abdominal ultrasound scan for AAA and AF screening (using a simple Kardia mobile ECG device), the screening session involved a range of other 'co-benefits'. Blood pressure was taken on all participants and smokers were given brief cessation advice and offered referral to quit smoking services. Participants were also given general health promotion advice.

Screening was supported by as far as possible by face-to-face discussions with an onsite clinician who was able to converse in Tongan. Screening results were given to participants immediately. Where participants are found to have an aortic diameter ≥30mm, a referral for further assessment and on-going surveillance was made and the GP notified. Screening and follow up were supported by routine quality assurance and failsafe processes.

Screening was completed in October 2020. Overall COVID-19 lockdowns delayed the completion of the pilot by approximately four months.

5. Results from the Tongan pilot

The pilot achieved a high rate of participation with low Did Not Attend (DNA) rates. Invitations sent to 227 Tongan men resulted in 150 men completing screening, an overall participation rate (66%) similar to the participation in the extended Māori AAA screening pilot. Two people had an informed decline to participate.

Of the 150 Tongan men screened:

- 7 AAA (≥ 30mm) were found (4.7%)
- 4 new cases of atrial fibrillation (1 of these cases was urgently referred via the project to cardiology, another to heart failure clinic at follow-up)
- 4 participants were referred back to their GP for very high blood pressure
- 4 participants were referred to smoking cessation services (39 participants were current smokers, 67 were ex-smokers).

Feedback from participants was very positive:

> *"…I am so happy to join this project. I am here today because I want to take care of my life."*
>
> *"….I really want to thank you for giving me this opportunity… I came a skeptic and I don't usually listen to health providers' advice, but today I am happy to give up smoking"*
>
> *"…the clear description and explanation you have given me is something a lot of Tongans out there need to hear. "*

6. Key implementation lessons learned from the Tongan pilot

- The positive feedback and high participation rates, indicate that, with careful attention to design of a person-centred and culturally appropriate programme, a one-off screen for AAA is highly acceptable to Tongan men.
- One of the key factors in the high uptake rate is likely to have been the employment of a Tongan lead with established relationships with the Tongan community, who publicised the project through Tongan radio and churches and was very active in following up invitees in their own language. While posted invitations served as a useful reference for subsequent conversations, only a few participants mentioned that they had seen and read the invitation letter.
- Close involvement of partners and family who were often active in supporting and taking responsibility for husband's health was important in achieving the outcomes for Tongan men.
- Accessible community locations for screening were important as transport was an issue for many participants.
- There were no cases of non-visualisation at screening, confirming the suitability of ultrasound to assess the abdominal aorta in this population.
- AF screening and other health checks were readily incorporated into the screening process.

7. Completion of the Pacific AAA/AF screening project

The Pacific AAA/AF screening programme continues to progress with other Pacific groups. Screening is on-going at participating PHOs for eligible Niuean and Cook Island populations (supported by Dr Colin Tukuitonga on Niue/Cook Island radio) and screening with Samoan men is in progress.Overall the project seeks to recruit 750 people to determine AAA prevalence in Pacific men.

Evaluation
Our previous interviews with participants of the Māori AAA pilots identified that some people experienced stress around attending the first specialist appointment (for example discomfort around asking questions) and a small proportion experienced anxiety relating to being diagnosed with an aneurysm.

As part of the project evaluation, follow up interviews are being conducted by a Tongan nurse with Tongan men found to have an aneurysm at screening. We are interested in their experience of the invitation process, the follow up specialist appointment at the hospital as well a how they are getting on now with their diagnosis.

Project data will be interpreted in the context of overseas programmes and recent Māori and non-Māori pilot programme.

8. Conclusion

Optimisation of the screening programme for Tongan population from the outset of project development appears to have supported a high uptake of the offer of screening and a positive screening experience. A formal evaluation is being completed; feedback to date suggests positive experiences can contribute to increased trust in the health system. While the sample in the Tongan men in the pilot was small, seven AAAs were identified, indicating the prevalence may be similar to that in Māori men. Some participants also received a range of co-benefits.

5.2 System Level Measures – Quarter 2 Report

Recommendation:

That the Community and Public Health Advisory Committee note the Quarter two[1] results for the fifth System Level Measures (SLM) Improvement Plan.

Prepared by: Wendy Bennett (Planning and Health Intelligence Manager)
Endorsed by: Dr Debbie Holdsworth (Community and Provider Funding and Procurement), Dr Karen Bartholomew (Director Health Outcomes) and Tim Wood (Executive Director Tier 1 Community Services)

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 that were paused over lockdown will take time to recover performance.

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 2020/21 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 two results (where available) on the current (fifth) improvement plan: 2020/21. The six System Level Measures are:

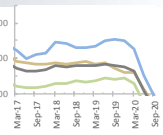
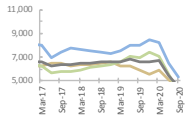
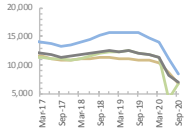
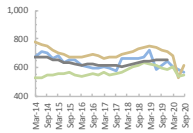
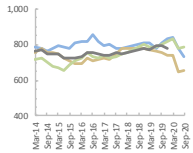
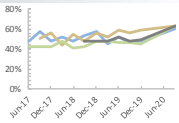
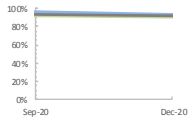
1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates
5. Babies living in smokefree households at six weeks
6. Youth are healthy, safe and supported.

For each SLM, there is an improvement milestone to be achieved in 2020/21. 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 2020/21, 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 two 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.

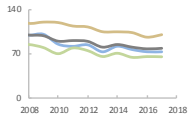
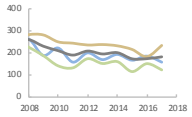
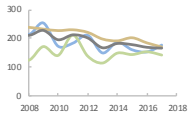
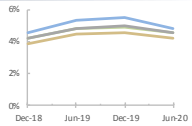
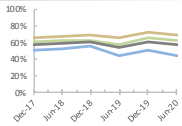
Scorecard – Part 1

		DHB / Region	Target		Performance: Actual	Performance: Data Period	Performance: Trend
1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds							
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Total Population	Auckland	7,749 (max.)	●	**4,822**	12-monthly	
		Counties Manukau	6,062	●	**4,380**	to	
Target 2020/21:	3% reduction	Waitemata	5,727	●	**3,511**	Sep-20	
		Metro Auckland	6,341	●	**4,162**		
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Maori	Auckland	8,155 (max.)	●	**5,294**	12-monthly	
		Counties Manukau	5,421	●	**4,539**	to	
Target 2020/21:	3% reduction	Waitemata	7,170	●	**4,095**	Sep-20	
		Metro Auckland	6,459	●	**4,518**		
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Pacific	Auckland	14,391 (max.)	●	**8,505**	12-monthly	
		Counties Manukau	10,440	●	**6,721**	to	
Target 2020/21:	3% reduction	Waitemata	11,510	●	**6,904**	Sep-20	
		Metro Auckland	11,503	●	**7,138**		
2. Acute Hospital Bed Days							
Measure:	Age-standardised rate per 1,000 domiciled population - Maori	Auckland	623 (max.)	●	**566**	12-monthly	
		Counties Manukau	686	●	**610**	to	
Target 2020/21:	3% reduction	Waitemata	567	●	**542**	Sep-20	
		Metro Auckland	631	●	**577**		
Measure:	Age-standardised rate per 1,000 domiciled population - Pacific	Auckland	809 (max.)	●	**729**	12-monthly	
		Counties Manukau	718	●	**655**	to	
Target 2020/21:	3% reduction	Waitemata	791	●	**789**	Sep-20	
		Metro Auckland	753	●	**698**		
3. Patient Experience of Care							
Measure:	DHB Adult Inpatient Experience Survey - medicine side effects question	Auckland	50%	●	**66%**	Quarterly	
		Counties Manukau	62%	●	**62%**	to	
		Waitemata	47%	●	**59%**	Dec-20	
Target 2020/21:	5% improvement	Metro Auckland	52%	●	**61%**		
Target 2020/21:	Primary Care Survey - cultural needs	Auckland	98%	●	**93%**	Quarterly	
		Counties Manukau	97%	●	**91%**	to	
		Waitemata	100%	●	**93%**	Dec-20	
Target 2020/21:	Establish baseline and then 5% improvement	Metro Auckland	98%	●	**92%**		

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 previous SLM Plans 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	69 (max.)	●	**73**	12 monthly	
		Counties Manukau	98	●	**100**	to	
Target 2020/21:	6% reduction by 2021	Waitemata	62	●	**65**	Dec-17	
		Metro Auckland	75	●	**78**		
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds - Maori	Auckland	180 (max.)	●	**156**	12 monthly	
		Counties Manukau	177	●	**232**	to	
Target 2020/21:	2% reduction by June 2021	Waitemata	146	●	**121**	Dec-17	
		Metro Auckland	168	●	**180**		
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds - Pacific	Auckland	150 (max.)	●	**177**	12 monthly	
		Counties Manukau	181	●	**171**	to	
Target 2020/21:	2% reduction by June 2021	Waitemata	151	●	**142**	Dec-17	
		Metro Auckland	166	●	**166**		
5. Youth Health							
Measure:	Chlamydia testing coverage for 15-24 year-old males.	Auckland	6%	●	**4.8%**	12 monthly	
		Counties Manukau	6%	●	**4.2%**	to	
Target 2020/21:	6% coverage rate by June 2021	Waitemata	6%	●	**4.6%**	Jun-20	
		Metro Auckland	6%	●	**4.5%**		
6. Babies Living in Smokefree Households							
Measure:	Proportion of babies living in smokefree homes at 6 weeks postnatal	Auckland	68%	●	**69%**	6 monthly	
		Counties Manukau	46%	●	**44%**	to	
Target 2020/21:	2% increase on baseline	Waitemata	59%	●	**62%**	Jun-20	
		Metro Auckland	56%	●	**57%**		

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 Q2:

- Implementation of the 2020/21 SLM Improvement Plan is well established.
- 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 2021/22 SLM Improvement Plan is currently under development.

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-19 baseline) (by ethnicity) by 30 June 2021

	Milestone Target			**Actual – 12 months to September 2020**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Total pop.	7,749	6,062	5,727	4,822	4,380	3,511
Māori	8,155	5,421	7,170	5,294	4,539	4,095
Pacific	14,391	10,440	11,510	8,505	6,721	6,904

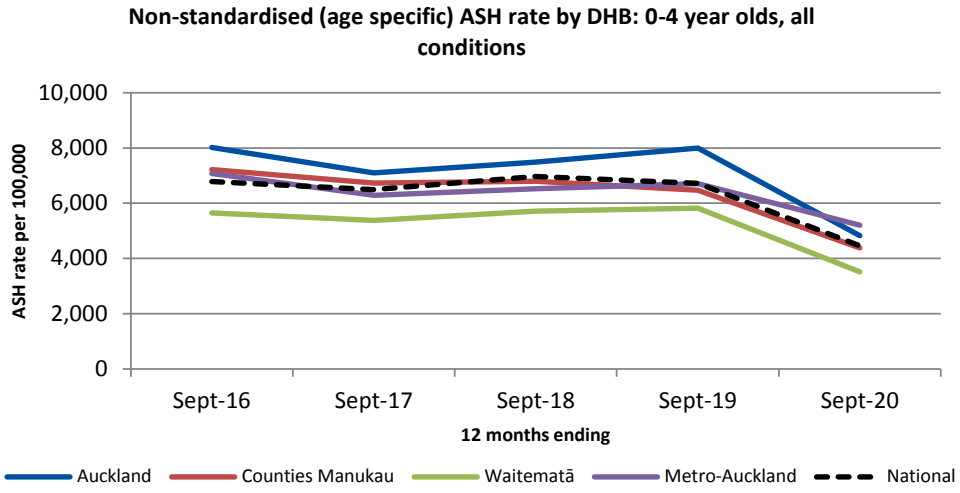
Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prevention or therapeutic interventions deliverable in a primary care setting.

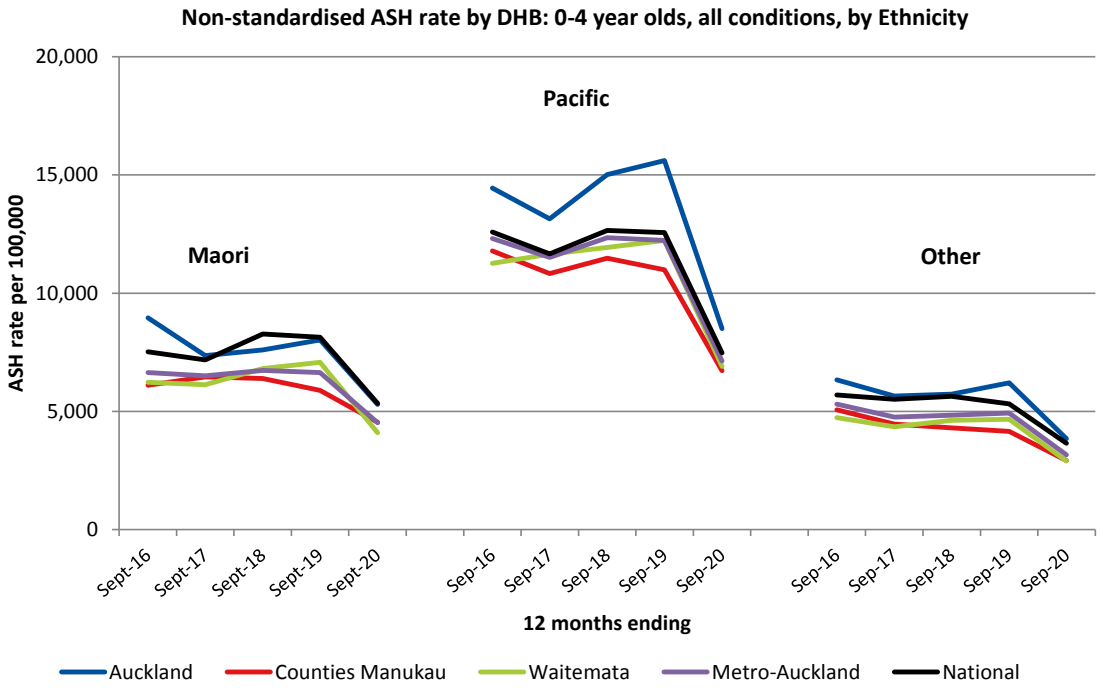
Determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure. It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor 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 2020/21, 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 2021. Ethnic specific targets are important to ensure that interventions reduce, not worsen inequity. Metro Auckland's rate is 4,162 per 100,000 for the 12 months to September 2020 for the total population. This is a 36% decrease (improvement) on the results to December 2019 (baseline) of 6,537 per 100,000 population. At an ethnic-specific level, the Māori and particularly Pacific rates also improved (by 32% and 40%) from baseline.

While these results show a very significant improvement compared to baseline, it should be noted that during the COVID-19 lockdown period (Apr-May 2020), many people avoided seeking treatment at healthcare facilities, including hospitals. Therefore lower rates of acute hospital admissions were observed during this period than expected, including admissions for ambulatory sensitive conditions, appearing to improve performance when compared to the previous year. The incidence of some ASH conditions improved through the efforts to reduce the spread of COVID-19 – seasonal influenza and other respiratory infection rates dropped due to social distancing and good hygiene practices (improved vaccination rates may also have impacted influenza rates). Performance will need to be monitored over time to determine if this improvement is sustained.





While the higher (non-standardised) rates for Pacific children and particularly Auckland DHB Pacific children persist, the decline as a result of COVID-19 is significant.

While the gap between ethnicities has declined with the overall decline in ASH admissions, when compared, rates for Pacific are still around four times that of 'Other' ethnicities across metro-Auckland for cellulitis, dermatitis and eczema and around three times the rate for respiratory infections and dental conditions.

Using health resources effectively

Total acute hospital bed days

Improvement Milestone: 3% reduction (on Dec-19 baseline) for Māori and Pacific population by 30 June 2021 (standardised)

	Milestone Target			**Actual – 12 months to September 2020 (latest available)**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Māori	623	686	567	566	610	542
Pacific	809	718	791	729	655	789

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 day's per capita rates will be illustrated using the number of bed days for acute hospital stays per 1,000 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.

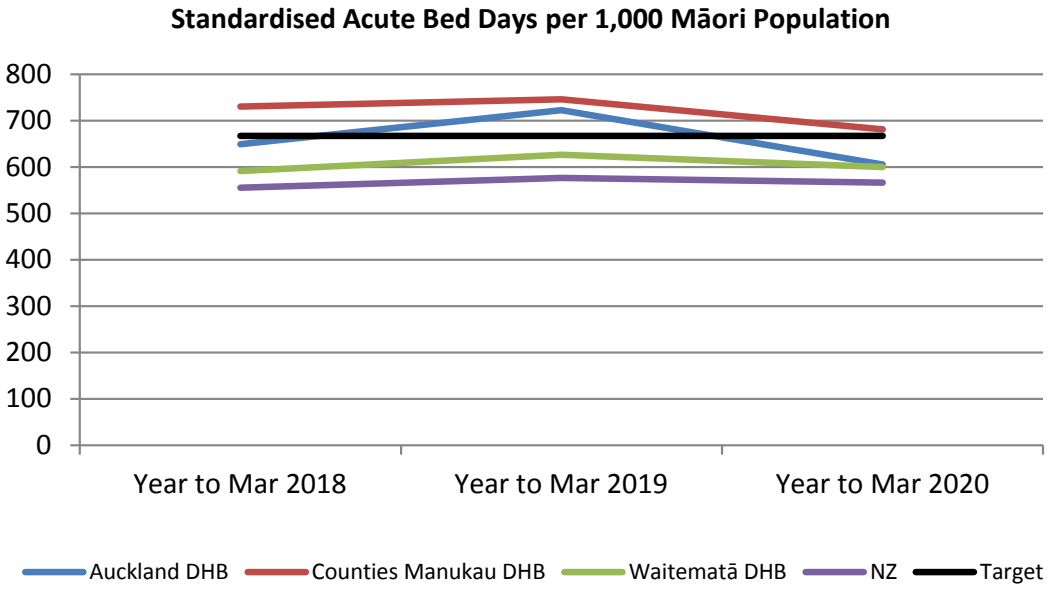
The Auckland Metro age standardised acute bed day rate per thousand population has been re-calculated and targets re-set to reduce the rate by:

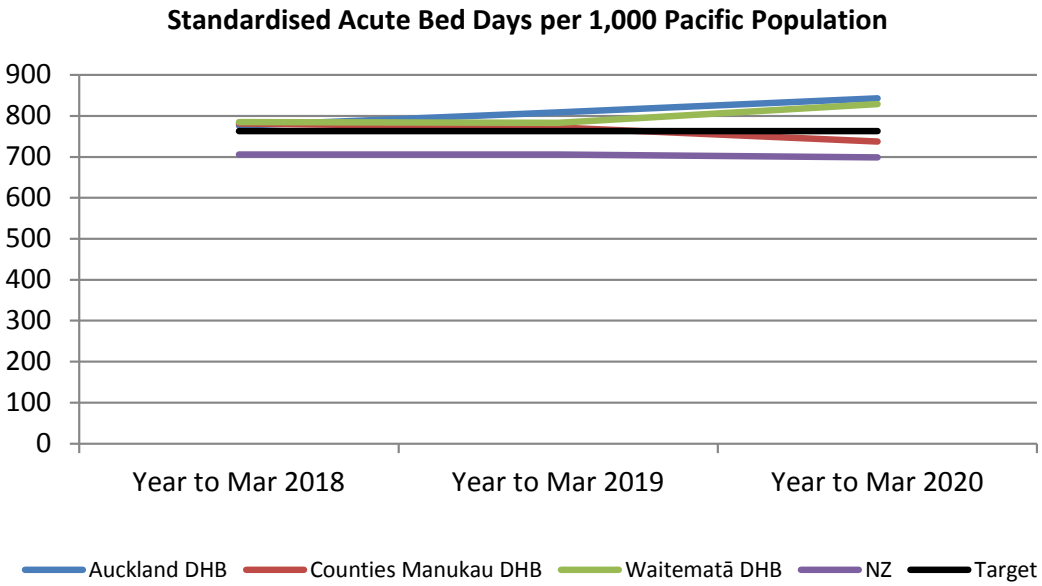
- 3% for the Māori population – target 667.0 standardised acute bed days/1000 by June 2020
- 3% for the Pacific population – target 762.6 standardised acute bed days/1000 by June 2020

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.

It is to be noted 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 in 2020, the HQSC has taken the opportunity to redevelop both the inpatient and outpatient surveys. The redeveloped survey was conducted for the first time in August 2020 and results are now available for the first quarter (August 2020 survey) and second quarter (November 2020) 2020/21 periods.

The monitored question has changed slightly between the previous Adult Inpatient Experience Survey and the new one:

> Previous question: Did a member of staff tell you about medication side effects to watch for when you went home?
>
> New question: Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?

The 2020/21 target is to achieve a 5% relative improvement on this inpatient survey question by 30 June 2021.

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, 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% relative improvement on the inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?' by 30 June 2021.

Hospital Inpatient survey – percentage of respondents who answered 'yes, completely', to the inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?'

2020/21 Targets			
Auckland DHB	**Counties Manukau DHB**	**Waitematā DHB**	**Metro-Auckland**
49.7%	61.8%	47.0%	49.4%
Results: % of 'yes, completely' result			
DHB	**Q1 2020/21**	**Q2 2020/21**	**Trend**
Auckland DHB	60.9%	66.3%	↑
Counties Manukau DHB	63.0%	61.5%	↓
Waitematā DHB	63.2%	59.0%	↓
Metro-Auckland	62.7%	61.2%	↓

With the exception of Counties Manukau DHB, the improvement target has been achieved for this measure in Q2 2020/21. However, only Auckland DHB results have improved between quarters one and two of this financial year.

Primary health care patient experience survey (PHC PES)

Primary care survey: 5% relative improvement on PES question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?' by 30 June 2021

The PHC PES was implemented in practices over the 2017/18 year. Since then, practice participation has steadily increased. As noted above, with the move to another reporting provider, the HQSC has taken the opportunity to redevelop both the inpatient and outpatient surveys. The redeveloped survey was conducted for the first time in August 2020 and results are now available for the first quarter (August 2020 survey) and second quarter (November 2020) 2020/21 periods.

Given this is the first year to monitor this particular question, no baseline data could be derived from previous years. Thus, the August 2020 results have been used as baseline to set targets. These results were very high – resulting in the targets being very high.

Primary health care patient experience survey – percentage of respondents who answered 'yes, completely', to the survey question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?'

2020/21 Targets			
Auckland DHB	**Counties Manukau DHB**	**Waitematā DHB**	**Metro-Auckland**
98.2%	96.6%	100%	98.1%
Results: % of 'yes, completely' result			
DHB	**Q1 2020/21 (Baseline)**	**Q2 2020/21**	**Trend**
Auckland DHB	93.5%	93.0%	↓
Counties Manukau DHB	92.0%	90.7%	↓
Waitematā DHB	95.9%	93.3%	↓
Metro-Auckland	93.5%	92.4%	↓

None of the three DHBs are meeting target in Q2 2020/21, although achievement is above 90% for all.

Preventing and detecting disease early

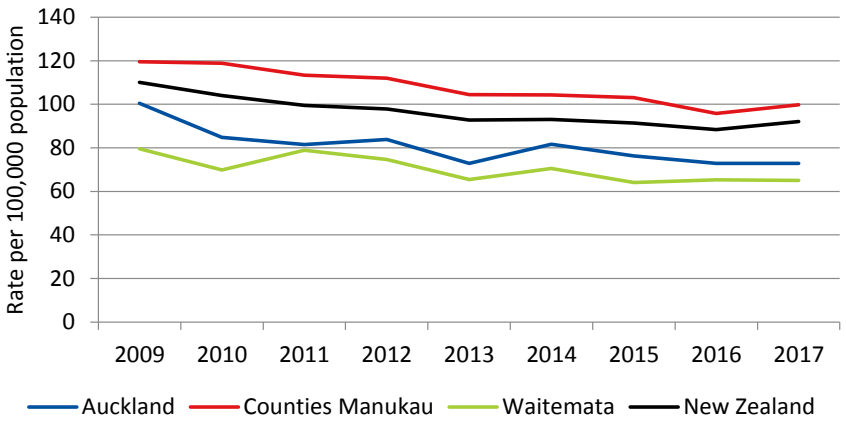
Amenable mortality

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

	Milestone Target			Actual – 2017 deaths		
	Auckland DHB	Counties Manukau DHB	Waitematā DHB	Auckland DHB	Counties Manukau DHB	Waitematā DHB
Total Pop	68.5	98.1	61.5	72.8	99.8	65.0
Māori	179.9	177.4	146.3	156.1	231.7	121.1
Pacific	150.1	180.9	150.5	177.1	170.5	142.3

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 mortality coded mortality data has been delayed, as such we are unable to provide updated results currently.

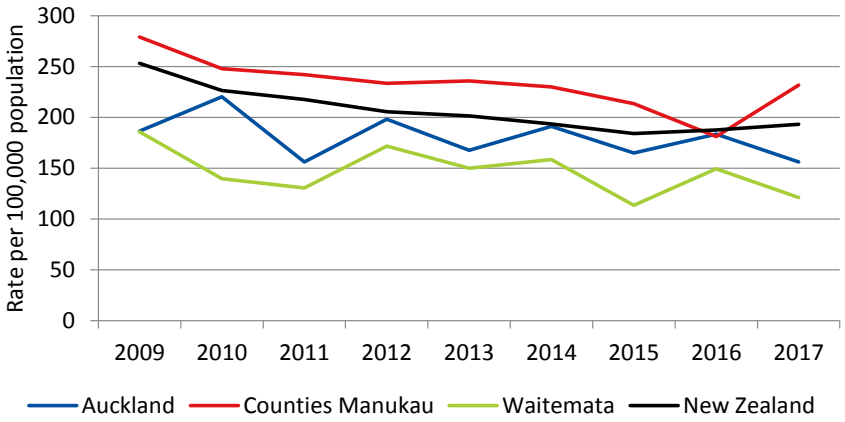
Amenable mortality age standardised rates 0-74 year olds 2009-2017



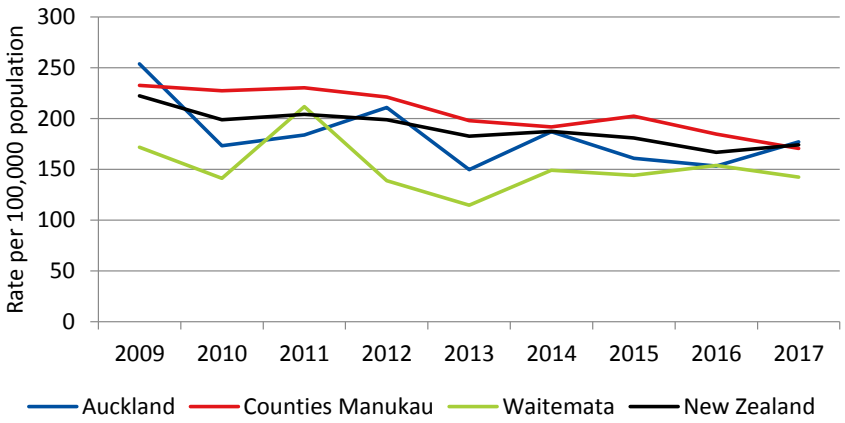
Based on trends over time, all three Metro Auckland DHBs show consistently declining rates as illustrated in the graph above, despite some fluctuation. Comparing current (2017) rates with baseline (2013) rates, there is a 2.3% decline in rates for metro-Auckland, against the targeted 6% reduction to be met by June 2021.

While rates for Māori and Pacific are also declining, the more consistent decline seen for overall rates is not evident and there has been a spike in rates for Counties Manukau DHB for Māori in the latest data.

Amenable mortality age standardised rates 0-74 year old Māori 2009-2017



Amenable mortality age standardised rates 0-74 year old Pacific 2009-2017



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 2021.

Results for the six-month period to June 2020 (latest available): males only – note this is at a population level (so may include males in this age group who are un-enrolled in a PHO).

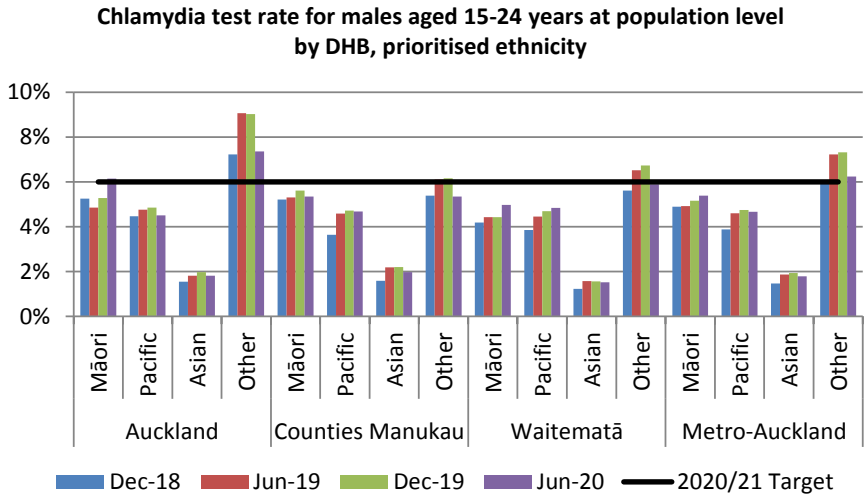
DHB	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	June 2020 Chlamydia test rate (%)	December 2019 Chlamydia test rate (%)	Change
Auckland	Māori	233	3790	**6.1%**	**5.3%**	↑
	Pacific	232	5150	**4.5%**	**4.9%**	↓
	Asian	256	14210	**1.8%**	**2.0%**	↓
	Other	1089	14790	**7.4%**	**9.0%**	↓
Counties Manukau	Māori	461	8630	**5.3%**	**5.6%**	↓
	Pacific	566	12120	**4.7%**	**4.7%**	-
	Asian	235	11920	**2.0%**	**2.2%**	↓
	Other	570	10670	**5.3%**	**6.2%**	↓
Waitematā	Māori	296	5960	**5.0%**	**4.4%**	↑
	Pacific	208	4300	**4.8%**	**4.7%**	↑
	Asian	157	10330	**1.5%**	**1.5%**	-
	Other	1247	21170	**5.9%**	**6.7%**	↓
Metro-Auckland	Māori	990	18380	**5.4%**	**5.2%**	↑
	Pacific	1006	21570	**4.7%**	**4.7%**	-
	Asian	648	36460	**1.8%**	**1.9%**	↓
	Other	2906	46630	**6.2%**	**7.3%**	↓

* 10 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 2020/21 is on increasing engagement with young people by working with general practices to encourage participation in the RNZCGP Maintenance of Professional Standards (MOPS) Youth Service audit, as well as increasing sexual health screening and funded sexual health consults for enrolled young people (including screening for pregnant woman).

At a population level, screening coverage rates for men declined slightly overall, when comparing the six months to June 2020 and the six months to June 2019, however, screening may well have been impacted by COVID-19. Between December 2019 and June 2020, rates for Māori improved slightly across the metro region, with the most improvement for Auckland DHB domiciled males, which was the only DHB to make target for Māori. However, the rates for all other ethnicities declined slightly. The gap between Māori and Other ethnicities (non-Māori, non-Pacific, non-Asian) appears to be declining over time and while this is also true for Pacific, it is less pronounced. Given the impacts of COVID-19 on this latest reporting period, further trend information will be required to ascertain if the gap data remains consistent.



Current results – at PHO enrolled population level:

Results at this level, although better, have generally decreased between reporting periods. Again, this is probably due to the impact of COVID-19 on primary care services as well as access behaviour, particularly over the lockdown periods.

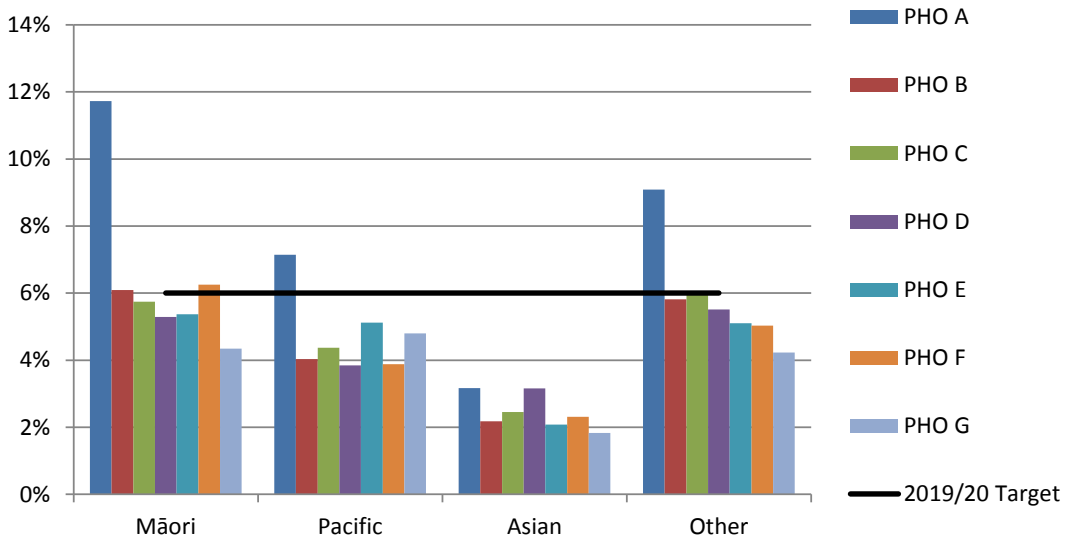
The differences between this level and population level coverage rates suggests that there is under-enrolment for this cohort of the population.

Results at June 2020 compared to December 2019 (2019/20 target 6%):

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	June 2020 Chlamydia test rate (%)	December 2019 Chlamydia test rate (%)	Change
PHO A	Māori	34	290	11.7%	9.0%	↑
	Pacific	26	364	7.1%	9.8%	↓
	Asian	35	1,104	3.2%	3.8%	↓
	Other	112	1,232	9.1%	9.7%	↓
PHO B	Māori	86	1,411	6.1%	6.2%	↓
	Pacific	61	1,513	4.0%	3.6%	↑
	Asian	49	2,250	2.2%	2.7%	↓
	Other	109	1,875	5.8%	7.6%	↓
PHO C	Māori	402	7,004	5.7%	6.2%	↓
	Pacific	367	8,405	4.4%	4.4%	-
	Asian	240	9,765	2.5%	2.6%	↓
	Other	1,512	25,105	6.0%	6.6%	↓
PHO D	Māori	74	1,398	5.3%	5.8%	↓
	Pacific	134	3,485	3.8%	4.4%	↓
	Asian	53	1,676	3.2%	3.3%	↓
	Other	107	1,942	5.5%	6.2%	↓
PHO E	Māori	61	1,136	5.4%	6.6%	↓
	Pacific	28	547	5.1%	4.9%	↑

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	June 2020 Chlamydia test rate (%)	December 2019 Chlamydia test rate (%)	Change
	Asian	37	1,780	2.1%	2.3%	↓
	Other	410	8,042	5.1%	5.8%	↓
PHO F	Māori	161	2,576	6.3%	6.9%	↓
	Pacific	255	6,572	3.9%	4.0%	↓
	Asian	76	3,287	2.3%	2.3%	-
	Other	71	1,412	5.0%	4.3%	↑
PHO G	Māori	14	322	4.3%	6.1%	↓
	Pacific	7	146	4.8%	4.9%	↓
	Asian	26	1,418	1.8%	1.9%	↓
	Other	137	3,240	4.2%	4.1%	↑

Chlaymdia test rate for males aged 15-24 years at PHO enrolled population level by ethnicity - 6 months to June 2020

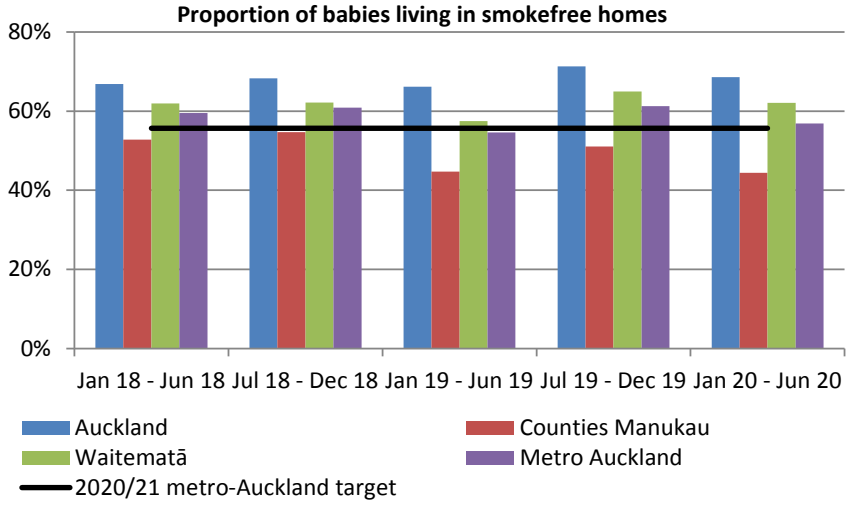


Healthy start

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% (Jan 19 – Jun 19 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%
Jan 20 – Jun 20	56.9%	68.6%	44.4%	62.1%
2020/21 Targets	**55.7%**	**67.5%**	**45.6%**	**58.6%**

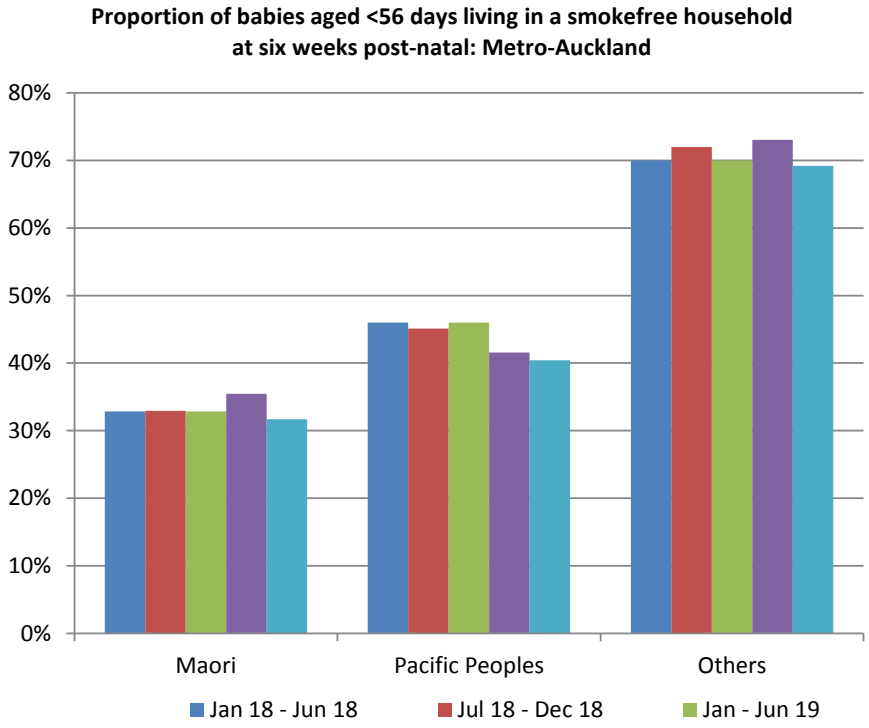


The methodology for calculating measures on previous Ministry of Health releases has been changing. The data from January 2018 uses the latest methodology. Results show that only Counties Manukau DHB is not reaching the DHB's individual target and performance has declined since the last reporting period for all DHBs.

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 56% of metro-Auckland babies live in a smokefree household at six weeks post-partum with a small improvement since the January - June 2019 reporting period.

The percentage of Māori babies living in smokefree homes is much lower than other ethnicities - 22% in Counties Manukau DHB, 39% in Waitematā DHB and 45% in Auckland DHB. Rates for Pacific are also lower than other ethnicities. Rates for all ethnicities have declined since the previous reporting period. While higher rates correlate with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations, there would also have been some impact from COVID-19 on this indicator.



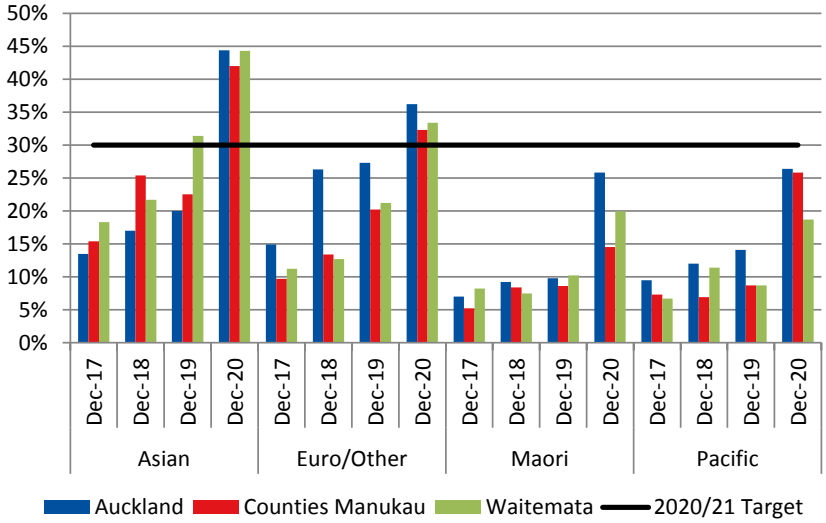
4. Improvement Activities and Contributory Measures

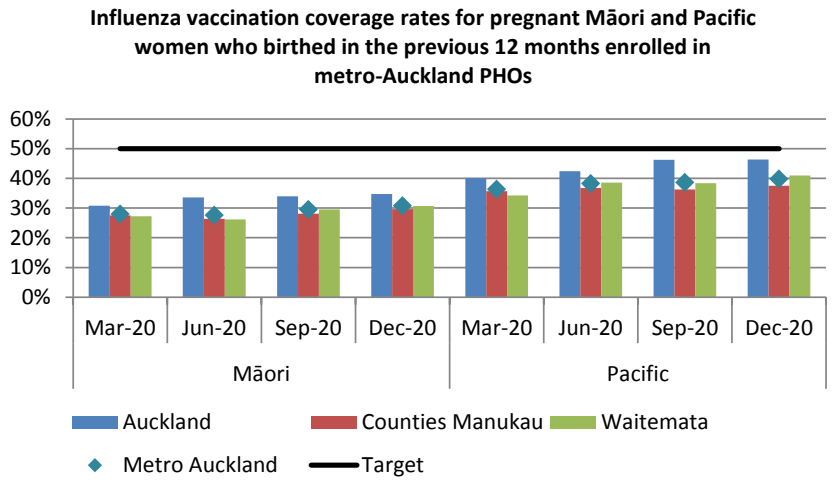
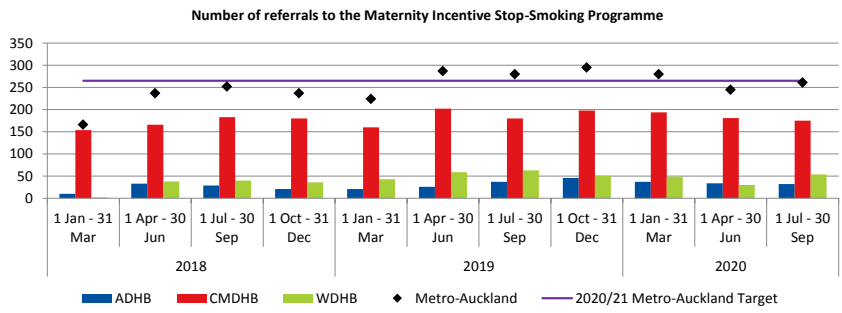
Improvement activities create change and contribute towards improved outcomes in the various SLM milestones. These activities are measured locally by contributory measures which support a continued focus in each area. Activities support the improvement of the system as a whole. For 2020/21, Auckland 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 intend to work 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	30%	***Flu vaccination rates at December 2017, December 2018, December 2019 and December 2020 for eligible children (those hospitalised with a respiratory condition)***  **Commentary** • Overall coverage has increased from 9.7% in December 2017 to 28.8% in December 2020. Coverage rates have consistently increased since monitoring and improvement activities began. • Auckland DHB domiciled children have the highest coverage at 33.2%, followed by Waitematā at 29.7% • While a coverage rate of nearly 29% has been achieved for the total population, rates for Māori and Pacific children continue to be much lower. While these rates though are also increasing, they are still below the 30% target for all DHBs • Only two of the seven PHOs have surpassed the 30% target for their eligible Māori children, while four 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** Antenatal influenza vaccination rates have improved markedly since June 2017, more than doubling 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 28% for Māori and nearly 37% for Pacific. Across 2018 and 2019 there has been a significant uplift across multiple ethnicities. To December 2020, the highest vaccination coverage rates (12 month period) are seen among women domiciled in Auckland DHB (63.0%), followed by Waitematā DHB (54.1%) and Counties Manukau DHB (42.2%). By ethnicity, Auckland and Waitematā DHBs have the best results for Māori at 36.0% and 31.3% respectively, with Counties Manukau at 23.9%.
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 is not meeting the 2020/21 target, with only Auckland DHB meeting their specific quarterly target. Referral numbers have declined over the last two reporting periods, but have been impacted by COVID-19. Note that the differences in referral number targets between DHBs reflect the size of the programme operating at each DHB – the Counties programme being much larger than the others. In the long term, PHOs believe that uptake and utilisation of the Best Start Pregnancy Assessment Tool will support bulk referrals. In the meantime, PHOs are considering ways they can query their own databases to match smoking status with antenatal blood tests for bulk referrals if practices agree. Progress has been made to get a Lead Maternity Carer representation on the SLM programme.

Alcohol Harm Reduction

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

Alcohol-related harm is recognised as an important and increasing health issue with widespread impacts across health, social, and economic sectors. The burden is not only the individual consuming alcohol, but also their whānau, friends, and the wider community. In New Zealand, rates of hazardous drinking are increasing with men, Māori, young people, and those living in more socioeconomically deprived areas at greater risk of alcohol related harm. Alcohol use is the leading risk factor for health loss for New Zealanders aged 15-49 years and is a major contributor to non-communicable disease burden e.g. cancers. It is a significant contributor to morbidity and mortality in general; for example the harmful use of alcohol is a causal factor in more than 200 diseases and injuries.

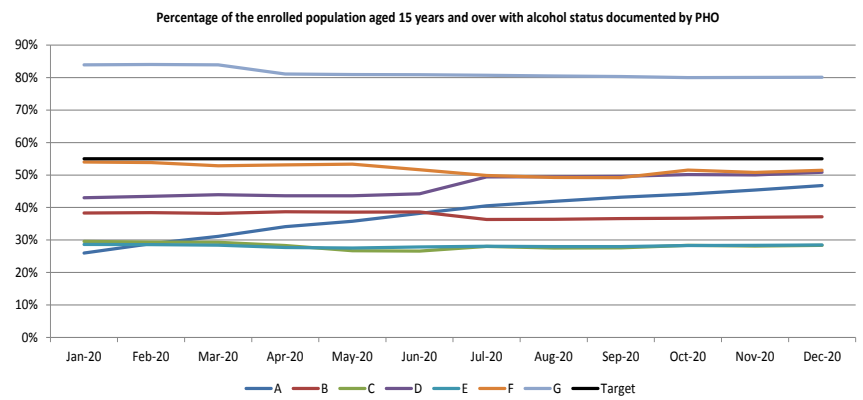
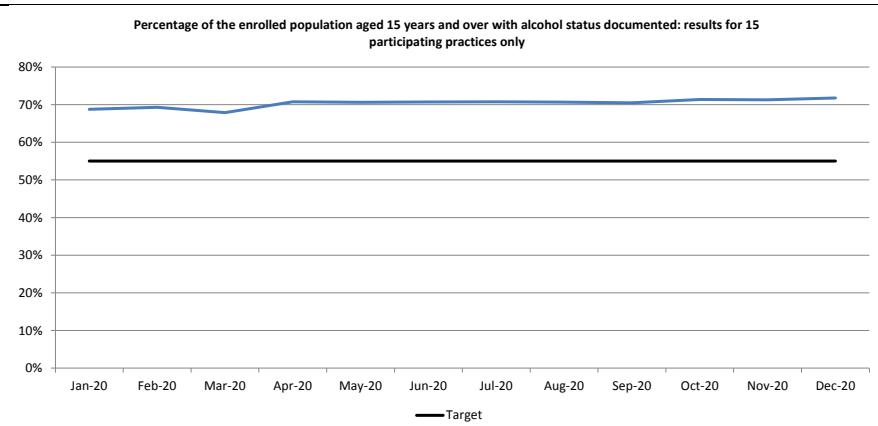
Harm reduction in alcohol, like tobacco, requires multiple health agencies and intersectoral working.

Recent work has been focused on the roll-out of a primary care based audit tool to assess patients attending clinical appointments – mainly in the Counties Manukau district. Using either the AUDIT-C or SACS (for youth) tools, patients are asked by a GP or nurse about alcohol use. Patients identified as consuming alcohol above the recommended 'low-risk drinking guidelines' can then be offered Brief Advice, including feedback about their assessment, advice and information about more appropriate levels of alcohol consumption in the context of their age and relevant health conditions/factors and, if appropriate, encouraged to access alcohol counselling.

The focus for 2020/21 is on improving the data collection and reporting on alcohol harm reduction interventions, through:

- The establishment of an alcohol ABC baseline in primary care for reporting indicators
- Providing general practices with localised resources, training and effective tools to support the systematic and equitable delivery of alcohol ABC to their enrolled population
- Improving data collection capability to multiple practice management systems.

The indicator being monitored is: the percentage of the enrolled population aged 15 years and over with alcohol status documented, with a target of **55**%. Data collection commenced during 2019. There are currently 15 Counties Manukau DHB practices formally engaged in the programme. Therefore, the results for these practices only are presented in the second graph below.

Indicator	Target	Results
Percentage of the enrolled population aged over 14 years with alcohol status documented *Note: PHOs de-identified*	55%	
Percentage of the enrolled population aged over 14 years with alcohol status documented *Note: data for participating 15 practices only*	55%	

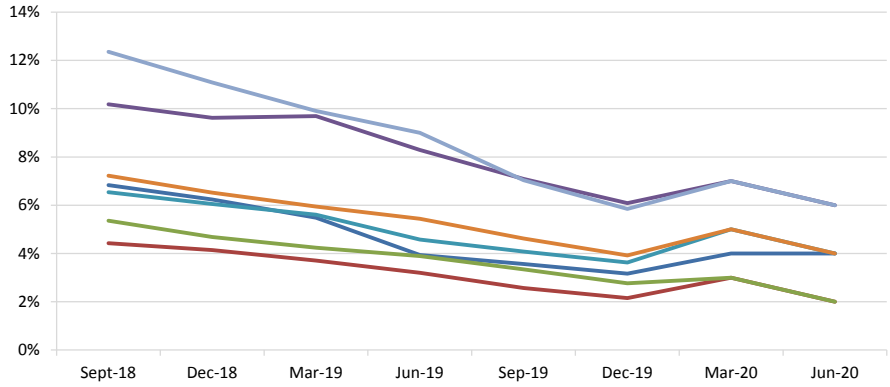
Commentary

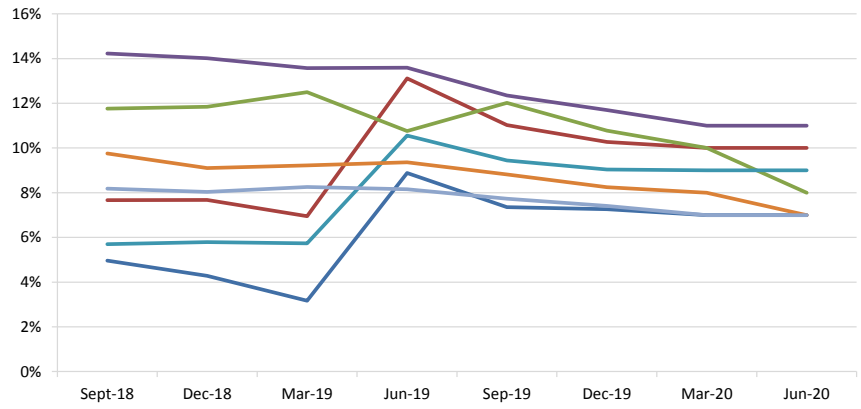
The data is only available from practices with Medtech PMS and represents 73% of the enrolled population aged over 14 years. Most PHOs are not meeting target, or only meeting it for some ethnic groups. One PHO is an exception though, reporting over 80% compliance overall and well surpassing the 55% target for all ethnic groups. 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*	6%	Referral rates have previously been measured using Read codes in the practice PMS. This has been found to be inaccurate hence a new definition was developed that measures referrals received by Ready Steady Quit and CMH Living Smokefree. **Smoking Cessation Referrals to Ready Steady Quit and Living Smokefree services** 

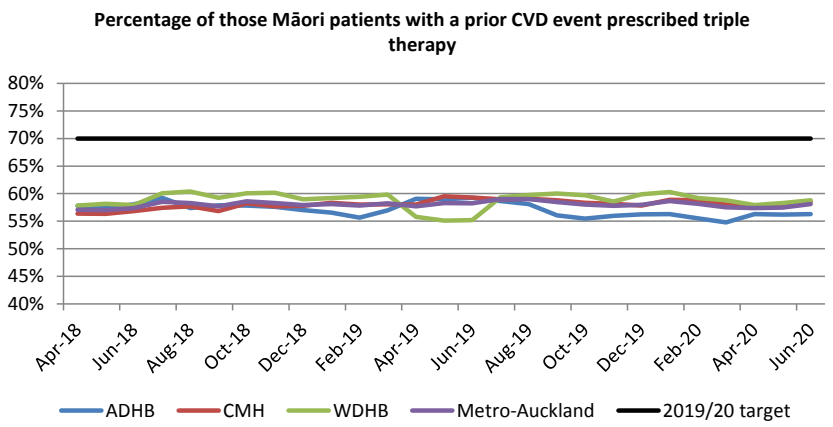
Indicator	Target	Commentary
Rate of prescribing of smoking cessation medications by PHO *Note: PHOs de-identified*	12%	Measuring prescribing rates using Read codes under reports primary care prescribing. Again, a new definition has been developed for this performance indicator that measures prescriptions supplied, sourced from PHOs' PMS systems. **Smoking Cessation Prescribed Medication (Meds)** 

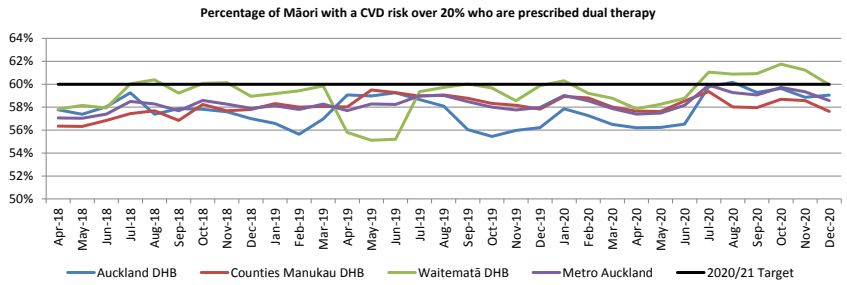
Cardiovascular Disease (CVD) Risk Assessment and Management

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.

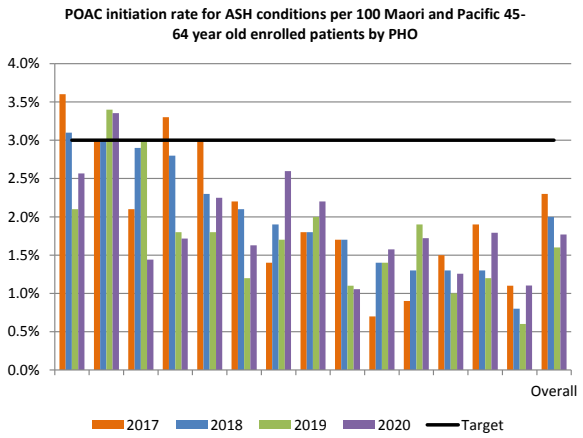
Indicator	Target	Commentary
CVD Risk Assessment (CVDRA) rates for Māori	90%	The introduction of the new CVDRA algorithms following the 2018 consensus statement has meant that primary care has needed to transition from the previous algorithm to the new one over time. The number of people eligible for risk assessment has increased as a result of the new algorithm. Considerable work has been done by PHOs to implement the new risk assessment algorithms, and the process for capturing data during the transition period is still being developed. Thus there is currently no data to report. Previous data (supplied by the Ministry of Health and based on the previous algorithm – up to December 2019) showed performance was declining over time. 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 care 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.
Percentage of Māori with a previous CVD event who are prescribed triple therapy	70%	 Results remain relatively static over time for Māori, with a relatively marked difference between Pacific and Māori (and Other ethnicities) – 55% and 48% respectively for the metro-Auckland region. Results are well below the 70% target.

Indicator	Target	Commentary
Percentage of Māori with a CVD risk over 20% who are prescribed dual therapy	60%	 Results remain relatively static over time with little difference between ethnic groups. All DHBs are at or very close to the 60% target. *Also, see commentary above.*

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.

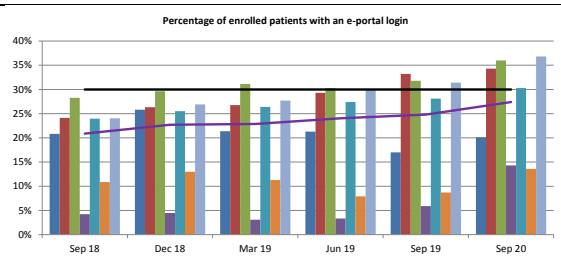
Indicator	Target	Results	Commentary
Increased POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions	3 per 100 (3%) per PHO	 **Variation by PHO (split by DHB location) across the metro-Auckland region (PHOs not identified)**	Initiation rates vary by geographic location, even where the PHO is the same. Overall, rates have improved between this and last reporting period. NHI level data is available to PHOs.

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 is missing for three of the last four quarters – it was not supplied by the Ministry of Health due to the prioritisation of COVID-19 response work. The latest available data shows the target was achieved in four 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.